New Hampshire

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 01/26/2022 10.07.16 AM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2022

End Year 2024

State DUNS Number

Number 011040545

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Bureau of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address 105 Pleasant Street

City Concord

Zip Code 03301

II. Contact Person for the Grantee of the Block Grant

First Name Julianne

Last Name Carbin

Agency Name Bureau of Mental Health Services, Division of Behavioral Health, NH DHHS

Mailing Address 105 Pleasant Street

City Concord

Zip Code 03301

Telephone 603-271-8378

Fax

Email Address Julianne.Carbin@dhhs.nh.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/2/2021 12:02:07 AM

Revision Date 1/6/2022 8:22:34 AM

VI. Contact Person Responsible for Application Submission

First Name Janelle

Last Name Lavin

Telephone 603-271-5118

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OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Julianne Carbin

Signature of CEO or Designee[1]: ______________________

Title: Director

Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE: New Hampshire

1. **Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.**

New Hampshire has dedicated great efforts, with the assistance of Community Mental Health Block Grant funding, to establish a system of care that meets the needs of all New Hampshire citizens, and considers the unique demographics of the State and the respective challenges those demographics present. This demonstration of commitment to the timely and appropriate service of its residents has been demonstrated throughout many of its programs and initiatives successes, and drives forward the commitment of the Department to continue its work in expanding and growing this system.

In 2019, the New Hampshire Department of Health & Human Services submitted to the Governor, Senate President, and Speaker of the House a 10-Year Mental Health Plan (referenced as Plan hereafter) that provided goals of its mental health services system spread out through the next 10 years. These goals were developed by taking into considerations the recommendations that were made to bolster and expand the current system in order to address identified gaps. Areas of need identified in the Plan include:

Alternatives to Emergency Department and Centralize Access

New Hampshire has seen success in establishing crisis services in targeted regions of the state. A core goal of the Plan is to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to expand New Hampshire's mobile crisis services to be statewide and integrated (serving all ages with both mental health and substance use disorders). This expansion will also include the development of a single, statewide crisis access point that will serve as a single crisis call center that will provide phone based triage, intervention, and deployment of regional mobile crisis teams. The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention. New Hampshire is still in the initial stage of implementation. Infrastructure investments are needed and it is evident that there is a need to expand stabilization services and develop a rural crisis response model for deployment and stabilization that will be practical and sustainable.

Suicide Prevention and Community Education

The Plan identified the need to coordinate suicide prevention efforts with the New Hampshire Suicide Prevention Council, the Department of Education (DOE), community mental health and substance use disorder service providers and advocacy organizations and be in line with the strategies outlined in the NH Suicide Prevention State Plan. Progress has been made but there is a significant need to conduct public outreach and education that follows national best practices of primary prevention. Additionally, as New Hampshire develops and expands services to meet the needs of its residents, we recognize that there has not been consistent marketing or advertising of such programs to aid residents in locating and accessing the services that they need. This is, in part, evidenced by the large numbers of individuals who first access the mental health system through hospital emergency rooms and/or the State hospital. With the promising growth of the service array, a messaging campaign has yet to be designed that will serve to alert and inform the public about what services are available and how to access them on a consistent basis. The Plan recognized this need in its goal of Community Education, focusing on ensuring that, as programs and initiatives develop, residents are

informed and know how to access those services. The goal includes launching a multi-media statewide campaign on what individuals can do to access services, recognize the signs of mental distress, suicide, and intervene. This also aligns with the goals established as part of the 9-8-8 implementation efforts to promote use of 9-8-8 and access to care.

Workforce Development & Infusion of Peers Throughout the System

Peers are essential to our system of care but New Hampshire does not have a robust peer workforce infrastructure or enough trained peers to meet the staffing demands. The Plan includes goals to integrate peers and natural supports through the continuum of care by expanding the availability of peers in practice settings through training and education. The Bureau worked with stakeholders to develop a Peer Advancement Work plan that outlines concrete recommendations needed to achieve this goal. The Workforce Advancement Plan was completed in May 2021 and an advisory board will convene in the fall 2021 to begin moving the recommendations forward.

Both the Bureau of Mental Health Services (Bureau) and The Bureau of Drug and Alcohol Services (BDAS) recognize that many of New Hampshire's residents experience mental illness with co-occurring substance use. To this address this reality, both Bureaus have historically worked in tandem to develop systems and services that meet the needs of all such residents experiencing co-occurring mental health and substance use disorders. Gaps continue to exist in large part due to workforce shortages and consequently strategies to cross-train the mental health and substance use workforce is needed. The Bureaus are committed to continuing this integrated work to develop systems and services that best serve the behavioral health needs of New Hampshire's citizens.

Expansion of Community Services and Housing Options

Housing is a significant barrier to recovery for many served through New Hampshire's mental health system so there is a need to address gaps that exist for permanent affordable housing. The Plan calls for an increase in bed capacity for expanded populations, including supervised housing for transition age youth, peer respite beds, crisis apartments, transitional housing and additional slots for the Housing Bridge subsidy program. There is not a centralized application process for individuals seeking mental health supported housing. Specifically the State's Housing Bridge Subsidy program that provides housing vouchers and housing support services to up to 500 individuals with severe mental illness while they await enrollment in a permanent housing voucher. There is a need to create a more accessible way for applications for the Housing Bridge program to be submitted, review, and tracked in order to expedite enrollment and more efficiently track peoples housing status over time.

The development of a data infrastructure and dashboard can assist in tracking all housing data. NH has been undergoing a multi-year data system overhaul to support the ongoing development of consistent data points, reporting, and utilization to inform our system as a whole. By investing in these platforms we can more consistently and effectively manage a multitude of programs in centrally located locations leading to more reliable and informative data.

Prevention and Early Intervention

Currently Early Severe Mental Illness/First Episode Psychosis (ESMI/FEP) is offered in one region of the state. As part of the effort to best support individuals who might be experiencing ESMI/FEP, the Bureau recognizes that services need to be available statewide. Efforts are underway to expand ESMI/FEP services to three additional regions. Infrastructure investments are needed such as provider training, technical assistance for teams to start programs in line with evidence-based practices, and targeted components of the model such as availability of family psychoeducation

statewide. In tandem with treatment programs, educating the public on what services are available and how to access them, is a core need.

In an effort to further address prevention and early intervention initiatives, New Hampshire's Infant Mental Health Plan was developed as a result of stakeholder engagement and one of the prioritized recommendations includes developing a new level of care for infants from birth to age five to support caregiver connections to foster health attachments and early mental health.

NH utilizes the Praed Foundation, who provides staff certification and data tracking to the NH Child and Adolescent Needs and Strength Tool/ Adult Needs and Strength Assessment (CANS/ANSA). The Families First Preventive Services ACT (FFSPA) and 42 USC 675a (c) requires that there is an Assessment, documentation, and judicial determination requirements in place for placement in a qualified residential treatment program. In the case of any child who is placed in a qualified residential treatment program or is being considered for treatment, a process for a comprehensive assessment, using a standardized assessment tool, must be conducted. Additionally NH SB 14 was signed into law on 7/11/2019, which requires the DHHS to determine which tool is to be used as a standard assessment tool across the system for Children's Behavioral Health. The tool selected by DHHS is the Child and Adolescent Needs and Strength Tool (CANS) that is already in use in NH by some DHHS providers. The online system for this tool is already in place and utilized by the community mental health system in NH. Due to the system expansion of child and early intervention services, ongoing access dues and increased numbers of those utilize the system leads to a higher cost of maintenance. Funds will support the next year of this increased system access needs.

Enhanced Regional Delivery and Supported Transitions

The Plan has triggered some exciting system transformation in New Hampshire and as the crisis system, children's continuum of care, and integrated mental health and physical health initiatives roll out, it is evident that alternative models need to be examined. NH recognizes that the continuum of care is inclusive of the whole person needs both within mental health and substance use, and physical health. Often times those with mental health and substance use needs struggle to access necessary care where and when needed. Data solutions are being explored and models such as Certified Community Behavioral Health Clinics (CCBHC) are being contemplated. CCBHCs expand access to care through community locations that address the whole person approach. New Hampshire is in need of engaging with a subject matter expert to assess the feasibility to adopt this infrastructure throughout our state, how to meld with the currently established system, and establish a plan that considers the long-term Medicaid payment models to ensure success. These efforts support the goal to review system models to ensure that there is a centralized infrastructure in place to enable individuals with mental health and or substance use disorders to have immediate access to care and receive support as they transition through levels of care.

Since the Plan's inception, New Hampshire has made ample progress in its work towards achieving these goals but remains focused on improving the system and addressing the gaps identified.

2. **Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.**

New Hampshire’s 10 Year Mental Health Plan (Plan) calls for centralization of access to services, including crisis services, an expansion of the crisis continuum, including Mobile Crisis Response Teams (MCRTs), and a renewed focus on suicide prevention. Expansion initiatives are underway to develop a centralized crisis operations center, statewide mobile crisis response system, and a State suicide prevention coordinator.

The current delivery system is comprised of one national suicide prevention lifeline and ten regionally based community mental health centers (CMHCs) that each provide services in their designated community mental health region, each with unique crisis phone number(s). In sum, there are more than 20 crisis phone numbers statewide, which makes accessing crisis services for individuals and families extremely confusing. This identifies the need for a central call center that can be accessed anywhere in the state for those in a crisis and that central location can provide warm handoffs to and deployment of regionally based mobile teams.

Mobile Crisis Response Team services and apartments are only located in the three, more urban regions of Nashua, Manchester and Concord. However, New Hampshire is undergoing a system re-design to expand MCRTs and crisis stabilization services into all regions of the state. These efforts align with goals of the Plan and national roll-out of 9-8-8.

Specifically, there is a need to expand Children’s Crisis Stabilization Services and the platform these are provided on. During the Covid-19 pandemic, it became very apparent that children’s services did not match the need for those with significant mental illness. While office based services were established, the need for a robust crisis response system and community deployment became apparent. Additionally, these age groups communicate in many different ways on different platforms than most of the adults being served, making it hard to establish lines of communication that felt accessible and comfortable to this age group. New Hampshire does not currently have a chat/text service therefore the Plan proposes to develop and implement this with the ARP funds to allow for increased access for this age group.

New Hampshire has one walk-in behavioral health crisis treatment center located in Concord. Crisis respite centers provide individuals with access 24/7 either by walk-in, through MCRT, via first responders, or any other way that they arrive with a need. By not having a 24/7 walk in centers accessible, individuals experiencing a crisis often find themselves attempting to access mental health or substance use disorder care through their local emergency rooms. This leads to increased wait times for these individuals as well as those looking for urgent medical care. This is a critical component of the Crisis Now model and something that New Hampshire needs to explore to identify models that will be sustainable and accessible statewide. Models such as crisis apartments, in-home stabilization services, and additional stationary crisis centers all need to be explored as potential solutions.

Additionally, there exists a need to assess and develop a crisis model to meet New Hampshire’s unique geographical needs. With a vast Northern region of the State, services can be a challenging to access due to geographical distance to service agencies and reduced or slower access to technology. A response model would look to break down those barriers, allowing residents in all regions immediate and appropriate supports during crisis, in addition to establishing a chat and text function. An

assessment will need to be completed to determine the unique needs of the more rural regions of the state, and the development of MCRT delivery options in rural New Hampshire communities.

As a part of the national roll-out of 9-8-8, New Hampshire's planning coalition has identified a need for public messaging, outreach, education, and training to inform the public about this service. Through public, first responders, and natural support system education and training, we can expect to see that those in crisis or who are experiencing mental illness receive support and services that are best suited to their individual needs, and connecting them to service agencies that can support them in the most informed way possible. It also expands the natural supports systems knowledge throughout the state allowing for more educated responses to mental illness needs and knowledge of supports available for those close to them and in their communities. A more robust messaging campaign also needs to be developed and implemented to ensure the public awareness of the 9-8-8 implementation is broadly heard and utilized throughout the state. In this same light, suicide prevention outreach and education have had minimal public messaging. This highlights another goal set in the Plan regarding Community Education. Additionally, in order to successfully implement the full vision of 9-8-8 in New Hampshire, which is inclusive of phone/text/chat, mobile, and location-based response, infrastructure investments are needed. For example, system-wide training of providers and partners; technology upgrades to enable community providers to interface with the centralized call center, law enforcement, and first responders; updates to electronic health records to improve documentation of crisis services; expanding capacity of our national suicide prevention lifeline to offer chat and text functionality; etc.

3. **Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.**

Mental Health Block Grant – Additional ARP Allocation September 1, 2021 - September 30, 2025 **Total allocation $5,083,896.74**	
Budget item	**Proposed spending for ARP**
Crisis Expansion & Infrastructure Investments - Expansion of crisis stabilization services via crisis apartments for adults w/SMI and in-home children's stabilization services for youth w/ SED and crisis stabilization centers - Development of a rural crisis response model for deployment and stabilization - Equity investments to ensure crisis system is accessible - Crisis training for providers, law enforcements, first responders, and peers - Expansion of infrastructure for implementation of statewide mobile crisis (e.g. needed technology upgrades such as data platforms, text/chat functionality, updates to EHRs, etc. - 9-8-8 & Crisis Expansion Planning Coalition; facilitate stakeholder and provider engagement for the early implementation phase of crisis system-transformation.	$2,363,432.25 2-4 year timeline
9-8-8 & Suicide Prevention Public Outreach & Education - 9-8-8 roll-out public messaging - Primary suicide prevention and access to care messaging	$400,000 3-4 year project
Peer Workforce Development - Implementation of the NH Peer Workforce Advancement Plan	$236,753 2 year project
Peer Support Services Infrastructure - Develop ethics and boundaries training curriculum - Deliver suicide prevention training - Define data requirements and platform needed for data tracking for peer delivered programs	$250,000 2 year project
Co-occurring disorder trainer - Work with MH providers to train and support the infrastructure for the provision of co-occurring disorder treatment	$250,000 4 year PT position
CANS/ANSA Assessment Access & Training for CMHC providers	$13,500
MH Housing Data Infrastructure & Dashboard - Development of a data system to input and track all MH housing data (Bridge & 811 PRA & Mainstream)	$150,000
CCBHC Enrollment Assessment - Conduct an assessment to determine feasibility for NH to adopt Certified Community Behavioral Health Clinic model of care.	$250,000
Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP) Set-Aside (required) - Funds will support training and technical assistance for providers and family members	$866,216

- Conduct outreach efforts regarding availability of ESMI/FEP services - Provide technical assistance to expansion sites	
Administration Set-Aside -Program Specialist II to provide oversight of implementation and reporting for grant deliverables.	$251,573.75
Mental Health ARP Allocation	**$5,031,475.00**

4. **Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.**

Following the distribution of the New Hampshire 10 Year Mental Health Plan (Plan), a request for information was published to garner input about how to design a comprehensive, accessible, responsive, and sustainable crisis system to meet the needs of both individuals with SMI and SED. Information gained from the more than 15 responses nationwide was used to inform the crisis transformation work that began in early 2020.

On the June 30, 2021 the New Hampshire Governor and Executive Council approved a new contract for the NH Rapid Response Access Point. This agreement, will provide the centralized crisis call center that will also dispatch and deploy Mobile Crisis Teams statewide; the population served includes individuals across the age continuum who experience a behavioral health crisis including individuals with SMI and SED. It is also anticipated that the Access Point will connect with the new national 9-8-8-crisis line and include phone, text and chat functionality. Also on June 30, 2021 Governor and Executive Council approved contracts with all 10 community mental health centers to begin planning for implementation of mobile crisis in all 10 regions. This will integrate crisis services for the general population and individuals with SMI/SED currently served through the community mental health system. New Hampshire's 9-8-8 planning coalition is also working to address access and collaboration efforts between the Access Point and Department of Safety.

Through expansion and infrastructure investments in current initiatives to address the crisis continuum, the State proposes to increase availability and accessibility to crisis apartments for adults with SMI and in-home children's stabilization services for youth with SED and crisis stabilization centers. Additionally, the State plans to explore alternative rural crisis response model(s) for deployment and stabilization while making investments in building equity to ensure the crisis system is accessible to all residents.

New Hampshire's 9-8-8 Planning Coalition guides and informs the implementation of the crisis transformation work that is underway. This multi-sector stakeholder group (as described below) is integral to informing the development of a system that is comprehensive and accessible.

In an effort to further address prevention and early intervention initiatives, New Hampshire's Infant Mental Health Plan was developed as a result of stakeholder engagement and one of the prioritized recommendations includes developing a new level of care for infants from birth to age five to support caregiver connections to foster healthy attachments early mental health. Young children birth to age five (5) can receive a mental health diagnosis and be considered SED if the DC 0-5 Manual (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and

Early Childhood) is used. DC 0-5 allows clinicians to diagnose infants and young children with mental health disorders and/or developmental disorders-which then allows clinicians to crosswalk the DC 0-5 with the DSM V. DC 0-5 also shows functional impairments, which aligns diagnostically with DSM 5, as well as the designation of SED. The CANS tool will be utilized to help determine eligibility for the proposed program. The CANS is the tool NH's community mental health centers use to determine SED for their eligibility. In addition, parent/caregiver with SMI/SED, along with their child/ren, will also be served under this program.

This service array (programming, services, and support) is prevention in that early identification and treatment of young children's SED can help prevent worsening and/or chronicity of the SED. In addition, the service array aims to improve family function and reduce adverse childhood experiences in order to prevent the development of additional SED diagnoses later on in childhood or adulthood, such as PTSD, mood and anxiety disorders. This service array is treatment in that the service array also aims to directly address the current SED in a person- and family-centered approach. This programming would include services and supports to children and their primary caregiver, once screened and found eligible using the CANS tool, and DC 0-5. The screening and eligibility process will not be included in this funding request. The services then delivered once the child is found to be eligible either through their own diagnosis and needs that indicate that they are SED, or if their primary caregiver is considered to have his/her own SED, SMI eligibility. The treatment and supportive services involved in this programming are;

- Treatment using evidences based modalities such as Child and Parent Psychotherapy
- Intensive in home services using a home visiting model.
- Peer support
- Respite- in home

New Hampshire has also expanded its efforts to increase awareness and reduce stigma related to mental illness in young people generally, and first episode psychosis specifically. We have implemented learning and education models such as Mental Health First Aid statewide. These programs have planted the seeds of awareness about mental illness and how to recognize early signs. We recognize that stigma reduction aids the general public in recognizing early symptoms, referring to appropriate services, and understanding the value in engaging treatment. As part of NH's 10-year mental health plan, early treatment models, including FEP were highlighted and identified by stakeholders as foundational recommendations in areas to address.

New Hampshire has been working on a plan to expand FEP services statewide. During SFY 2019-21, the State carried out a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide ESMI or FEP treatment model using the 10% set aside Block Grant funds. The initiative included two components; proposing a treatment model that we can scale to provide ESMI/FEP services statewide, and developing a public awareness campaign that focuses on the importance in, and availability of, early interventions.

The State is fortunate to have a national expert on our staff. Mary Brunette, MD, who serves as our Medical Director, is an Associate Professor of Psychiatry at Dartmouth-Hitchcock. Dr. Brunette has worked on the RAISE NAVIGATE research team from its inception. Dr. Brunette provides expertise to the FEP/ESMI BMHS project management team.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

New Hampshire's 9-8-8 Planning Coalition guides and informs the development of the New Hampshire 9-8-8 Implementation Plan. The Coalition is specifically tasked with the following responsibilities:

- Developing clear roadmaps for how to address key coordination, capacity, funding, and communication strategies that are foundational to the launching of 9-8-8, and
- Plan for the long-term improvement of in-state answer rates for 9-8-8 calls.

Members of the New Hampshire 9-8-8 Planning Coalition are diverse stakeholders in NH's behavioral health system including: Individuals with lived experience, Lifeline crisis center staff, NH's State suicide prevention coordinator, Law enforcement leaders, 9-1-1/PSAP leaders and major state mental health and suicide prevention advocacy groups like NAMI and AFSP, as well as staff from NH's Department of Health and Human Services, Department of Safety, Department of Justice and the Governor's Office.

The New Hampshire 9-8-8 Planning Coalition also formed subcommittees to meet more frequently on specific goals of the Implementation plan and process. These goals are focused on: Sustainable funding, Volume Forecasting and Projections, Public Messaging and Communications, Coordinating with First Responders, and Operational Capacity. The subcommittees expanded membership to include members of the public who are investing in making change to the NH crisis system. This allows for deeper participation and robust dialogue outside of traditional planning meetings.

A specific focus of NH's 9-8-8 planning coalition is through the Law Enforcement subcommittee which has representation from the Office of the Governor, Department of Safety, and Department of Justice, local first responders in both urban and rural regions, 9-1-1 and Bureau of EMS in addition to several other stakeholders. This subcommittee has identifies this need and is committed to working with the Bureau to increase first responder training.

Many of the New Hampshire's mental health system initiatives are the result of a collaborative effort between the Bureau of Mental Health Services, Bureau of Drug and Alcohol Services and the Bureau for Children's Behavioral Health. The crisis continuum and support services are designed to be an integration of services to address both mental health and substance use concerns. This spending plan reflects that New Hampshire believes in the importance of ensuring services meet the need of the client presentation to allow for a more robust delivery of services, as well as addressing workforce shortages in the field.

New Hampshire has been consistent in considering the cross-section of the Mental Health and SUD systems in the work that has been done and is currently ongoing. New Hampshire recognizes that many of its residents experience both mental health and substance use co-occurring disorders which produce needs that are best met and addressed by dually diagnosed trained staff and initiatives that are developed with this ideology in mind.

Approximately half of people with SMI/SPMI develop a co-occurring substance use disorder during their lifetime. Alcohol is the most common substance followed by cannabis, opioids and then stimulants. This rate is three times higher than general population rates of substance use disorder.

People with co-occurring SMI/SPMI and substance use disorders have higher rates of treatment nonadherence, experience a worse course of illness, utilize emergency rooms and hospitals at higher rates, and experience premature mortality.

Conversely, about a third people with substance use disorders have higher rates of co-occurring mental illnesses during their lifetime; among people in treatment settings, two-thirds have co-occurring mental illnesses with the substance use disorder. Mood disorders, post-traumatic stress disorder and anxiety disorders are common. People with these co-occurring disorders also experience worse outcomes.

Due to the high rates of co-occurring disorders among people receiving treatment in New Hampshire, clinicians need the knowledge and skills to help service recipients manage both illnesses – the substance use disorder and the mental illness - in order to achieve recovery and return to community functioning. Over the past five years, the Bureau of Mental Health Services has documented that our mental health centers have consistently lacked skills in the area of co-occurring disorders treatment. Our service providers have requested training and technical assistance in this area to help their existing employees gain the necessary knowledge and skills for evidence-based co-occurring disorders treatment.

As New Hampshire assesses and redesigns our behavioral health system of care, it is clear that additional training is required for mental health professionals in the area of substance misuse and for substance misuse professionals in the area of mental health. This funding would support a full time trainer to address these needs across the behavioral health continuum of care.

6. **Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.**

Currently, one FEP program is operational in New Hampshire. Starting in July 2021, three additional providers will begin to implement FEP/ESMP coordinated specialty care (CSC) teams. These providers requested training and funds to implement these teams in their region in order to meet the increased demand for FEP/ESMI services in their region of the state.

The State will use the ten percent set aside on the expansion of services and workforce development, to aide in the delivery of FEP/ESMI services. New Hampshire is in the process of expanding teams to three additional regions, and the funds will support a learning community, provider and family member training, professional development, expansion of core elements such as family psychoeducation, and infrastructure improvements needed to implement ESMI/FEP services in all regions.

7. **Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.**

By expanding the crisis continuum of care, NH is providing assistance to the most vulnerable populations as they attempt to avoid a psychiatric hospital stay or transition from institutional to community-based care. Additionally by lowering the emergency department utilization among individuals with co-occurring disorders and immediately connecting them with community based

providers will address the ongoing high rates of mental health and substance use concerns in New Hampshire. Studies show that the use of Peer Support Specialists are very effective for this group and increase engagement and access to services in times of need. By further educated the peer workforce throughout our state and integrating them further into all care settings, there is a higher likelihood that individuals will reach out to and engage in established services.

By recognizing the need to establish a more interlocking system of care to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple mental health and substance use disorder service agencies, New Hampshire hopes to reduce the high rates of mental health and substance use.

As a result of school and college closures due to the Covid-19 pandemic, many youth and young adults spent extensive periods of time at home and socially isolated. Consequently, New Hampshire is experiencing an increased demand for children's behavioral health services and specifically an increased need for specialty services to treat youth who are experiencing FEP/ESMI. The usage of the identified FEP/ESMI 10% set aside further supports the development and establishments of programs to address these needs.

The Office of Health Equity (OHE) assures equitable access to effective, quality programs and services across all populations, with specialized focus on racial, ethnic, language, gender and sexual minorities, and individuals with disabilities. OHE provides coaching and TA to the Bureau as well as external organizations to improve systems and practices for organizations to be able to serve all people with high quality care and services. These include effective strategies for communication access, cultural competence, data collection to identify disparities, community engagement, CLAS Standards implementation, gender identity 101, immigrant/refugee integration, and more. The Bureau often partners with OHE on data collection standards, training of providers, and technical assistance needed to ensure programs and services are meeting the needs of all populations in our state.

Specifically, the OHE has worked with NH's 9-8-8 planning coalition to provide an equity foundation across the work of all subcommittees and prioritized a resident centric approach to building a system that is community driven and community informed and inclusive of voice of underserved and unserved populations including those with lived experience, people who use drugs, immigrant and refugee communities, deaf and hard of hearing residents, and voices of youth being prioritized in the planning.

8. **Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (**https://www.healthit.gov/isa/ **), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.**

The MH Housing Data Infrastructure and Dashboard planned for implementation will be a cloud hosted solution leveraging a HIPAA compliant platform and will not employ

interoperability functions and as a result there are no plans at the moment to employ health IT standards as it relates to connecting systems together. The planned effort is goaled at streamlining services by replacing a legacy system requiring manual processing with the cloud accessible system for providers and state employees to utilize. The system will not be connected to other systems at this time.

The Department of Health and Human Services leverages National Institute of Standards and Technology (NIST) standards, NIST is a supporting collaborator for the Office of the National Coordinator certification criteria in health IT products. These standards describe the security requirements surrounding the data and systems that are utilized by the department to include the data classification, data sharing, information risk management, disposition of data and incident management. As part of the implementation if the scope changes the department will update the scope for approval (as applicable) along with a comprehensive review and update of any standards in accordance with the Office of the National Coordinator certification criteria in 45 C.F.R 170 as well as consider standards identified in the Interoperability Standards Advisory.

Addendum to 9-8-8 Section

The State of New Hampshire is requesting a waiver for the American Rescue Plan Act Funds Application to allow for a public messaging campaign activity.

9-8-8 is a new, three-digit number for mental health crisis, substance misuse, and suicide response which will be launched nationally by July 2022. When implemented, calls to the new 9-8-8 number will be automatically routed to the National Suicide Prevention Lifeline's network of local crisis call centers.

In 2018, suicide accounted for the deaths of 279 residents and cost the State over $222M in lifetime medical and work loss costs. Nationally, suicide is the second leading cause of death for those aged 10 through 34, the 4th leading cause of death for people aged 35-44, and the 8th cause of death for those aged 55-64. Suicide death rates in New Hampshire are approximately 35% higher than the national rate (19.27 per 100,000 in NH compared to 14.21 per 100,000 nationally in 2018). New Hampshire ranks 12th in the country for suicide deaths, and while suicide is the 8th leading cause of death across all Granite State residents, it is the 2nd leading cause of death for those aged 10-44.

New Hampshire has seen success in establishing crisis services in targeted regions of the state. A core goal of the Plan is to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to expand New Hampshire's mobile crisis services to be statewide and integrated (serving all ages with both mental health and substance use disorders). This expansion will also include the development of a single, statewide crisis access point that will serve as a single crisis call center that will provide phone based triage, intervention, and deployment of regional mobile crisis teams. The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention. New Hampshire is still in the initial stage of implementation. Infrastructure investments are needed and it is evident that there is a need to expand stabilization services and develop a rural crisis response model for deployment and stabilization that will be practical and sustainable.

SUPPLEMENTAL JOB DESCRIPTION

Classification: PROGRAM SPECIALIST II
Function Code: XXXX-XX

Position Title: Program Specialist II
Date Established: XX/XX/XXXX

Position Number: XXXXX
Date of Last Amendment: XX/XX/XXXX

SCOPE OF WORK: To assist the State Planner in the management and oversight of the Substance Abuse and Mental Health Service Administrations (SAMHSA) federally funded Community Mental Health Services Block Grants through the planning and monitoring of Grant activities including contract planning, monitoring, implementation, evaluation, and reporting.

ACCOUNTABILITIES:

- Provides technical assistance and support for the implementation of Community Mental Health Block Grant activities.
- Coordinates with professional staff in other work units concerning the development of projects and programs.
- Collaborates with Bureau staff, provider agencies, peer/family constituents, and other stakeholders, in the development and implementation of service system monitoring activities.
- Responds to requests for current information from contracted vendors, Community Agencies, and the Mental Health Planning and Advisory Council members; distributes information regarding state and federal policies and procedures to individuals, groups, and community mental health centers and peer support agencies.
- Monitors contract compliance in the area of invoice submissions.
- Assist the State Planner in the oversight of Crisis Expansion, Suicide Prevention Public Outreach & Education, Peer Workforce Development, Peer Support Services Infrastructure, and Co-Occurring Mental Health Disorder Training contract oversight.
- Maintains an electronic filing system of past and present BG funding requests, and associated contracts, as well as contract progress.
- Assists the State Planner in contracting with community mental health centers, peer support agencies, and other providers.

MINIMUM QUALIFICATIONS:

Education: Bachelor's degree from a recognized college or university with major study in program planning, social work, psychology, mental health, social services, public administration, human services or related field. Each additional year of approved formal education may be substituted for one year of required work experience.

Experience: Three years' experience in program planning, social work, psychology, mental health, social services, public administration, human services or related field, with responsibility for program planning, monitoring and evaluation. Each additional year of approved work experience may be substituted for one year of required formal education.

License/Certification: Valid New Hampshire driver's license.

RECOMMENDED WORK TRAITS: Knowledge of the policies and regulations relevant to the program area in which assigned. Knowledge of grant proposal writing. Knowledge of training, planning, budgeting and programming within specialized program area. Working knowledge of research and planning methods and planning techniques. General knowledge of current social and economic problems. Ability to detect and define problem areas and causes and to create and develop effective solutions, including the exercise of sound judgment in evaluating situations, planning action, making decisions and setting priorities. Ability to work independently to develop new or alternative approaches to meet changing and variable conditions. Ability to communicate effectively orally and in writing. Ability to establish and maintain effective working relationships with various levels of government and the general public. Must be willing to maintain appearance appropriate to assigned duties and responsibilities as determined by the agency appointing authority.

DISCLAIMER STATEMENT: The supplemental job description lists typical examples of work and is not intended to include every job duty and responsibility specific to a position. An employee may be required to perform other related duties not listed on the supplemental job description provided that such duties are characteristic of that classification.

SIGNATURES: I have reviewed this job description for content.
Reviewer's Name, Title & Position #: Lauren Quann, Administrator of Operations, #9U411

Reviewer's Signature ______________________ Date Reviewed ______________________

I have reviewed the content of the above job description with my supervisor.

Employee's Name and Signature ______________________ Date ______________________

Supervisor's Name, Title, & Position #: Janelle Lavin, Program Planning & Review Specialist, #14916
I have discussed the work responsibilities outlined by this supplemental job description with the above employee.

Supervisor's Signature ______________________ Date Reviewed ______________________

Jennifer J. Elberfeld MR XX/XX/XXXX

Division of Personnel ______________________ Date Approved ______________________

HR – XX/XX/XXXX

MHBG ARP funding Plan: Internal working document

MHBG ARP funding Plan: Internal working document

*Regular block grant rules apply. Available September 1, 2021 until funds exhausted, but no later than September 30, 2025.

Total allocation $5,031,475 - $4,276,753.75 general, $503,147.50 ESMI required set-aside and up to $251,573.75 for admin.

Description	Budget
Crisis Stabilization expansion of services (years 2-4)	$ 968,432.25
Consultant to develop Crisis Stabilization Model and provide 1-year of training and TA supports/services.	$ 200,000.00
Rural implementation of mobile crisis and crisis stabilization services	$ 400,000.00
Equity Investments to ensure crisis system is accessible	$ 50,000.00
Crisis training for providers, law enforcements, first responders, and peers & new mental health professionals.	$ 300,000.00
Expansion of infrastructure for implementation of statewide mobile crisis	$ 300,000.00
9-8-8 & Crisis Expansion Planning Coalition	$ 145,000.00
Crisis Expansion & Infrastructure Investments TOTAL: ***Allocations can vary within the category**	**$ 2,363,432.25**
Public education & outreach	$ 400,000.00
peer workforce development	$ 236,753.00
peer support services infastructure	$ 250,000.00
co-occuring disorder trainer	$ 250,000.00
CANS/ANSA	$ 13,500.00
MH Housing data	$ 150,000.00
CCBHC enrollment assessmnet	$ 250,000.00
ESMI/FEP set aside	$ 866,216.00
Program Specialist II	$ 251,573.75
TOTAL	$ 5,031,475.00

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Julianne Carbin

Signature of CEO or Designee[1]: Julianne Carbin

Title: Director Bureau of Mental Health Services

Date Signed: 9/1/2021
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
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c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Julianne Carbin

Signature of CEO or Designee[1]: [signature]

Title: Director Bureau of Mental Health Services

Date Signed: 9/1/2021
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standarc for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
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   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Julianne Carbin

Signature of CEO or Designee[1]: Julianne Carbin

Title: Director Bureau of Mental Health Services

Date Signed: 9/1/2021
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Julianne Carbin

Signature of CEO or Designee[1]: Julianne Carbin

Title: Director Bureau of Mental Health Services

Date Signed: 9/1/2021

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

August 28, 2017

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Formal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Mental Health Block Grant (MHBG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services (NH DHHS), which will serve as the State Mental Health Authority (SMHA). I authorize the NH DHHS Director of the Bureau of Mental Health Services, or anyone officially acting in this role in the instance of a vacancy, to administer transactions required for the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.governor.nh.gov/ • Email: governorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Julianne Carbin

Title

Director

Organization

Bureau of Mental Health Services

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services.
The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

System Overview

In State Fiscal Year (SFY) 2020, 3.3 % of NH's 2020 estimated population of 1,377,529 people: 45,541 individuals, including adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), were engaged in the public mental health system. (Source: U.S. Census and SAMHSA URS tables).

As the State of New Hampshire Mental Health Authority (SMHA), the Bureau of Mental Health Services (BMHS) and Bureau of Children's Behavioral Health (BCBH) responsibilities include: designing and planning our service system;; contracting with the private providers that deliver services and managed care companies that manage services and payments; and regulating and monitoring New Hampshire's system of public mental health services. This system is available for eligible adults with a serious, or a severe and persistent, mental illness (SMI/SPMI) and children with a serious emotional disturbance (SED), the populations the State MH system is statutorily required to assist. In addition, the BMHS and BCBH oversee new program development and provide training and technical assistance to the community mental health system and their partners in the NH service system.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The New Hampshire Department of Health and Human Services (DHHS) is the largest agency in New Hampshire state government, responsible for the health, safety and well-being of the citizens of New Hampshire. 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.

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

New Hampshire, in compliance with the Social Security Act Title XIX §1900, has established a system of care for individuals with mental illness in a comprehensive system of care. The NH Department of Health and Human Services is the agent for the variety of Departments, Divisions, and Bureaus that ensure these functions. Below we will describe the many elements of our system and the treatment values our system promotes.

Rehabilitative Services

Of particular interest within the context of this grant application, New Hampshire's mental health service system is administered by the Department of Health and Human Services (DHHS) Bureau of Mental Health Services (BMHS), that serves as the State Mental Health Authority (SMHA). The BMHS, as part of the Division for Behavioral Health (DBH), works with the Bureau for Children's Behavioral Health (BCBH) to maintain and coordinate policies governing New Hampshire's system of care for adults with severe mental illness (SMI) and youth with severe emotional disturbance (SED). This governance ensures the comprehensive, effective, and efficient system of services for persons with mental illness intended to reduce the occurrence, severity and duration of mental, emotional, and behavioral disabilities, and prevent mentally ill persons from harming themselves or others.

Community-Based Mental Health

Rehabilitative services are provided through 10 regional community mental health centers (CMHC) and other community-benefit organizations. CMHCs are private, non-profit providers that contract with the SMHA as providers of designated behavioral health services in specific geographic regions.

State Eligibility for Community-Based Mental Health Services

New Hampshire's current statutes and administrative rules detail the SMHA's authority. Through its provider network, the SMHA maintains responsibility for the determination and redetermination of the eligibility of individuals for community-based mental health therapeutic and rehabilitative services which are covered under New Hampshire's Medicaid State Plan Rehabilitation Option and Targeted Care Management Option.

Per New Hampshire's Administrative Rules and State Medicaid Plan, a Community Mental Health Program (CMHP) shall provide the following, either directly or through a contractual relationship:

►Intake assessment

►Medication services, including psychiatric and nursing assessment

►Case management

►Individual service plan development and monitoring

►Discrete employment services for adults with mental illness

►Mobile, psychiatric emergency services

►Outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system and providing non-office-based diagnostic and treatment services

►Collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options

►Individual, group, and family psychotherapy

►Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support

►Evidence-based illness management and recovery services, including those services provided in community settings

► NHH census management services, including a staff liaison who has NHH privileges and participates in NHH treatment and discharge planning meetings on a regular basis

► Peer Support Services

►Specialized treatment services to eligible persons with mental illness and a concomitant alcohol and/or substance use disorder

Supported Employment

For nearly 20 years all Community Mental Health Centers (CMHCs) have provided Evidence-Based Supported Employment (EBSE), based on the Dartmouth model. The Community Mental Health Agreement (CMHA) called for the State to expand its delivery of supported employment services, which includes providing individualized assistance in identifying, obtaining, and maintaining integrated, paid, competitive employment: the CMHA called for the State to increase its penetration rate of individuals with SMI receiving EBSE services to 18.6 percent of eligible individuals with SMI by June 30, 2017. As of March 2019, the statewide penetration rate is 21.6%.

Supported Employment is emphasized in the CMHA as an integral part of the Assertive Community Treatment (ACT) program and is embedded in the requirement for improved discharge and transition planning from Glencliff Home and New Hampshire Hospital.

Housing Services

One of the most significant challenges that individuals with mental illness face is the inability to secure and maintain safe, affordable housing. Limits on income and transportation are two common barriers to finding housing in safe, accessible neighborhoods. Everyone's needs are different therefore, a variety of housing options need to exist in order to meet the support needs and housing preferences of diverse individuals with mental illness. Stable housing is an important part of recovery and although it may take some time to find the right home, NH has several programs described here to help people access the housing opportunities appropriate to the level of care they need.

The primary program, Housing Bridge Subsidy Program (HBSP). The HBSP prioritizes individuals ready for discharge from New Hampshire Hospital, Glencliff Home, and Transitional Housing. Additional prioritized individuals include those being served by Assertive Community Treatment teams in the community who are homeless or at risk of becoming homeless due to their economic circumstances, and

individuals served by CMHPs currently in community residences who are ready to transition into the community.

HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, and ongoing supports and access to mental health services (if desired by the individual). At least 400 individuals receive a State subsidy at any one time that combined with the individual's own contribution toward rent, fulfill monthly rent payments and maintains the individual's access to the apartment. This also allows the individual to remain on a waiting list for traditional HUD funded programs, other municipally administered programs, or until the individual's own income exceeds the HBSP's financial eligibility guidelines.

The Housing Bridge Subsidy program, administered by the SMHA, is proving to be highly successful, moving eligible persons out of the state hospital or transitional housing, as well as individuals facing chronic homelessness, into safe, affordable residences in the community. This program uses NH general fund dollars to provide housing case management services and rental subsidies to adults with SMI who are homeless or at risk of becoming homeless.

Housing Bridge Subsidy Program: Clients Linked Measure	*As of 3/31/2021*	*As of 12/31/2020*
Housing Bridge Clients Linked to Mental Health Care Provider Services	*375/410 (91.5%)*	*356/396 (90%)*

(Source: New Hampshire Community Mental Health Agreement Quarterly Data Report: January - March 2019)

Additionally, the State supports individuals who need more intensive supports and services to return to the community post psychiatric hospitalization through transitional housing programs (THP). These programs combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living. Transitional Housing Programs offers the following:

- Services that are designed to be responsive to the unique needs of the individual and to effectively engage natural and community services support systems so that community integration is wholly obtainable.
- Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational and day treatment services.
- Support for community connectedness and family involvement.
- Open communication with families and individuals.
- A comprehensive approach to service delivery driven by consumer involvement.
- Evidence-based practice approaches that include Illness Management and Recovery and IPS/Supported Employment.

State provides members of the target population who do not need ongoing supports to maintain housing with access to HUD supported 811 units. This includes providing assistance with the application process, locating available units, and working with landlords to successfully secure housing. Units accessed under this program are, in effect, long term expansions to NH's affordable housing inventory – created specifically for this population under a grant. The State expanded this service in the previous year to serve 79 more individuals. Twenty new sites, geographically distributed in the state in ten different towns, enabled these individuals to leave institutional settings and return to the community through a more integrated model specific to their needs.

Lastly throughout 8 of the 10 CMHCs regions exists a total of 120 community residence beds that are agency run residences that provide an independent living arrangement in which on site daily living support and skill building is provided by the staff of the CMHC. These residences provide a supported living environment for those who may not be able to reside on their own without assistance but seek a more independent lifestyle while maintaining their recovery in their community.

Health and Mental Health Services

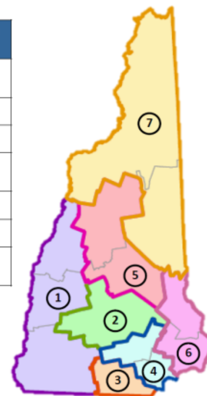
Through the New Hampshire's 1115(a) Medicaid Waiver, the Delivery System Reform Incentive Payment Program, regionally-based networks of providers called Integrated Delivery Networks ('IDNs') have been a driving system transformation by designing and implementing projects in each geographic region. These projects have spanned a variety of populations and strategies to improve quality of care, communication between providers and integration of services. NH is in the final year of its 5-year DSRIP waiver funding. The department is exploring lessons learned and successes the department will promote in an ongoing fashion.

Integrating the MH/SUD Portal and its regional hub and spokes within the IDN structure, while simultaneously extending the reach of the IDNs beyond the Medicaid population makes sense, as the IDNs seek sustainability beyond the current period of grant funding.

Seven NH IDNs have been established, covering every region of the state.

Illustrative IDN	Regional Public Health Networks (RPHN) Included	# of Medicaid members
1. Monadnock, Sullivan, Upper Valley	Greater Monadnock, Greater Sullivan County, Upper Valley	21,550
2. Capital	Capital Area	15,520
3. Nashua	Greater Nashua	19,110
4. Derry & Manchester	Greater Derry, Greater Manchester	34,900
5. Central, Winnipesaukee	Central NH, Winnipesaukee	15,230
6. Seacoast & Strafford	Strafford County, Seacoast	25,440
7. North Country & Carroll	North Country RHPN, Carroll County RHPN	15,300

Providers in each IDN region are encouraged to work together to form one IDN, particularly in less populated parts of the State.



One example of the work conducted by IDNs was to improve transitions is the community re-entry program. Research indicates that significant numbers of adults in correctional facilities and youth in juvenile justice residential facilities have diagnosed and undiagnosed mental illness and/or substance use

disorders. Community re-entry is a time-limited program to assist those individuals with behavioral health conditions to safely transition back into community life. The program is initiated pre- discharge and continues for 12 months post discharge.

The program's objectives focused on:

- Supporting adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues (mental health and/or substance misuse or substance use disorders) in maintaining their health and recovery as they return to the community.
- Preventing unnecessary hospitalizations and ED usage among these individuals by connecting them with integrated primary and behavioral health services, care coordination and social and family supports.

The project approach will blend after-care planning efforts that occur within corrections with enhanced case management, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

Public and Private Employment Services

NH's Medicaid for Employed Adults with Disabilities (MEAD) program and the Supplemental Security Income (SSI) Plan to Achieve Self Support (PASS) program allows adults with disabilities, including mental illness, to work without losing their Medicaid eligibility.

The state has a number of employment services available through the New Hampshire Department of Employment Security (DES) and NH Works.

Additional services are available through the Division of Vocational Rehabilitation (DVR), of the NH Department of Education (DOE).

Vocational Rehabilitation is a joint State/Federal program that seeks to empower people to make informed choices, build viable careers, and live more independently in the community.

Work Incentive Coordinators at Granite State Independent Living (GSIL), a statewide private non-profit and New Hampshire's only Center for Independent Living, provide assistance to individuals with disabilities who are interested in working while retaining their Medicaid eligibility. More than 51% of board members and staff at GSIL identify as individuals with disabilities.

Among adults served in New Hampshire's community mental health system in 2021, 55% of those aged 18–20, and 72.9% of those aged 21–64 participated in the labor force. The increased implementation of Evidence-Based Supported Employment in NH's CMHCs and NH Peer Support Agencies and Clubhouse programs all promote recovery through employment.

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

Educational Services

New Hampshire public schools provide an array of behavioral health services to students. Community-based mental health and other rehabilitation programs necessarily possess an educational and/or vocational aspect. Community Mental Health case management programs work closely with schools, incorporating Individual Education Plans (IEPs) or 504 plans that may be managed by school Special Education programs on behalf of an SED child or youth, into their mental health treatment.

Schools throughout New Hampshire seek to support all students, and particularly those who need additional resources in order to access an appropriate, rigorous, and individualized education. The Department of Education (DOE) supports the education of the whole child, and in doing so, recognizes the need for evidence-based, timely, and seamless interventions. To this end, the Bureau of Integrated Programs at the DOE supports a balance of local participation and statewide administration. Specifically, the Title programs do not mandate how a school or district may use its funds so long as those funds meet the intention of the law. Schools and districts use needs assessments to ensure the neediest students have access to appropriate supports. Through their needs assessments, schools identify students who are struggling with behavioral health issues and work with care providers, community members, parents, and at times students themselves in order to choose the best intervention based on a student's needs. The process itself demonstrates elements of a system of care.

In NH, Services and programs to assist adults with SMI in improving or attaining their educational goals have traditionally been provided by Vocational Rehabilitation. The mission of New Hampshire Bureau of Vocational Rehabilitation is to assist eligible New Hampshire citizens with disabilities secure suitable employment and financial and personal independence by providing rehabilitation services.

Substance Use Disorder Treatment

The striking escalation of substance misuse is affecting individuals, families, and communities throughout the state. In 2020, there were 413 total drug deaths, of which 356 deaths involved opiates/opioids. Reducing substance use disorders and related problems is critical to the physical and mental health, safety, and overall quality of life of New Hampshire residents, as well as the state's economy. Substance use disorders are preventable and treatable, and the State is implementing a comprehensive and lasting response to address this epidemic.

Recognizing that substance use disorders (SUD) are complex, chronic, and life-threatening diseases, New Hampshire is striving to implement a comprehensive approach toward a continuum of care that includes prevention, treatment, and recovery services as an integral part of every region of the state's public health and healthcare system. The State's collective response to date, as well as the continued coordinated response, moves New Hampshire further toward that goal.

NH- DHHS has been authorized by the Governor and Executive Council to enter into agreements with multiple vendors to provide substance use disorder prevention, treatment and recovery support services statewide.

The importance of the ability of the state to provide SUD treatment has increased because of the availability of treatment services through Medicaid.

Between 4/1/2020 and 3/31/2021, the number of Medicaid recipients that NH-DHHS reported received the following services;

- 63,132 Medicaid recipients received mental health services
- 15,078 Medicaid recipients received substance use disorder services

"State Opioid Response (SOR): "Hub and Spoke"

For 2019, NH's Office of the Chief Medical Examiner reported 415 deaths due to drug overdoses, down for the second year in a row (2018 - 471; 2017 – 490), which is counter to national trends.

SAMHSA State Opioid Response (SOR) funding led to the establishment of The Doorways on January 1, 2019. The 9 Doorway locations throughout the State create clear points of entry for any resident with an opioid use disorder (OUD) or Stimulant Use Disorder (StimUD) with help less than an hour away. Funding is also expanding access to MAT, peer recovery supports services, and evidence-based prevention programs, among other activities.

The program model includes:

- Increasing availability of naloxone for those at risk of an overdose event.
- Expanding access to residential treatment.
- Increasing the Doorways' funding for services such as co-pays, transportation, childcare, housing and other social services to enable their clients' participation in treatment and recovery services.
- Enhancements to services funded through the SOR grant, including the 24/7 hotline: the dial 211 call center capacity, medication assisted treatment, and those designed to serve justice-involved individuals, pregnant women and children and families.

In its first two years, the Doorways program served 18,283 individuals, including 6,333 clinical evaluations, and 10,100 referrals for treatment. Information about the Doorway locations is available at www.theDoorway.nh.gov.

Inpatient Care

Inpatient services are provided through general hospitals with inpatient psychiatric capacity, New Hampshire Hospital (NHH), one community based Acute Psychiatric Residential Treatment Program (APRTP), and five Designated Receiving Facilities (DRFs): treatment facilities designated by the Department of Health and Human Services Commissioner to accept for care, custody, and treatment adults and youth involuntarily admitted to the state mental health services system.

New Hampshire Hospital (NHH) is a fully accredited public state-operated acute-care psychiatric facility. It is operated independent of the SMHA and has 187 beds serving. NHH is the only freestanding

psychiatric facility in the State. It is managed in clinical partnership with Dartmouth Mary Hitchcock Medical Center. The objective of all programs is the reintegration of all persons into the community. New protocols, mandated by the CMHA, are being structured to strengthen the discharge transition planning process. Other private psychiatric inpatient units provide care for people with very high acuity mental health treatment needs.

Case Management Services for Individuals Admitted to a Hospital
Managing the cases of SMI and SED individuals who have had psychiatric hospital admissions requires coordinated case management. NHH, DRFs, and community mental health centers are responsible for partnering on case coordination, including coordination of client evaluation, treatment planning, discharge, and linkage with appropriate community services, for those individuals who are existing community mental health center clients. Community mental health centers follow the individual during their hospital stay, making sure that services and supports are established and maintained within the community.

Case managers maintain contact with community agencies and individuals to develop community resources other than those offered through the state mental health system, and to encourage community support to the individual in order to foster a smooth transition to the community after discharge.

Case management throughout the community mental health center system serves to assure linkage with all necessary services and people involved in the recipients' care, coordinated service planning, and monitoring of progress toward goals.

Long-Term Care Rehabilitative Services
The Glencliff Home serves Adults with SMI 60 years of age or older who meet the requirements for long-term care that identifies the Glencliff Home as the least restrictive environment and providing the level of medical care the person requires.

The Glencliff Home consistently has a list of individuals waiting for admission. Staff and community mental health centers also work actively with current residents to facilitate a successful transition back into the community for individuals who are identified and deemed clinically appropriate to transition to a lower level of care.

Ensuring Equity for Diverse Minorities
Although NH, similar to the rest of New England, has a lower proportion of racial and ethnic minorities than many states in the country, our state is becoming increasingly diverse. For example, NH participates in a robust refugee resettlement program, and has substantial racial and/or ethnic minority communities in several regions of the state. In addition, NH, like the rest of the country, increasingly is recognizing the high prevalence of people who identify with a sexual preference and/or gender affiliation minority status.

The SMHA, recognizing the increasing diversity of the NH population overall and the corresponding diversity in CMHC clients, felt compelled to measure equality of access and other outcomes. For the 2020 Community Mental Health Satisfaction Survey, administered by the SMHA through application of MHBG BHSIS funds, the SMHA invited randomly selected adult clients and family members of child clients to participate in the survey to enable comparison of satisfaction scores and behavioral. The surveys

included a Babel sheet with information on accessing the survey in 20 additional languages. For adult respondents, 3% identified as Black or African American; 86% White; 4% American Indian/Alaska Native; <1% Asian; 4% Other Race; and 6% Identified as Hispanic/Latino. For family members of child respondents 6% of children identified as Black or African American; 86% White; 3% American Indian/Alaska Native; 2% Asian; <1% Native Hawaiian/Pacific Islander; 3% Other Race; and 9% Identified the child as Hispanic/Latino.

Overall, there were no statistically significant differences in satisfaction by racial identification (White versus non-White) or ethnic identification (Hispanic versus not Hispanic). Although not statistically significant, clients who identified as minority race and/or Hispanic/Latino ethnicity had higher scores in 5 of the nine satisfaction domains. For example, 78% of people who identify as racial minorities (non-white) responded positively in the general satisfaction and self-determination domains (versus 76% and 73% among Whites respectively).

Additionally, 82% of people who identify as Hispanic/Latino were generally satisfied, compared to 75% among non-Hispanics.

Other Support Services

Supports identified in the Community Mental Health Agreement

New Hampshire's 2014 Mental Health "Olmstead" Settlement Agreement (the Community Mental Health Agreement), had, among its objectives, to improve the lives of individuals with serious mental illness by reducing institutionalization at New Hampshire Hospital & Glencliff Home. There are 5 Core Components: (1) Supported Housing; (2) Supported Employment; (3) Assertive Community Treatment; (4) Mobile Crisis Teams; and (5) Peer Support/Family Support.

The DHHS issues quarterly Progress Reports reflecting recent activity and month-over-month progress made in support of the Community Mental Health Agreement. These reports are specific to achievement of milestones contained in the agreed upon CMHA Project Plan to fulfill the core components. Where appropriate, the Report includes CMHA lifetime-to-date achievements. New Hampshire has made significant strides in expanding services in these five areas.

NH CarePath

The NH CarePath was designed to be New Hampshire's "front door" that quickly connects individuals to a full range of community services and supports. CarePath serves to educate and publicize No Wrong Door linkage efforts and state partners, including the ServiceLink assistance program.

ServiceLink

The ServiceLink Resource Center is a web-based product of the NH Department of Health and Human Services. Through contracts with local agencies ServiceLink helps seniors, adults living with disabilities and their families access and make connections to long term services and supports, access family caregiver information and supports, explore options and understand and access Medicare and Medicaid.

Peer Support Center Warm Lines

Unlike hotlines, warm lines are for situations that are not considered emergencies but could potentially escalate if left unaddressed. Peer telephone operators can offer compassion, and support callers on topics such as loneliness, anxiety, and sleeplessness. When individuals use warm lines, they are encouraged to talk through their concerns with operators and, in turn, operators may relate information about their own experiences to help the caller to address their own concerns. Operators can help callers that may feel isolated or "stuck" and, as a result, they may calm or reassure the callers. Operators refrain from offering advice; rather, they give a message of hope and provide resources.

Criterion 2: Mental Health System Data Epidemiology*: Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.*

Mental Health System Data and Epidemiology

The US Census Bureau estimates the 2019 New Hampshire population at 1,359,711. Youth age 18 and under are estimated at 19% of the population; adults at 81%. NH Community Mental Health Programs served 4.6% of NH children and 3% of NH adults.

SFY 2020

The total served in Community Mental Health Centers statewide in SFY20 was 45,541 (estimated 3.5% state population).

Of clients served, SFY20 data indicates that 44% of adults served were reported to be eligible (SMI + SPMI) for state-supported community-based services, similar to 2017. While adult admissions to the NH service system have increased, the proportion of service recipients who are experiencing SMI has remained stable and consistently below other states' reporting and the national average. This is likely due to the limited dataset used in NH: URS data consists solely of CMHC data, in contrast with other states, whose SMHAs are authorized to collect mental health treatment data from a broader spectrum of providers.

Of clients served, SFY20 data indicates that 75.8% of total children and youth served were experiencing a Severe Emotional Disturbance (SED) or Severe Emotional Disturbance with Interagency Involvement (SED-IA) for state-supported community services.

Each center monitors its caseload, service utilization and costs locally; the state of NH collects case information in its Phoenix database system, via monthly uploads managed jointly by the CMHCs and the DHHS data unit.

Criterion 3: Children's Services*: Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive*

system of care include social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

The Department of Health and Human Services has worked cross-departmentally to blend funding and leverage resources to meet the needs of children and youth who have intense behavioral health needs. The early stages of this work of 'de-siloing' services and funding streams within DHHS has provided a foundation to help continue efforts. Shared or blended resources and funding have helped keep children and youth in New Hampshire from moving into more costly and ineffective service systems such as psychiatric hospitalizations, out-of-home placements, and court involvement.

The Bureau of Children's Behavioral Health (BCBH), established in 2016, brings to the Division for Behavioral Health (DBH) a focus on children, youth, and families experiencing behavioral health issues, by developing programming with an appreciation of the system of care approach. Established to promote a coordinated system of care for children and families, the BCBH joined the Bureau of Mental Health Services and the Bureau of Drug and Alcohol Services in a consolidated DHHS Division for Behavioral Health. The Bureau's mission is to expand the System of Care for all children, youth and families needing and receiving publicly funded behavioral health services. The Bureau is responsible for overseeing child and youth focused Behavioral Health services delivered by 10 Community Mental Health Centers, 2 Care Management Entities, 10 Residential Treatment Facilities and any new programming that the Bureau develops to enhance the SoC in New Hampshire. These collective efforts have resulted in a shared vision and commitment to SoC values, along with growing capacity to implement that vision with high fidelity. NH has an emerging critical mass of qualified Wraparound coordinators and family/youth peer supports, spreading implementation of the evidence-based MTSS-B model in schools, and accumulating reach into the target population. Moreover, bipartisan support in the current legislative session for substantial investments in the 10-year Mental Health Plan attests to a collective commitment to build on these early successes.

Over the last 2 years (2019-present), there have been several new enhancements developed into NH's Children's SOC work, which include but are not limited to Mobile Crisis Response Teams, Residential Transformation, Expanded Care Management Entity responsibilities to include Transitional support for youth in residential treatment, and an Evidence Based Practice Clearinghouse. The BCBH has also co-lead collaborative efforts with the Division of Children Youth and Families (DCYF) to implement prevention work mandated Families First federal legislation. This joined effort has included the expanded use of the Child Adolescent Needs and Strengths (CANS) Assessment tool across NH, as well as blend referral pathways for community based voluntary services and care management entity services to help prevent silos and offer supports too many more youth with behavioral health needs.

Community Mental Health Centers

The CMHCs provide statewide comprehensive service array of mental health care for children and their families. Their specialists work with children experiencing serious emotional difficulties such as depression, attention deficit and hyperactivity disorder, autism, disruptive behaviors, substance use disorders, and trauma associated with emotional, physical or sexual abuse. Emotional health impacts each area of a child's life including family, school and social relationships. Each CMHC encourages an

approach that, whenever possible and necessary, pulls together other community resources to address the interconnected areas of a child's life. The CMHCs are committed to an outreach approach that provides many services to children in their home, at school or in other community settings.

Per New Hampshire Administrative Rule and State Medicaid Plan, CMHCs shall provide the following developmentally appropriate services to children who are eligible pursuant to the applicable rules and shall give priority to children connected to the division for children, youth and families. Services provided to eligible children shall be community based, and shall include the following:

►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

►Individual service plan development and monitoring

►Outreach support to children and their families, both in their homes and in community settings

►Functional support services.

The Block Grant advisory council in NH: the Mental Health Planning and Advisory Council, plays an active role in monitoring and advocating for issues relating to Children. The standing committee on Children and Youth is one of the more dynamic and active standing committees, meeting monthly, between quarterly meetings of the Council at large.

NH Medicaid - Health Coverage for Children

NH Medicaid - Health Coverage for Children provides free health, mental health and dental coverage for children up to age 20 with net income no higher than 196% of the federal poverty levels (FPL). Expanded Children's Medicaid (Expanded CM): provides free health, mental health and dental coverage for children up to age 19 with net income higher than 196% of the FPL but no higher than 318% of the FPL.

Children's Behavioral Health Collaborative (2010-2019) and the Children's System of Care Advisory Council (CSOC)

A coalition of more than 50 youth serving agencies organized under a Collective Impact model, the CBHC mission is to support a comprehensive and integrated System of Care for children experiencing behavioral health challenges in NH. The CBHC promulgated NH's first Children's Behavioral Health Plan in 2013, articulating the values - youth/family guided, community-based, culturally and linguistically competent - that would continue to guide all subsequent SoC initiatives in the state.

In June 2019, legislation through SB14, which amends RSA 135F, required New Hampshire to develop and create a Children's System of Care advisory council. With several similarities to the Children's Behavioral Health Collaborative, since the fall of 2019, this group has been established and functioning as a group that advises system changes. As of June 2021, there are 125 active members of the advisory council.

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

NH's 10-Year Mental Health Plan (2019 to current)

Unlike the previous NH 10-yr Mental Health Plan, the 2019 plan addresses the needs of children as well as adults. Recommendations included scaling up the FAST Forward wraparound model (which have increased from serving 150 families in 2019 to serving over 425 in 2021); enhancing mobile crisis capacity to serve children (Mobile Crisis Response Teams are being developed in 2021); community education to reduce stigma and improve access to care for at-risk youth; supporting the Infant Mental Health Plan (Infant Mental Health Plan is in development and involving the Care Management Entities using a 2-Phase approach); and creating new DHHS staff positions with expertise in early childhood mental health (all but one BCBH positions are filled).

Regional System of Care Projects

The Bureau of Children's Behavioral Health has worked collaboratively with multiple regional System of Care projects in NH. Many of these regional projects have utilized the NH Wraparound Model in efforts to provide evidenced based practice to their programs and the families that they serve. Below are examples of projects that BCBH has worked closely with:

The County of Cheshire, NH was awarded four years of funding to develop a SoC in the Monadnock Region (southwest NH) in October 2016 by the Substance Abuse and Mental Health Services Administration (SAMHSA). In 2019, the City of Manchester, NH was awarded a grant by SAMHSA to extend a SoC approach to the youngest (0-8 years old) and most vulnerable residents of NH's largest and most diverse city. In 2020, Dartmouth (Sullivan County regional area) was awarded and SOC grant to support youth 0 to 17, supporting youth with SED of parents who experience substance use challenges.

DCYF Adequacy and Enhancement Assessment (2018)

Citing the need for "a more preventive, integrated, and organized continuum of services and supports that are aligned to the needs of the children, youth, and families they serve" (p.33), this assessment urged "continued adoption and expansion of the SoC principles and models that NH has put into law under RSA 135-F" (p39). Described in some detail in the Year 3 and Year 4 reports, this assessment emphasized the intention of DHHS to divert families from DCYF intervention and out of home placement, in favor of addressing their needs through a more preventive and integrated community-based system of care. Many examples above, show the efforts cross-departmentally to address these findings.

Department of Education (2014- 2021)

Coinciding with the genesis of FAST Forward, the forerunner of the OSEW was established within the DOE to promote and support the development of comprehensive systems of support in NH schools to promote student wellness including social and emotional and behavioral health. Around the same time, the State was awarded the SAMHSA-funded Safe Schools/Healthy Students project (2013-2018), which served as a springboard for the development of NH's Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model, providing guidance and support to school districts for embedding social emotional wellness within the mission of NH's educational institutions. Since then, the OSEW has brought a number of other grant-funded projects and Social Emotional Wellness resources to the state, including:

Project Aware (2014-2020)

Expanded the MTSS-B model to 12 additional schools and early childhood settings in NH's North Country and Lakes Region through funding, technical assistance and training.

Project GROW (2016-2021). A partnership between the NH DOE Office of Social & Emotional Wellness and Bureau of Student Support, and the Behavioral Health Improvement Institute at Keene State College, GROW provides expert leadership and training in the development of trauma-informed schools and community care systems.

NHSOC/FAST Forward 2020 (2016-2020)

In October 2016, the NH Department of Education was awarded four years of funding by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the New Hampshire System of Care project (NHSoC) – also known as FAST Forward 2020. NHSoC began serving youth and families in August 2017. NHSoC aims to improve school climate and the behavioral health and wellness of students in seven NH school districts by 1) creating a more hospitable infrastructure/environment; 2) adopting NH's Multi-tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model; and 3) implementing a team-based form of care coordination – called Wraparound – for those students (and their families) with the most serious/complex behavioral health needs.

School Climate Transformation Grant (2019-2024) The NH Department of Education, received funding from the US Education Department to build state infrastructure to support MTSS-B scale-up in schools across the state to improve school climate and culture; and to support the use of best practices to support positive school culture and climate across the state through partnerships between local communities and Office of Social & Emotional Wellness staff, especially MTSS-B consultants, and local communities.

The NH DOE's BSW-OSEW recently secured additional funding from SAMHSA, including an additional 4 years award for Project Aware and 4 years System of Care Expansion and Sustainability grant funding which will increases capacity and expansion of support to NH schools across the state including 2 additional MTSS-B Consultants. With the hiring of the 2 additional consultants, each of the 5 regions of the state (North Country, Lakes Region, South Central, South West, and South East) would have a dedicated consultant to supporting them with implementation of MTSS-B).

NHDOE SOC Expansion and Sustainability Project (2020 to current)

In August 2020, the NHDOE was awarded a System of Care Expansion and Sustainability grant to extend its school mental health efforts in four new local education agencies (LEAs). The project uses NH's Multi-Tiered System of Support for Behavioral Health & Wellness (MTSS-B) model, an interconnected systems framework, to integrate mental health services in schools. Through implementation of MTSS-B, schools and community mental health agencies collaborate to establish facilitated referral pathways, feedback loops, a comprehensive service array, and training for all staff involved in student behavioral health. A primary component of the grant is partnership with NH DHHS and community mental health centers to create School Liaison positions to act as a bridge between CMHCs and the schools engaging in the work of the grant.

Choose LOVE Movement (Office of Governor Sununu, 2018 to current)

Choose Love for Schools, is a NH supported mission to create safer and more loving communities through free, groundbreaking next-generation social and emotional learning (SEL) programs that are suited for all stages of life from Infant-Toddler, and Pre-K through 12th grade. The programming includes character development and Social and Emotional Learning (SEL) curriculum that teaches educators and their students how to choose love in any circumstance through simple yet powerful themes and practices for the classroom that naturally evolve into a culture where students feel safe, nurtured, connected, and empowered.

The program success in engaging students and schools has led to the creation and implementation of additional programs to teach and reinforce these character values outside of school, including on athletics teams, at home and throughout work places and communities (Champions Choose Love, Choose Love for Home, Choose Love for Communities and Business Leaders.) During the reporting period Choose Love training/implementation occurred throughout the state in schools (PreK-Grade 12); as part of the School Safety Preparedness Task Force; infant/toddler programs- (with a goal of growing this outreach); homes (again, with a goal of reaching more); community agencies and organizations; DCYF Youth Voices Summit; NH's Foster Parent Conference (with work happening to hopefully have Choose Love become permanently part of their training- This vision is for both foster parents and biological parents to help with reunification and continue this with the children); Initial steps also established with the Department of Corrections; Partnership with our AG's Office Task Force on Child Abuse and Neglect; Collaboration with NH Child Advocate; serving on the CSOC (Children's System of Care) Advisory Council.

Targeted Services to Rural and Homeless Populations

Rural New Hampshire
Primary Care Office
The Primary Care Office (PCO) works with other agencies and stakeholders to support and improve access to comprehensive, culturally competent, quality, primary health care services for underserved and vulnerable populations. This is done through three program areas:
1) Statewide Primary Care Needs Assessment,
2) Shortage Designation Coordination, and
3) Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care.

The Primary Care Office uses geographic area and population data at county and sub-county levels to identify lack of access to primary care services; identify shortage of primary care providers; identify key barriers to access to health care; and identify the highest need for health services. The PCO also contains the Health Professions Workforce Data Center.

Shortage Designation Coordination
The Rural Health and Primary Care (RHPC) Section works to ensure NH residents in all areas of the state have access to healthcare services by targeting the workforce. RHPC provides technical assistance to organizations and communities regarding the necessary steps for shortage designation and maintains communication with entities on program eligibility and the application process. The RHPC is also

responsible for applying for new shortage designations and maintaining and updating existing designations. According to the 2018 US Census, 39.6% of New Hampshire's population qualifies as rural. All home and community-based services are available to the eligible population, regardless of location. BBH contracts with community mental health centers in all areas of the state, which includes the provision of services via satellite sites to reach the most rural parts of the state.

As of the date of this application, five NH counties have been designated as Health Professional Shortage Areas (HPSAs) (SOURCE: HRSA Data Warehouse).

The State Office of Rural Health (SORH) offers technical assistance to rural health care providers and organizations and provides healthcare-related information to rural healthcare stakeholders. SORH serves as a liaison between rural healthcare organizations and many DHHS programs.

The Workforce Development office works with each of the above program areas to increase or retain the supply of health professionals serving New Hampshire. There is a particular focus on those professionals whose service will meet the needs of rural and underserved populations. Workforce Development administers New Hampshire's State Loan Repayment Program, the J1 Visa Waiver (Conrad 30) program, and the National Interest Waiver program.

New Hampshire's Homeless

Community Mental Health Centers and Peer Support Agencies are required by administrative rule to provide outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system and providing non-office-based diagnostic and treatment services.

The State of New Hampshire Bureau of Housing Services (BHS) provides an array of statewide services, falling under the Homeless Prevention/Intervention Service spectrum, which together with the emergency shelter system, act as a safety net.

The Projects for Assistance in Transition from Homelessness (PATH) program is funded through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) branch of the US Department of Health and Human Services with funds contracted to community mental health and Community Action Agencies.

The entities through which Housing and Urban Development (HUD) funds the Homeless Assistance Supportive Housing Programs are in the Continuum of Care (CoC). New Hampshire has three distinct CoCs, Greater Nashua, Manchester, and the Balance of State. The Bureau of Housing Supports (BHS) coordinates the activities of the Balance of State Continuum of Care (BOSCOC).

Targeted Services to Diverse Racial, Ethnic, and Gender Minority Populations

New Hampshire has historically been composed of a homogeneous population. According to the 2019 US Census, 6.9% of New Hampshire's population was, at that time, race minorities or of Latino descent.

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

Services to SMI and SED minorities at Community Mental Health Centers

The data system used by the State Mental Health Authority (SMHA) is named Phoenix and has capacity to report race, ethnicity, gender, sexual orientation, and age. During 2020 through 2021 the SMHA has worked alongside the CMHCs to ensure this data is mapped correctly in their system and an emphasis on the importance of accurate data was placed. The quality of that data submitted has improved and is continued to be monitored for errors and unknowns with active feedback occurring at the agency level.

The Office of Health Equity

The Office of Health Equity has a strategic plan to provide culturally competent mental health screening services to refugees and minorities in the state of New Hampshire (NH). The Office of Health Equity partners with the SMHA as well as with contracted agencies to also provide a wide array of supportive services such as language interpreters, language teaching services, and case management to assist people with resettlement.

The CMHCs have language interpreters both onsite and available through outside agencies such as Certified Languages International and the Language Bank. All CMHCs are also contractually required to provide meaningful and effective treatment for those consumers who are deaf or hard of hearing. The Deaf Service Program ensures that CMHC staff who are fluent in American Sign Language (ASL) are available for these consumers.

CLAS Standards in New Hampshire

The National CLAS (Culturally and Linguistically Appropriate Services) Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

In 1999, DHHS created the Office of Minority Health to help ensure that all residents of New Hampshire have access to DHHS services and to improve the health of minorities. Renamed the Office of Health Equity, this bureau has assisted in meeting the needs of minorities by instituting processes to respect the National CLAS Standards:

As of July 1st, 2014, all NH-DHHS Requests for Proposals (RFPs) will include a CLAS Section with an explicit statement of contractors' obligation to comply with all applicable Federal Civil Rights laws, and a list of the laws. The RFP template provides the four-factor analysis bidders should use to determine the mix of language assistance services they need to provide to Limited English Proficient (LEP) clients to comply with Title VI of the Civil Rights Act of 1964.

Criterion 5: Management Systems*: States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.*

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

Emergency Mental Health Services

Each CMHC has staff responsible for 24-hour emergency, or crisis, services. Services are required by administrative rule to be available 7 days per week, 24 hours per day; include clinical/psychiatric evaluation and treatment, medication services, and referral to inpatient treatment; and be available at the CMHP and other community locations including hospitals, homeless shelters, police stations, and residences.

The state of NH is undergoing exciting changes in terms of crisis response. NH, like the rest of the country, is planning to transition to the number "988" for all crisis calls in the state. This will include calls that would normally go to any of the 10 CMHC ES departments, calls that would go to 911 (for behavioral health calls), and calls that go to the current National Suicide Prevention Lifeline (NSPL). The change will be officially implemented in July 2022.

Since 2015 New Hampshire has held contracts with three (3) agencies that employ distinct mobile crisis response teams within the greater Nashua region, the greater Manchester region, and the greater Concord region. Mobile Crisis Response Teams (MCRT) and beds are identified for individuals eighteen (18) years or older who are experiencing a mental health crisis, including those with a co-occurring substance use disorders. These current MCRTs each provide mobile crisis stabilization services 24 hours a day, 7 days a week, a central phone triage system where trained clinicians complete an initial risk assessment, provide crisis stabilizations services and interventions inclusive of peer support services, and provide mobile crisis apartments that serve as an alternative to hospitalization and/or institutionalization. Plans are underway to expand New Hampshire's mobile crisis services to be statewide and integrated (serving all ages with both mental health and substance use disorders). This expansion will also include the development of a single, statewide crisis access point that will serve as the state's crisis call center and provide phone based triage, intervention, deployment of regional mobile crisis teams, and follow-up contact with all callers through Beacon Health. The SMHA in partnership with the CMHCs and Beacon Health will also be engaging in community education and outreach. The expectation is launch a broad public awareness campaign to blanket the state in educational materials and announcements regarding access to crisis services. The goal being to inform NH citizens about the availability of crisis services in their community and how to easy access care while experiencing a behavioral health crisis.

The 5% Crisis Services Set Aside shall be utilized by the centralized access point to support start-up and implementation outlined above. Funds will be targeted to support the clinical staff needed to provide telephonic crisis intervention services to all callers and to coordinate deployment and warm hand-off referrals, including deployment of mobile response teams, as clinically determined.

All of New Hampshire's CMHCs are involved in regional planning, training, and drills in behavioral health emergency/disaster response. Administrative rule He-M 403 requires that Behavioral Health Disaster Response Plans provide:

► Coordination with other local and regional agencies that provide emergency management services including relief from a disaster;

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

► Identification of members of the community at large who are vulnerable to behavioral health crises during times of disaster;

► Provision of onsite crisis assessment and diagnostic and counseling services; and

►Addressing the acute psychiatric treatment needs of community members and assuring the availability of community support and treatment services to consumers of the state mental health system who are vulnerable during times of disaster due to the nature of their mental illness

The BMHS Acute Care Services Coordinator assists with, and advocates for, the mental health training for emergency health services, participates in suicide prevention activities, is the liaison to the Office of the Chief Medical Examiner (OCME) for the DHHS and for the New Hampshire National Guard, liaison to the CMHC Emergency Services Departments, the Designated Receiving Facilities (DRF), and is on the Advisory Board of the Disaster Behavioral Health Response Team (DBHRT) as well as being a member of DBHRT.

Grant Expenditure Manner
The majority of the MH block grant award for NH supports contracts with eight Peer Support Agencies (PSAs). The remainder of the grant will be spent in the areas also described below.

The PSAs have locations at fourteen sites and two outreach programs, serving all ten (10) MH regions, sustaining statewide access to peer support as an alternative and/or adjunct to clinical and medical models of service provision. PSAs provide an array of recovery-oriented services.

Peer Support Agencies (PSAs) are community-based private not-for-profit agencies that have contracted with BBH to provide peer-to-peer support by adults with mental illness, intended to assist adults with mental illness in their personal recovery.

NH has had a long commitment to mental health consumer peer support, starting with both the establishment of the first Office of Consumer Affairs with a state mental health authority nationally and the first peer support agency (PSA) in NH, both in the late 1980's.

The eight PSAs are the recipients of nearly 65% of the State's total MHBG award. Some peer support agencies have been successful at accessing additional funding through such sources as private donations, the United Way and the Community Development Block Grant.

In additional to PSAs, the block grant also has supported a variety of programs for early intervention, training and outcomes assessment. For 2019 through 2021, block grant funds were also used to support First Episode Psychosis (FEP) program initiation and maintenance, support of training and infrastructure for the children's programs statewide incorporating the MATCH – ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Conduct, or Trauma Problems), professional business practice trainings for the regionally based Peer Support Agencies, and the maintenance of the CANS and ANSA outcomes reporting system that is implemented statewide.

Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

Outcomes reports and data tables generated by the administration and analysis of results of the annual Consumer Satisfaction Survey were made possible through the application of federal BHSIS grant funds associated with the Mental Health Block Grant. CMHCs and the MHPAC look forward to the presentation of quality metrics provided by the vendor responsible for data collection, analysis, and presentation. CMHC-specific outcomes are incorporated into quality initiatives at the centers. Year-over-year data is monitored by the DHHS through its CMHP reapproval processes,

The grant also supports the State Planner position and activities of that office, which includes serving as liaison and subject matter expert to MHPAC. The State Planner oversees the block grant, represents the Bureau at required national meetings, and provides or arranges the staff support, direct consultation, instrumental support, research materials and financial support for the Council activities and manages all block grant related initiatives. The Planner coordinates and collects multi-source data for the NRI National Profile and similar projects requested of the state, related to the SMHA.

The State Mental Health Planning & Advisory Council

The State Mental Health Planning & Advisory Council (MHPAC) is 100% supported by the grant, which, at a minimum, provides staff, operational support and incentives for consumers and family members who would otherwise be unable to participate in Council and SMHA activities.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Step 2:

Step 2: Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

New Hampshire Priorities & Areas of Need

PART I: BACKGROUND

A. Community Mental Health Settlement Agreement

There are certain parameters within which our work must occur; and certain priorities that we are required to address in response to legal challenges:

The State of New Hampshire's needs assessment "A Strategy for Restoration" (also known as the Ten Year Plan) was crafted in 2008. Since then, claims of over-utilization of institutions and prolonged wait times resulted in a class action lawsuit, *Amanda D. v. Hassan, United States v. New Hampshire, No. 1:12-cv-53-SM,* filed in 2013, alleging "New Hampshire's administration of its mental health system violates the rights of individuals with SMI". NH underwent a newly developed 10 year mental health plan that was issued in 2019.This plan further addresses and provides a guideline for action steps to address emergency room wait times for psychiatric services, increased community based services aimed at prevention, and system wide expansions for workforce needs. This is further detailed in section B below.

Priority populations named in the CMHA are adults who reside at New Hampshire Hospital (NHH) or Glencliff Home (GH) who may have been "unnecessarily institutionalized"; the impact of the provisions of the CMHA is being felt largely by the CMHCs, upon whose shoulders rest the responsibility to implement these expanded programs and demonstrate their success to the State of New Hampshire.

As specified in the Agreement, the Expert Reviewer (ER) has submitted to all parties involved in the settlement biannual public reports of the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to facilitate or sustain compliance with the Settlement Agreement.

The most recent report of the Expert Reviewer (ER), required under the Settlement Agreement was released January 27, 2021. This report reflects the end of six and one half years of implementation of the CMHA.

Although the CMHA makes service improvements mandatory, they are, of course, reliant on funding and workforce resources. Given the nationwide shortage of psychiatrists and the overall behavioral health workforce shortage that existed before COVID-19 arrived in the US, the pandemic's impact on work and NH families, and NH's rapidly recovering economy in NH, staffing challenges continue to be a significant impediment to fulfilling some CMHA milestones.

Planning Step 2:

The parties originally anticipated that the CMHA could be fully implemented in five years, with a sixth year for maintenance of effort. The CMHA was approved and filed with the Federal Court on February 12, 2014, and the five-year anniversary of that event has passed and all parties continue to work collaboratively to fulfill expectation of the agreement.

The initiatives that have been mandated by the CMHA are intended to serve individuals in the least restrictive setting and to avoid unnecessary institutionalization. The efforts should have a combined effect to increase retention within the community, reduce hospitalization, and to alleviate the wait times that individuals with severe mental illness (SMI) experience for a bed at New Hampshire Hospital, as well as to successfully transition individuals from NH Hospital to the community.

Analyses of inpatient psychiatric bed waiting and 30-day readmission rates, along with data on providers and individual engagement in state mental health system treatment and service, surfaced a system improvement opportunity pertaining to the timeliness with which an individual chooses to engage in treatment. Findings indicated that more than 50% of individuals needing an inpatient psychiatric stay were not already engaged in mental health treatment and did not have a prior NH Hospital admission. Of these individuals, approximately half chose to begin receiving state mental health system services after their first NH Hospital discharge, yet many delayed engagement until after their second NH Hospital discharge. The impact of delayed engagement can also be seen in the 30-day readmission rate across all NH hospitals, including NH Hospital.

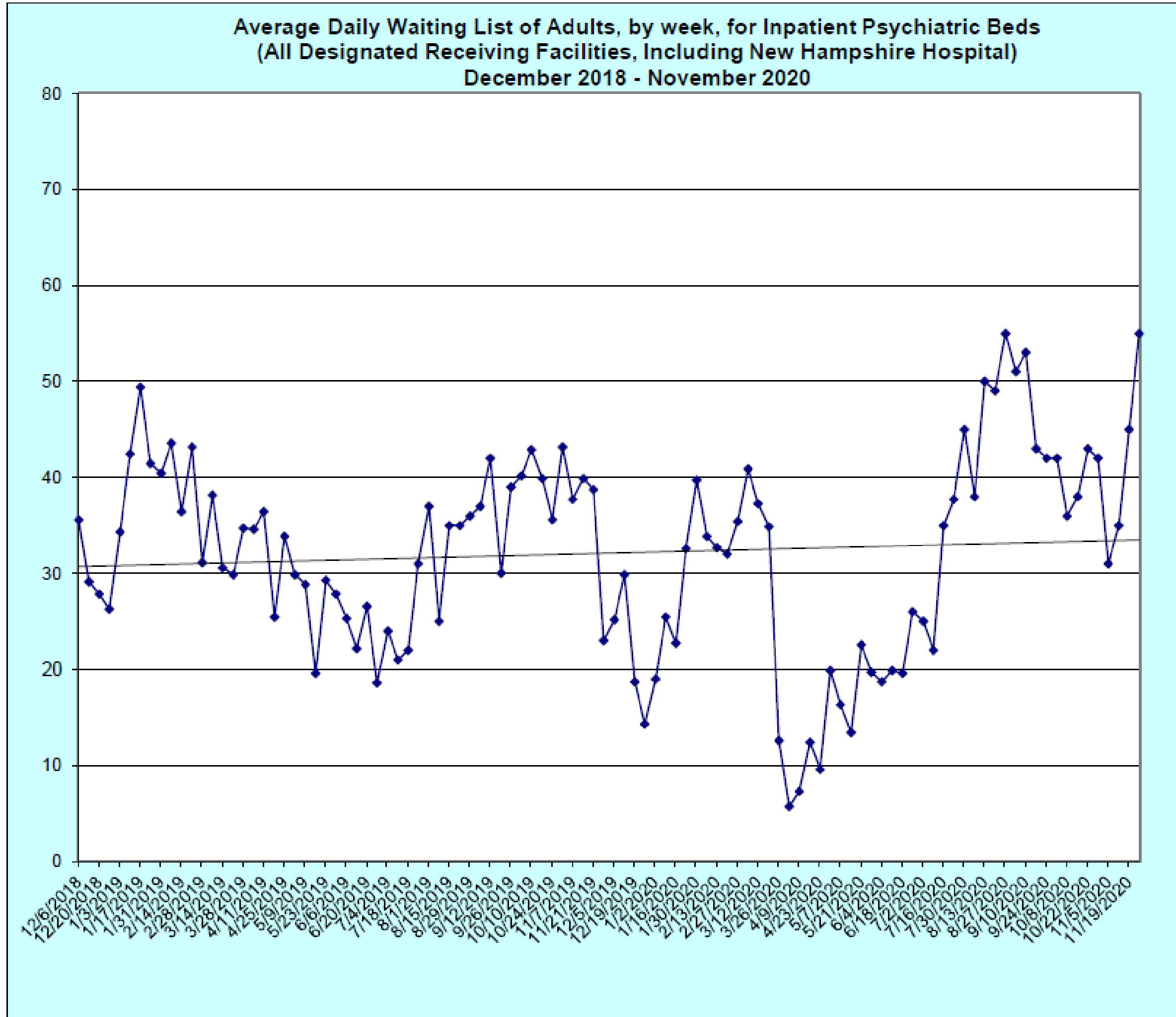
The ER report indicates that 22.7% of all those discharged from NHH are readmitted within 180 days; this is an approximate 35% reduction in the rate over a two-year period. Robust and innovative programs and services designed to help reduce the number of hospital readmissions throughout the state, if such individuals are promptly screened, referred and engaged in services, including peer-based programs, can make a positive impact, as seen with the improving 180-day readmission rate vs. the 30-day readmission trend for people not engaging with services. Supporting programs and services to improve engagement and access to innovative programs will need to continue and expand as much as possible by the MHBG to bring NH into compliance with the CMHA.

New Hampshire Hospital Admissions and Inpatient Psychiatric Bed Wait List

For the time period July through September 2020, DHHS reports that NHH effectuated 244 admissions and 244 discharges. The mean daily census was 180, and the median length of stay for discharges was 21 days. The total number of NHH beds set aside for involuntary admissions is 187 Including all of the voluntary beds along with other psychiatric beds at general admissions hospitals, and the designated receiving facilities, the total number of inpatient psychiatric beds in NH numbers 496.

Based on information reported by DHHS, a daily average of 31 adults were waiting for a NHH inpatient psychiatric bed from October of 2019 through September of 2020. The average number of adults waiting for admission trended downward 40% during the two year period of October 2018 to September of 2020.

Planning Step 2:



SOURCE: New Hampshire Community Mental Health Agreement Expert Reviewer Report Number Nine, January 27, 2021

B. The 10-Year Mental Health Plan

In January 2019, The Department of Health and Human Services (DHHS), pursuant to 2017 Laws Chapter 112 (House Bill 400), developed the Department's 10-Year Mental Health Plan (10-Year Plan). This Plan takes a comprehensive approach to essential services and supports across the life span. The 2008 Plan and the Community Mental Health Agreement (CHMA), signed in 2014, only took into account the needs of adults, leaving out children. The 2019 10-Year Plan includes child-focused strategies and recommendations.

New Hampshire's 10-Year Mental Health Plan was developed from a statewide stakeholder process that included input from hundreds of interested parties who took a critical look at the current system. Input came from focus groups, workgroups, and public sessions held in recent weeks. The Plan addresses the needs of individuals and families across the continuum of care, and provides innovative models to meet the evolving environment and increasing complexity of the mental health system.

Planning Step 2:

Summary of Activities, Priorities and Progress toward Implementation of the 10-year Mental Health Plan September, 2020

Recommendation #1: Medicaid Rate Increase for Mental Health Services:

In SFY2019, the Department temporarily increased by $6M in total funds Medicaid rates for providers of mental health services. The funding is included in the biennial budget that was passed by the NH Legislature.

The biennial budget passed by the Legislature also included significant increases to Medicaid rates for providers. These increases included two 3.1% increases for all Medicaid services; One in January 2020 and another 3.1% increase in January 2021.

In addition, the Department received 8 million dollars to increase Medicaid rates to targeted mental health and substance use disorder (SUD) treatment services. The plan for how the targeted behavioral health rate increases will be applied is still being vetted by Departmental staff.

Mental Health Medicaid Directed Payments

As authorized by the Centers for Medicare and Medicaid Services (CMS), the NH Department of Health and Human Services' (DHHS) – through its Medicaid Care Management agreements and contracted Managed Care Organizations (MCOs), have supported a multitude of directed payments models in the state. These model payments are specifically directed to improve mental health outcomes. The directed payments include:

1. SFY 2020 – A $5m CMS approved plan that included directed payments for the period September 2019 through June 2020, as follows:

    - Assertive Community Treatment (ACT) I – a payment, to promote fidelity, based upon the number of CMH system eligible individuals served.
    - Assertive Community Treatment (ACT) II – a payment, to promote access, based on the number of ACT clients above the baseline count.
    - Same Day/Next Day Follow-up – a payment for individuals receiving a face-to-face CMHC service within 24 hours of discharge from New Hampshire Hospital (NHH).
    - Mobile Crisis Teams (MCT) – a payment for individuals seen face-to-face by Mobile Crisis Team, up to one time per month.
    - Specialty Residential Placement – a payment for individuals dually diagnosed with a developmental disability and serious mental illness, discharged from New Hampshire Hospital or transitioning to a more independent living situation and receiving coordinated care from a multidisciplinary approach.

2. SFY 2021 – A $5m CMS approved plan that included directed payments for the period July 1, 2020 – June 30, 2021, as follows:

- ACT I and ACT II, as described above.
- Same Day/Next Day Follow-up – a payment for individuals receiving a face-to-face CMHC service within 24 hours of discharge from NHH or a designated receiving facility (DRF), and an additional payment for each subsequent, consecutive weekly face-to-face services, up to 180 days, to improve follow-up care and decrease readmission rates.
- Mobile Crisis Teams (MCT) – as described above.
- Special Residential Services – as described above.

3. SFY 2022 – A $5m plan, which is still pending CMS approval, for the period of July 1, 2021 – June 30, 2022, as follows:

    - Same Day/Next Day Follow-up (NHH and DRFs) –as described above.
    - Timely Prescriber – an enhanced uniform payment for all individuals (CMH eligible and non-eligible) who receive a prescriber appointment within 21 days of a new CMHC intake appointment.
    - Illness Management and Recovery Services (IMR) – an enhanced uniform payment for individuals who receive at least 60 minutes of IMR services per week for a minimum of 10 weeks in a 13-week period.

4. SFY 2022 – A $5m plan, which is still pending CMS approval, for the period of July 1, 2021 – June 30, 2022, as follows:

    - Same Day/Next Day Follow-up (NHH and DRFs) – a payment for individuals receiving a CMHC services within 24 hours of discharge for psychiatric inpatient stay, and an additional payment for each subsequent, consecutive week that the individual receives a face-to-face (orif applicable, telehealth) CMHC service (not to exceed one additional directed payment per week), for up to 90-days out.
    - Timely Prescriber – an enhanced uniform payment for all individuals (CMH eligible and non-eligible) who receive a prescriber appointment within 21 days of a new CMHC intake appointment.
    - Illness Management and Recovery Services (IMR) – an enhanced uniform payment for individuals who receive at least 60 minutes (4 units) of IMR services per week for a minimum of 10 weeks in a 13-week period.

Recommendation #2: Address Emergency Department Waits:

I. Short term measures

   i. Mobile Crisis Services: Senate Bills 11 and 14 include provisions and funds to expand crisis services such as Mobile Crisis Response Teams (MCRT) and

Behavioral Health Crisis Treatment Centers (BHCTC) for both adults and children. SB 14 requires the development of statewide MCRT for children and youth and the Department is actively undergoing stand up for these programs. In July of 2021 a statewide crisis support line is being implemented that will serve as the hub for behavioral health crisis calls. This HUB will work with the ten local community mental health center mobile crisis response teams for regionally based crisis needs for adults and youth.

ii. Rates for community-based Designated Receiving Facilities (DRF): Senate Bill 11 provides for an increase to DRF rates, for the establishment of an atypical rate for voluntary inpatient psychiatric admissions, and for funds to renovate existing hospital facilities to expanded DRF capacity statewide. In accordance with House Bill 1, eight (8) new DRF beds were established through contract with the Department.

iii. The Department is in the process of developing an application with CMS for a new Section 1115 Institution for Mental Disease (IMD) waiver. The waiver will allow providers to receive for Medicaid reimbursement for mental health services provided to adults with severe mental illness and children with severe emotional disturbance who receive acute care provided in psychiatric hospitals for greater than fifteen days.

iv. Funding was provided in the State budget to construct forty (40) new transitional housing beds specifically designated to serve forensic patients, those with complex behavioral health conditions, or those transitioning from NH Hospital. These beds are still being worked on to be established.

II. The Department, working with the Governor and Legislature, officially closed the children's unit from NHH in June of 2021 and transitioned youth inpatient psychiatric stays to Hampstead Hospital, expanding its scope of acute psychiatric treatment services for children on both a voluntary and involuntary basis. This move will ensure access to a specialized treatment setting designed to meet the unique needs of children and youth experiencing mental illness. This move will also serve to increase capacity at NHH by converting the existing 24 child and youth beds to more than 40 adult beds.

Recommendation #3 Renewed and Intensified Efforts to Address Suicide Prevention:
HB 652 requires the state Board of Education to adopt rules requiring teachers and administrators in the public schools to receive annual training in suicide awareness and prevention.

HB 1 (the proposed biennial budget) includes $200,000 in each fiscal year to support the state's suicide hotline and $250,000 in each fiscal year to support suicide prevention training.

The Suicide Prevention Council (SPC) submitted a written request to the Department to use part of the allocated $250,000 to fund a fulltime staff position to serve as a statewide suicide prevention specialist. In making this request, they noted that the Suicide Prevention Resource Center, which is the national

technical assistance provider on suicide prevention for SAMHSA, recently released a white paper on *Recommendations for State Suicide Prevention Infrastructure.* The top four (4) recommendations are: Designate a lead division or organization, Identify and secure resources, maintain a suicide prevention plan, which is updated every 3-5 years, and maintain a dedicated leadership position. The Department has accepted this recommendation and established a position for this purpose. The Department continues to work closely with the SPC, with the directors of the Bureau of Mental Health Services and Children's Behavioral Health serving as its co-facilitators. The SPC will begin updating their strategic plan in 2020 and incorporate best practices and recommendations outlined in the 10 Year Plan.

Recommendation #4 Enhanced Regional Delivery of Mental Health Services
The Department is exploring its options to fulfill the call for a mental health portal, which would provide an integrated point of entry for local and regional information for mental health, substance use and other services. The Department is examining the current regional infrastructure which includes, but is not limited to the Doorway program, Integrated Delivery Networks and Regional Public Health Networks to determine how to leverage and centralize access points for individuals and families.

SB 14 requires statewide mobile crisis response for children; expansion of community based services for children; consolidated parent information; and an evidence-based practice clearinghouse. These components can be designed to be connected to a regional entity for behavioral health access and information. Work has commenced on approaches for the other requirements stated above.

Recommendation #5 Community Services and Housing Supports
SB 11 appropriates funds for the purpose of contracting with programs that enable individuals with serious mental illness to attain and maintain integrated, affordable, supported housing. The Department is following the guidance in the 10-year plan to determine how to allocate these funds.

SB 14 requires the expansion of the FAST (Families and Systems Together) Forward program and Care Coordination services provided beyond the FAST Forward program by the Care Management Entity (CME). SB 14 also requires the CME to expand their responsibilities to oversee children and youth who are in residential treatment and acute psychiatric hospital care; ensure goals are appropriate, are attained, and treatment progresses; and develop and actively use safety plans with all children or youth who enter treatment settings. Financial resources that will adequately address these requirements are included in the biennial budget, and work has begun to draft the scope of work related to these requirements.

HB 1 also includes funds to expand the Housing Bridge Subsidy program and transitional housing for adults and youth. Program expansion has already begun to be implemented to support the ongoing housing needs.

Recommendation #6 Step-up/Step-down Options
The peer-run crisis response model would provide short-term, temporary housing for individuals who need a higher level of support to avoid inpatient psychiatric hospitalization or individuals recently discharged from psychiatric hospitalization who need additional supports to facilitate a safe return home.

Certified Peer Support Specialists who are specifically trained in methods designed to support peers experiencing psychiatric crises would operate such programs. The Department is pursuing rule changes to include step-up/step-down programs in He-M 402, Peer Support. There are many step up/step down models and HB 1 includes funds to support step-up/step-down programs in SFY 20/21. In early 2021 four regionally based peer support agencies opened or were beginning to open a total of four 3-bed Recovery Oriented Step-up/Step-down programs.

SB 14 and the federal Families First Prevention Services Act provide opportunities to look critically at how NH uses residential treatment for children and youth. The State is making progress to enhance and revamp the residential treatment system to meet the needs of all children more effectively. This includes reviewing cases of children and youth currently in treatment either in- or out of state; developing a level of care system framework with clear descriptions and inclusion/exclusion criteria; selecting a single standardized assessment tool for use across all children's behavioral health providers; and cross-walking eligibility criteria with levels of care and the chosen assessment tool. Resources to address these requirements were incorporated into HB 1.

Recommendation #7 Integration of Peers and Natural Supports
The Department is collaborating with peer support agencies and community mental health programs to evaluate training needs, increase the pool of state trainers, focus on core training requirements, and explore opportunities to blend funding and cross-train peers in various parts of the system.

In support of Recommendation #7, the Department to date has:

- Contracted with the NH Center for Nonprofits on a series of eight trainings for peer-run agencies to strengthen governance, management, technical and adaptive skills, and nonprofit best practices.
- Contracted with the National Alliance on Mental Illness - New Hampshire (NAMI-NH) to offer peer leadership trainings to promote the engagement of individuals with lived experience across all levels of the mental health system in order to change knowledge, attitudes and, ultimately, culture regarding the integration and leadership of peers throughout the State's mental health system. The first training, a two-day training and technical assistance workshop, focused on lived experience of people who have experienced suicidal struggles to help others and prevent future suicidal behavior. The five-day second training is designed to promote leadership skills and work with individuals in a suicidal crisis by providing peer support services in traditional care settings as well as in non-traditional peer supported settings.
- Identified two individuals who will attend a national Intentional Peer Support (IPS) train-the-trainer event in SFY 2020. These additional IPS state trainers will allow for greater flexibility, support for and expansion of the peer workforce.

Recommendation #8 Establish a Commission to Address Justice Involvement
Governor Sununu's Executive Order 2019-02 established the Governor's Advisory Commission on Mental Illness and the Corrections System that will look at how to reduce incarceration and improve

services for such individuals, and to support individuals with mental illness who are transitioning from jail back to their communities.

Recommendation #9 Community Education
The Department has been making presentations on the 10 Year Plan to various groups and at conferences, including to a group of legislators at Representatives Hall and the National Alliance on the Mental Illness-New Hampshire.

The Department will continue to seek opportunities to partner with behavioral health services systems to educate community members about mental illness and wellness as well as the need to consider the social determinants of health as part of the continuum of care.

As part of a Department-wide suicide prevention integration team, the Department launched *I Care*, a Department-wide initiative to educate the workforce about suicide prevention. *I Care*, which was created to promote awareness and provide information on available resources so that all staff can support someone who may be struggling, has also been shared with local and state agencies interested in educating their workforce on suicide prevention awareness.

In accordance with SB 14, the Department is working to establish a statewide family information and resource center. This information and resource center will provide public information and education material for parents and caregivers to assist them in access and navigation of the mental health system.

Recommendation #10 Prevention & Early Intervention
The Department developed an infant and early childhood mental health plan that identifies best practices and strategies to enhance the system's ability to effectively serve this young population. Strategies include training the provider workforce; establishing a billing process that best suits this population; and focusing on screenings to drive level of care determinations. Other infant and early childhood mental health strategies include the expansion of early childhood treatment models and support models, such as home visiting. Funding for the program is contained in HB 1.

HB 131 establishes a commission to develop and promote mental health programs and behavioral health and wellness programs in kindergarten through grade 12.

In 2020-2021, the Department contracted with Mary-Hitchcock Memorial Hospital using federal mental health block grant funds that are designated to address early severe mental illness (ESMI) and first episode psychosis (FEP). Under this contract, Mary-Hitchcock facilitated a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide ESMI or FEP treatment model. HB 1 includes funds to support the implementation of the selected ESMI/FEP model.

In July of 2021 NH had one established FEP program in the greater Nashua region and contracted with and additional three community mental health centers to begin establishment of FEP/ESMI programs within their regions.

Recommendation #11 Workforce Coordination
Governor Sununu's Executive Order 2019-03 established the Statewide Oversight Commission on Mental Health Workforce Development. The Commission shall serve as a statewide coordinator for all efforts to address NH's mental health workforce shortage and shall develop strategies to boost recruitment and retention of a mental health workforce for the state.
HB 1 included funds to expand NH's State loan repayment program, which includes opportunities for individuals working in the behavioral health system to apply for loan repayment.

Recommendation # 12 Quality Improvement and Monitoring/DHHS Capacity
HB 1 included funding for additional DHHS staff positions to assist with the oversight of quality, implementation, and improvement oversight.

SB 14 includes additional staff positions to support the implementation and oversight of investments to the children's behavioral health system.

Position development and organizational strategies for inclusion of the new positions has occurred and the position approval process is underway with some positions being actively recruited for or filled.

Recommendation #13 Streamlining Administrative Requirements
Governor Sununu's Executive Order 2019-04 established a DHHS Division of Performance Evaluation and Innovation to improve transparency, streamline operations, review administrative and reporting requirements. This new Division will determine any redundancies for mental health providers and ensure efficiencies to disseminate new funding opportunities without unnecessary delay. The Department has appointed a Division Director to lead implementation of the new Division.

Per Executive Order 2019-04, the Division for Behavioral Health has been conducting an inventory of all of the requirements for community mental health providers. The inventory includes the number of touch points the DHHS has with providers, creating a crosswalk of quality service reviews, fidelity reviews, designations and re-designations, Community Mental Health Agreement-related activities, (including periodic Expert Reviewer site visits), all of these touch points require critical provider staff time that is not directly spent meeting the needs of individuals with severe mental illness. The inventory also includes a review of state statute and administrative rules. As part of this effort, several workflow improvements were realized pertaining to the Quality Service Review (QSR) process, including the elimination of manual data entry into redundant forms, the creation of a central data repository to increase efficiency, and the standardization of the five-day on-site review process for client record reviews, client and staff interviews. As a result, CMHC site readiness has improved. The Department is in the process of updating administrative rules and will be drafting a proposal that will be vetted with stakeholders prior to initiating the formal rulemaking process.

Recommendation #14 Reporting on Implementation

Planning Step 2:

SB 292, relative to implementation of the new 10-year plan, requires the DHHS commissioner to submit a report containing the priorities for implementation of New Hampshire's 10-year mental health plan on an annual basis. Reports are to include the status of implementation, unmet benchmarks, recommendations for any necessary barrier resolution, adjustments, or modifications needed to the plan, and any recommendations for legislation needed to fully implement the 10-year plan. The Department will include this information in its annual report.

Future Plans

Moving forward, annual reports on the status of the implementation of the 10-year mental health plan including, but not limited to, unmet benchmarks and recommendations for any necessary barrier resolution or necessary adjustments or modifications to the plan to better serve New Hampshire citizens will occur. The goals of the 10-year mental health plan can only be realized if fully supported and fully funded. Review and adaptation of the 10-year mental health plan to changing conditions in concert with the biennial budget cycle is critical to successful implementation. The Department is committed to the 10-year mental health plan but cannot carry the plan forward alone. As stakeholders asserted, actualizing the plan will rely on leadership, active collaboration, and ongoing support. The Governor and Legislature must champion the plan and continue funding the next phase of implementation. This includes expanding step-up/step-down programs, statewide mobile crisis response teams for all populations, including adults, and diversifying the availability of peer support services throughout the continuum of care. The Department will continue to work with stakeholders to identify legislation and funding needed to meet our shared goal of full implementation.

Annual progress reports are posted to the DHHS website: https://www.dhhs.nh.gov/dcbcs/bbh/10-year-mh-plan.htm

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Reduce Psychiatric Hospitalizations

Priority Type: MHS

Population(s): SMI, ESMI

Goal of the priority area:

Reduce psychiatric hospitalizations by providing alternatives to hospitalization.

Strategies to attain the goal:

Establish contractual relationships with providers to add community-based supported housing beds including wraparound services and supports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of mental health-supported housing beds statewide.

Baseline Measurement: Statewide, there are 764 mental health-supported housing beds, including transitional housing, community residences, peer respite, Housing Bridge, and PRA 811 units.

First-year target/outcome measurement: Increase the number of supported housing beds over baseline by at least 72 to 836.

Second-year target/outcome measurement:

Data Source:

The Office of Legal and Regulatory Services and the SMHA track all mental health-supported housing in an internal database. Statewide mental health-supported housing beds are intended for adults that have been referred from the state psychiatric hospital and/or it's Designated Receiving Facilities (DRF).

Description of Data:

The data reports consist of data illustrating the increased capacity and service provision across the state, in response to the Community Mental Health Agreement (CMHA): the Olmstead settlement agreement, and the NH DHHS 10 Year Mental Health Plan.

Data issues/caveats that affect outcome measures:

Funds have been included in the state budget for fiscal years 2022 & 2023 to assist in establishing the additional supported housing beds. If funding is not sustained, that could potentially jeopardize the sustainability of new beds.

Priority #: 2

Priority Area: Improved Access to Recovery Services

Priority Type: MHS

Population(s): SMI, ESMI

Goal of the priority area:

Increased participation at Peer Support Agencies through the recovery-oriented Step-up, Step-down program.

Strategies to attain the goal:

Provide funding and support for pilot Step-up, Step-down programming in the Peer Support Agencies and implement four, 3-bed recovery-oriented Step-up, Step-down beds statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Statistical Report: Average Daily Attendance

Baseline Measurement: 12 individuals in SFY21

First-year target/outcome measurement: 60 individuals served

Second-year target/outcome measurement: 75 individuals served

Data Source:

Peer Support Agencies' Statistical Reports

Description of Data:

Comprehensive utilization reports filed and aggregated each quarter, and at the end of the State Fiscal Year.

Data issues/caveats that affect outcome measures:

Many individual participants require transportation assistance, so access can be a significant barrier to attendance.

Priority #: 3

Priority Area: Address Early Serious Mental Illness

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase the number of individuals accessing evidence-based programs to treat early serious mental illness.

Strategies to attain the goal:

Work with partners to increase community education and outreach regarding the availability of ESMI programs, and expand the number of ESMI teams available in NH.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased ESMI Program Participants

Baseline Measurement: Current participants total 27/year

First-year target/outcome measurement: Addition of three (3) new FEP Teams to increase enrollment to 42 participants

Second-year target/outcome measurement: Increase enrollment to 55 participants

Data Source:

Annual ESMI program statistical reports that include clients served.

Description of Data:

Tabular data elements embedded in outcomes reports

Data issues/caveats that affect outcome measures:

The SMHA is implementing Phoenix data enhancements to include collection of ESMI/FEP data in the fall of 2021. This will enable the SMHA to gather enrollment data directly from the CMHCs.

Priority #: 4

Priority Area: Continue to strengthen the implementation and utilization of MATCH across all centers

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

With MATCH being implemented across all ten community mental health centers, continued implementation strategies will be utilized to help support this goal. Strategies may include but are not limited to: An established MATCH Steering Committee, continued use of the TRAC data outputs, continued training of newly hired staff, continued supervisor training to support train the trainer sessions, and cross collaboration between centers in efforts to support growth and need.

Strategies to attain the goal:

Maintain internal structures to train CMHCs statewide in the Modular Approach to Treatment for Children (MATCH). This will continue to provide skills and a supportive environment to promote staff retention and recruitment, as well as expanding trainers as needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of CMHC centers with staff trained in MATCH.

Baseline Measurement: All ten CMHCs are now trained

First-year target/outcome measurement: Maintain 10 CMHCs with staff trained in MATCH

Second-year target/outcome measurement: Continue to develop the MATCH Steering Committee to address needs and focus on sustainability

Data Source:

The NH MATCH Steering Committee

Description of Data:

A report out from the MATCH Steer Committee and NH DHHS' participation in this committee will maintain the ability to gather and provide data.

Data issues/caveats that affect outcome measures:

Centers historically experience a high rate of staff turnover. It can be difficult to maintain a stable implementation when so many evidence-based practices utilize a team approach as part of their fidelity models. NH's CMHCs are experiencing severe staff shortages..

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[c]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$440,000.00						$291,296.00		$866,216.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital				$22,980,183.00	$40,441,682.00	$29,431,152.00				
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care		$1,841,210.00	$144,922,202.00	$2,028,912.00	$29,998,994.00			$2,330,367.00		$250,253.00
9. Administration (excluding program/provider level)[e] MHBG and SABG must be reported separately		$126,734.00						$145,648.00		$251,574.00
10. Crisis Services (5 percent set-aside)[f]		$126,734.00			$17,052,486.00			$145,648.00		$2,363,432.00
11. Total	**$0.00**	**$2,534,678.00**	**$144,922,202.00**	**$25,009,095.00**	**$87,493,162.00**	**$29,431,152.00**	**$0.00**	**$2,912,959.00**	**$0.00**	**$3,731,475.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[c] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[f] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 09/01/2021 MHBG Planning Period End Date: 09/30/2022

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems			$150,000.00			
2. Infrastructure Support			$250,000.00			
3. Partnerships, community outreach, and needs assessment			$650,000.00			
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education			$250,000.00			
8. Total	**$0.00**	**$0.00**	**$1,300,000.00**	**$0.00**	**$0.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

ProHealth New Hampshire Integrated Health Homes:
The Department received a five-year grant from SAMHSA in 2018 to provide integrated physical health care within services at three Community Mental Health Centers (CMHCs) in New Hampshire. This project, called ProHealth NH, aims to improve health and wellness for young people with serious emotional disturbance (SED), and serious mental illness (SMI). ProHealth NH was implemented utilizing partnerships between Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHC) that serve over one-third of the state. Primary care services are now co-located and integrated at three CMHCs with this project. The other seven CMHCs in the state have also implemented or are now implementing an integrated care program. The initial goal of the project was to provide integrated care to young people in order to improve the early identification of physical and mental health issues and to address these problems through treatment and wellness interventions, with the intention of preventing such problems from developing into serious diseases, such as coronary artery disease, in the future. To date, the ProHealth program has enrolled over 350 youth and young adults age sixteen (16) and older with SED or SMI; including a substantial proportion of people who identify as a cultural or linguistic minority. Across the state, over 650 individuals are enrolled in integrated care services.

The program achieves its goals through:
1) Evidence based screening, detection, and treatment of health conditions,
2) Evidence based screening and treatment of behavioral health conditions, and
3) Wellness programs for smoking and obesity

The five (5) key strategies of this project include:
1) Utilization of experienced primary care and mental health providers;
2) Co-location and integration of services;
3) Engagement in care with support of peer community health workers;
4) Utilization of care coordinators to ensure overall coordination of care; and
5) Use of health mentors to provide support for tailored wellness services and incentives for health behavior change.

Thus far, ProHealth participants are 28 years old on average, 4% identify as transgender or non-male/female, 29.4% identify as LGBQ, 22.6% identify as black or multi-racial, and 10.7% identify as Hispanic. The integrated care teams identified very high rates of health behaviors and conditions: 54% had obesity, 61.1% had elevated blood pressure, 39.6% had borderline high or high triglycerides, and 40.7% smoke tobacco daily. Almost half of the individuals served (40.2%) reported that they were dissatisfied or

very dissatisfied with their health, highlighting the opportunity to assist this group with addressing their physical health in concert with their mental health concerns. Further, over ¼ of the group (27.2%) had visited the emergency department two or more times in the past year, indicating opportunity for integrated outpatient care to reduce use of potentially unnecessary institutional care.

This program encountered incredible challenges over the course of the COVID-19 pandemic. However the partnerships were able to pivot to the extensive use of telemedicine, which allowed them to continue to enroll participants and provide integrated care to the vast majority of participants. Over the coming two years, the evaluation team will gather enough data to be able to examine outcomes of integrated care. The expectation is that integration can increase access to and receipt of recommended outpatient screening and treatment for both physical and mental health conditions, and that such treatment will reduce unnecessary emergency room visits and hospital stays. The team also expects that service recipients' physical and mental health will stabilize and improve with treatment and that satisfaction will be high.

Support for integration through Managed Care Organizations
New Hampshire contracts with three Managed Care Organizations (MCOs) who also support the integration for physical health services. The MCOs have worked to promote the values of whole person care and foster a coordinated continuum of care. To that end, they have focused on building collaborative relationships across providers. Specific accomplishments include:
• Developed provider resource packets that were distributed in March 2020 to the entire provider network. Included in the resource packet was a primary care physician (PCP) toolkit providing tools to screen for the most common behavioral health diagnoses and social determinants. Packets also included referral information and behavioral health resources.
• Supported behavioral health (BH) and physical health integration through use of the University of Washington AIMS Center integration model.
• Implemented an on-site BH clinician at high volume primary care practice (PCP) sites.
• Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals physical needs and specialists serving an individual's BH needs.
• Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care. The platform went live in February 2020.
• Provided training and education to all providers with a focus on whole person approach, reducing stigma associated with mental health issues and suicide prevention.
• Provided IDN partners with comprehensive care gap reports, Healthcare Effectiveness Data and Information Set (HEDIS) rates, and under/over-utilization reports.
• Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our twenty-four hour, seven days a week (24/7) nurse advice line to their entire provider network.

Alternatives to Emergency Department and Centralized Access
In support of integrated care, New Hampshire has been successful in establishing crisis services in targeted regions of the state. NH plans to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to expand New Hampshire's mobile crisis services to be statewide and integrated (serving all ages with both mental health and substance use disorders). This expansion will also include the development of a single, statewide crisis access point that will serve as a single crisis call center that will provide phone based triage, intervention, and deployment of regional mobile crisis teams. The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention. New Hampshire is still in the initial stage of implementation. Infrastructure investments are needed and it is evident that there is a need to expand stabilization services and develop a rural crisis response model for deployment and stabilization that will be practical and sustainable.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

In New Hampshire, the demand for mental health and substance use services is increasing. Current provider capacity is not currently structured to meet the need for services and deliver the comprehensive and integrated care that is most effective in addressing the needs of New Hampshire residents with severe behavioral health or comorbid physical and behavioral health problems. A number of factors make behavioral health transformation a priority of the state, including the enactment of the New Hampshire Health Protection Program (NHHPP) to cover a new adult group, in which an estimated one in six have extensive mental health or substance use care needs. New Hampshire now covers substance use disorder (SUD) services to the NHHPP population.

New Hampshire, through the NHHPP, seeks to transform its behavioral health delivery system through:
• Integrating physical and behavioral health to better address the full range of the qualified population's needs;
• Expanding provider capacity to address behavioral health needs in appropriate settings; and
• Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Demonstration project and Integrated Delivery Networks
In 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire (NH) Department of Health and Human Services (DHHS) five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by

establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs were charged with participating in statewide planning efforts and selecting and implementing specific evidence-supported projects. These projects were built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

The major focus of the networks is the integration of care across primary care, behavioral health and social support services. This includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions; to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

Specific achievements include:
• Supported expanded implementation of Medication Assisted Treatment (MAT) for people with substance use disorders in conjunction with the Doorways that have been established in New Hampshire. Doorways are points of entry for people seeking help for substance use.
• Critical Time Intervention (CTI), an evidence-based practice was used in several regions to improve transitions from emergency departments, in-patient care, residential settings, or incarceration to stable housing and community recovery, (individual IDN's targeted different segments of the population)
• Established multiple communities of practice for IDN-supported, community led interventions, such as:
• Pediatric psychiatric care
• Real time collaborative multi-disciplinary discussions and case presentations
• Supported primary care providers (PCPs) in delivering MAT
• Clinical case management support in the community
• Convened multiple agency partners to discuss status and gain insights from other organizations during Covid-19
• Improved Health Information Technology to enhance integration, improve transitions and promote quality
• Implementation of a real time event notification system; electronic shared care plan; and statewide direct and secure messaging
• IDNs supported expansion of telehealth during Covid-19 public health state of emergency (funding, training, ongoing technical support)
• Supported Workforce expansion through investments in
• Recruitment, staffing, retention
• Training & professional development initiatives
• Behavioral Health Scholars Program
• Workforce Development and BH Career Lattice and Position Description
• Training for Certified Recovery Support Workers(CRSW), Community Health Workers (CHW) & Medical Interpretation Scholarship Programs
• Granite State College Mini-Certificate Cohort Program & Professional Development to enable practitioners to grow into management and leadership roles
• Design and development of self-paced training for front line staff in stigma reduction
• Initiated cross training of CHWs and Peer Recovery Coaches
• Integration of primary care and behavioral health
• Standardized protocols across multidisciplinary providers for comprehensive assessment, workflows, timely exchange of information, closed loop referrals, multidisciplinary care teams
• Implemented various levels and types of co-located Primary care and Behavioral Health
• reverse integration clinics for people with SMI/SED
• Several IDNs have designed and implemented a Collaborative Care Model (CoCM) inclusive of the development of process and protocols
• Integrated Care and Enhanced Care Coordination between hospitals, SUD, FQHCs, CMHCs

The convening, facilitation, support, and technical assistance Provided by the department of health and human services built and strengthened key relationships between organizations in each region of the state, providing an important foundation for ongoing development and implementation of integrated and other impactful care models

Future Directions building of the IDN waiver work include:
• Most IDNs are sustaining activities into 2021 at varying levels/timelines while searching for alternate funding opportunities to sustain and expand on the progress that was made during the demonstration
• NH DHHS is developing a comprehensive, statewide CTI Program to support transitions from psychiatric hospitalization to community living based on lessons learned by the early CTI pilot projects
• NH DHHS has contracted with Collective Medical, the company that provides software infrastructure to support event notification, admission/discharge/transfer (ADT) and shared care plan platform utilized by most of the IDNs throughout the demonstration. This contract entails sending ADT information including demographic information, vaccine information, and anticipated discharge date from NH Hospital, the state supported psychiatric hospital that takes involuntary admissions, to the community mental health centers to facilitate timely and effective follow-up care in the community.
• NH DHHS has contracted with a vendor that provides a technology platform to house a resource database and referral tracking

to assist with ensuring closed loop referrals.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ◉ Yes ○ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The New Hampshire Insurance Department (NHID) regulates the insurance industry in New Hampshire.

New Hampshire's Health Insurance Marketplace is run by a partnership between the federal government and the state. The Insurance Department reviews forms and rates and then recommends them for final approval by the federal government, which operates the Marketplace.

The NHID Behavioral Health and Addiction Services Advisory Committee includes New Hampshire state senators, state representatives: including a representative from the DHHS Division of Behavioral Health, substance use disorder treatment providers and advocates, behavioral health providers and advocates, and insurance company representatives. The public is encouraged to sign up to receive email updates on the committee.

The NH 3 MCOs all have baseline access quality metrics that ensures individuals have access to care. For psychiatry and CMHC services, each member must have access to both within 60 minutes or 45 miles from their place of residence. For Psychologists, each member must have access within 45 minutes or 25 miles from their place of residence. For SUD comprehensive and SUD outpatient care, each member must have access to each within 60 minutes or 45 miles from their place of residence. Lastly for MLADCs each member must have access within 45 minutes or 15 miles from their place of residence.

Below outlines the MCM Quality Strategy Goals related to Network Adequacy and Access Monitoring.
Goal 2 – Assure members have access to care and a quality experience of care

Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.

On a semi-annual basis, the MCM Quality Program evaluates each MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include:
• Annual member utilization of services provided by this provider type;
• Reasons for the unmet standards;
• MCO solution for deficiency;
• Progress on the solution if this was a previously requested exception; and
• Provider level detail.

Exceptions are reviewed by a cross-functional group of Department staff to approve the MCO's requests for exceptions. Reasons for exception that are currently under consideration are:
• An insufficient number of qualified New Hampshire Medicaid and commercial providers or facilities are available to meet the geographic and timely access standards;
• The plan's failure to develop a provider network that is sufficient in number and type of providers to meet all of the standards in the Medicaid Care Management Contract (due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons); and
• The required service can be obtained using telemedicine or telehealth from an in-network participating provider.

Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue.

The MCO contract includes all requirements of 42 CFR 438.340 for assuring member access to care and availability of services. For monitoring member access to care and availability of services, the NH MCM Quality Program harmonizes with elements of NH's strategy for the CMS required Medicaid Fee for Service Access Report.

On a quarterly basis, the MCM Quality Program reviews a selection of performance measures designed to evaluate beneficiary needs as well as service utilization. Measures include but are not limited to:
• Grievances and Appeals;
• Services utilization (i.e., emergency department, office/clinic visits);
• Emergency department visits for conditions treatable in primary care;
• Beneficiary requests for primary care and specialist; and
• Member experience of care survey measures.

For each measure, control limits based on historical trends are employed in quarterly charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations

(following conventional practice[1]) from the mean based on historical data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that requires intensive analysis. For member experience of care survey measures, MCM rates will be evaluated to determine if they are at least equal to or better than the national average.

Annually, each MCO conducts a provider survey to determine compliance with the availability of services standards in the MCO contract and submits to the SMHA for review.

Annually, an External Quality Review Organization will conduct a secret shopper study for selected New Hampshire provider types. While each study will have a different focus, the core of the initiative will determine:
• New Hampshire providers accepting Medicaid;
• New Hampshire providers accepting Medicaid and accepting new patients; and
• Projected wait times for new appointments.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ◉ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The biggest parity concern was the requirement of prior approval for all MH and SUD services. The New Hampshire DHHS engaged with Milliman from 2017 and 2019 and found substantial disparity between payments for mental health and primary care services across the U.S. While this was a problem in most states, parity was a substantial problem in NH. NH Insurance Department therefore performed an evaluation of mental health parity in three private market health insurance companies. The evaluation results were published in February 14, 2020 and found that two of the three companies did not provide evidence to support parity, or the "comparability requirement." These companies are participating in compliance Assurance Plans and 2-year monitoring and reporting. The Department will continue to do parity exams in the coming years.

10. Does the state have any activities related to this section that you would like to highlight?

System Transformation and Integration
The SMHA has been working towards methods of integrating services for people with serious mental illness and serious emotional disturbances. The Department has been implementing regional integrated delivery networks for six years, and received support from the substance abuse and mental health services administration to co-locate and integrate primary care clinics into three community mental health clinics in 2018, as described above. In addition, seven community mental health centers independently developed integrated, co-located primary care, some with funding from SAMHSA. Thus, at present, all of the CMHCs in New Hampshire offer integrated primary care and community mental health services.

Currently, eight of New Hampshire's Community Mental Health Centers confirmed that they are providing integrated primary care on site. The extent of integrated care indicates a broad interest across the state.

NHCarePath
Initiatives for NH were put in place through NHCarePath, the state of New Hampshire's "No Wrong Door (NWD)" system overseen by DHHS, to increase access to long-term services and supports. "No Wrong Door" systems promote person- and family-centered practice to connect people of all ages, disabilities and income levels to information, assistance, or care they need.

As a result, NHCarePath Partners across the service spectrum meet quarterly for regional program updates, system partner cross training and practice discussions. In addition, there are Statewide NHCarePath leadership meetings where there are presentations and Department update provided. Goals of a NWD system include coordination and information sharing, developing plans to mirror the same information on how to streamline eligibility and access services across partner agencies regardless of what door the client/family enters. This group effort has connected partners locally and across regions, allowing the building of relationships to foster system improvements, and allows for dialog between providers and DHHS to discuss roadblocks and challenges for clients attempting to navigate the aging & disability system within NH and obtain eligibility to seek needed

services.

This Partnership, with the institution of contracted Eligibility Coordinators, who work directly with NWD Partner organizations across the state, has led to process improvements within DHHS systems and warm hand-offs between providers/area agencies.

In addition to providing community mental health services, the Community Mental Health Centers will provide services by participating as agencies under the NHCarePath. Under the NHCarePath model, the CMHCs will operate as eligibility and referral partners for individuals who may inquire or may benefit from the community long terms supports and services.

AARP has released No Wrong Door: Person- and Family-Centered Practices in Long-Term Services and Supports, and spotlights NHCarePath, Featured in this report are services provided by NHCarePath and ServiceLink (see page 8 of the report) programs that assist New Hampshire's aging and disabled residents in connecting to services.

Consumer and Provider Guidance: Assisting with Behavioral Health Insurance Issues
The NH Insurance Department (NHID) has produced a document to assist NH citizens and providers with their access behavioral health care and parity concerns, titled, Provider Guidance: Assisting with Behavioral Health Insurance Issues, addressing issues a consumer or provider may encounter. This document provides information regarding filing for an internal appeal within an insurance carrier, filing for an external review by an independent review organization, and contacting the Consumer Services Unit using a 1-800 number. The NHID does not directly regulate carriers' treatment of providers, which is governed by the terms of the contract between the carrier and the provider. As a consequence, the NHID does not have the ability or the authority to intercede with carriers on behalf of specific providers as it does with policyholders. However, if the NHID discovers through an investigation or market conduct examination that a carrier is not meeting a particular legal standard, it can order the carrier to correct the violation, and may potentially take other enforcement action such as imposing administrative fines. These standards including promptly paying contracted providers for the services they provide, and complying with mental health parity requirements.

A Resource Guide For Addiction and Mental Health Care Consumers was produced in September 2016. The Guide, subtitled Answering Questions about Insurance Coverage and Parity for Addiction and Mental Health Care Services, provides consumers with A Quick Guide to Getting Help and Coverage for Addiction and Mental Health Care Services. With regard to the requirement that insurance enables access and pays for mental health and substance use treatment within 45 minutes from their home. The MH_SUD_FactSheet also provides a toll free number within the department through which consumers can get their questions answered.

Please indicate areas of technical assistance needed related to this section

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

Please respond to the following items:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

ProHealth New Hampshire Integrated Health Homes:
The Department received a five-year grant from SAMHSA in 2018 to provide integrated physical health care within services at three Community Mental Health Centers (CMHCs) in New Hampshire. This project, called ProHealth NH, aims to improve health and wellness for young people with serious emotional

disturbance (SED), and serious mental illness (SMI). ProHealth NH was implemented utilizing partnerships between Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHC) that serve over one-third of the state. Primary care services are now co-located and integrated at three CMHCs with this project. The other seven CMHCs in the state have also implemented or are now implementing an integrated care program. The initial goal of the project was to provide integrated care to young people in order to improve the early identification of physical and mental health issues and to address these problems through treatment and wellness interventions, with the intention of preventing such problems from developing into serious diseases, such as coronary artery disease, in the future. To date, the ProHealth program has enrolled over 350 youth and young adults age sixteen (16) and older with SED or SMI; including a substantial proportion of people who identify as a cultural or linguistic minority. Across the state, over 650 individuals are enrolled in integrated care services.

The program achieves its goals through:

1) Evidence based screening, detection, and treatment of health conditions,
2) Evidence based screening and treatment of behavioral health conditions, and
3) Wellness programs for smoking and obesity

The five (5) key strategies of this project include:

1) Utilization of experienced primary care and mental health providers;
2) Co-location and integration of services;
3) Engagement in care with support of peer community health workers;
4) Utilization of care coordinators to ensure overall coordination of care; and
5) Use of health mentors to provide support for tailored wellness services and incentives for health behavior change.

Thus far, ProHealth participants are 28 years old on average, 4% identify as transgender or non-male/female, 29.4% identify as LGBQ, 22.6% identify as black or multi-racial, and 10.7% identify as Hispanic. The integrated care teams identified very high rates of health behaviors and conditions: 54% had obesity, 61.1% had elevated blood pressure, 39.6% had borderline high or high triglycerides, and 40.7% smoke tobacco daily. Almost half of the individuals served (40.2%) reported that they were dissatisfied or very dissatisfied with their health, highlighting the opportunity to assist this group with addressing their physical health in concert with their mental health concerns. Further, over ¼ of the group (27.2%) had visited the emergency department two or more times in the past year, indicating opportunity for integrated outpatient care to reduce use of potentially unnecessary institutional care.

This program encountered incredible challenges over the course of the COVID-19 pandemic. However the partnerships were able to pivot to the extensive use of telemedicine, which allowed them to continue to enroll participants and provide integrated care to the vast majority of participants. Over the coming two years, the evaluation team will gather enough data to be able to examine outcomes of integrated care. The expectation is that integration can increase access to and receipt of recommended outpatient screening and treatment for both physical and mental health conditions, and that such treatment will reduce unnecessary emergency room visits and hospital stays. The team also expects that service recipients' physical and mental health will stabilize and improve with treatment and that satisfaction will be high.

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Demonstration project and Integrated Delivery Networks

In 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire (NH) Department of Health and Human Services (DHHS) five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs were charged with participating in statewide planning efforts and selecting and implementing specific evidence-supported projects. These projects were built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

The major focus of the networks is the integration of care across primary care, behavioral health and social support services. This includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions; to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

Specific achievements include:

- Supported expanded implementation of Medication Assisted Treatment (MAT) for people with substance use disorders in conjunction with the Doorways that have been established in New Hampshire. Doorways are points of entry for people seeking help for substance use.
- Critical Time Intervention (CTI), an evidence-based practice was used in several regions to improve transitions from emergency departments, in-patient care, residential settings, or incarceration to stable housing and community recovery, (individual IDN's targeted different segments of the population)
- Established multiple communities of practice for IDN-supported, community led interventions, such as:
    - Pediatric psychiatric care

- Real time collaborative multi-disciplinary discussions and case presentations
- Supported primary care providers (PCPs) in delivering MAT
- Clinical case management support in the community

- Convened multiple agency partners to discuss status and gain insights from other organizations during Covid-19
- Improved Health Information Technology to enhance integration, improve transitions and promote quality
  - Implementation of a real time event notification system; electronic shared care plan; and statewide direct and secure messaging
  - IDNs supported expansion of telehealth during Covid-19 public health state of emergency (funding, training, ongoing technical support)
- Supported Workforce expansion through investments in
  - Recruitment, staffing, retention
  - Training & professional development initiatives
    - Behavioral Health Scholars Program
    - Workforce Development and BH Career Lattice and Position Description
    - Training for Certified Recovery Support Workers(CRSW), Community Health Workers (CHW) & Medical Interpretation Scholarship Programs
    - Granite State College Mini-Certificate Cohort Program & Professional Development to enable practitioners to grow into management and leadership roles
    - Design and development of self-paced training for front line staff in stigma reduction
    - Initiated cross training of CHWs and Peer Recovery Coaches
- Integration of primary care and behavioral health
  - Standardized protocols across multidisciplinary providers for comprehensive assessment, workflows, timely exchange of information, closed loop referrals, multidisciplinary care teams
  - Implemented various levels and types of co-located Primary care and Behavioral Health
    - reverse integration clinics for people with SMI/SED
  - Several IDNs have designed and implemented a Collaborative Care Model (CoCM) inclusive of the development of process and protocols
  - Integrated Care and Enhanced Care Coordination between hospitals, SUD, FQHCs, CMHCs

The convening, facilitation, support, and technical assistance Provided by the department of health and human services built and strengthened key relationships between organizations in each region of the state, providing an important foundation for ongoing development and implementation of integrated and other impactful care models

Future Directions building of the IDN waiver work include:

- Most IDNs are sustaining activities into 2021 at varying levels/timelines while searching for alternate funding opportunities to sustain and expand on the progress that was made during the demonstration
- NH DHHS is developing a comprehensive, statewide CTI Program to support transitions from psychiatric hospitalization to community living based on lessons learned by the early CTI pilot projects
- NH DHHS has contracted with Collective Medical, the company that provides software infrastructure to support event notification, admission/discharge/transfer (ADT) and shared care plan platform utilized by most of the IDNs throughout the demonstration. This contract entails

sending ADT information including demographic information, vaccine information, and anticipated discharge date from NH Hospital, the state supported psychiatric hospital that takes involuntary admissions, to the community mental health centers to facilitate timely and effective follow-up care in the community.

- NH DHHS has contracted with a vendor that provides a technology platform to house a resource database and referral tracking to assist with ensuring closed loop referrals.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans?
Yes
and Medicaid? □□
Yes

4. Who is responsible for monitoring access to M/SUD services by the QHP?
The New Hampshire Insurance Department (NHID) regulates the insurance industry in New Hampshire. New Hampshire's Health Insurance Marketplace is run by a partnership between the federal government and the state. The Insurance Department reviews forms and rates and then recommends them for final approval by the federal government, which operates the Marketplace.

The NHID Behavioral Health and Addiction Services Advisory Committee includes New Hampshire state senators, state representatives: including a representative from the DHHS Division of Behavioral Health, substance use disorder treatment providers and advocates, behavioral health providers and advocates, and insurance company representatives. The public is encouraged to sign up to receive email updates on the committee.

The NH 3 MCOs all have baseline access quality metrics that ensures individuals have access to care. For psychiatry and CMHC services, each member must have access to both within 60 minutes or 45 miles from their place of residence. For Psychologists, each member must have access within 45 minutes or 25 miles from their place of residence. For SUD comprehensive and SUD outpatient care, each member must have access to each within 60 minutes or 45 miles from their place of residence. Lastly for MLADCs each member must have access within 45 minutes or 15 miles from their place of residence.

Below outlines the MCM Quality Strategy Goals related to Network Adequacy and Access Monitoring.

Goal 2 – Assure members have access to care and a quality experience of care

Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.

On a semi-annual basis, the MCM Quality Program evaluates each MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include:

- Annual member utilization of services provided by this provider type;
- Reasons for the unmet standards;

- MCO solution for deficiency;
- Progress on the solution if this was a previously requested exception; and
- Provider level detail.

Exceptions are reviewed by a cross-functional group of Department staff to approve the MCO's requests for exceptions. Reasons for exception that are currently under consideration are:

- An insufficient number of qualified New Hampshire Medicaid and commercial providers or facilities are available to meet the geographic and timely access standards;
- The plan's failure to develop a provider network that is sufficient in number and type of providers to meet all of the standards in the Medicaid Care Management Contract (due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons); and
- The required service can be obtained using telemedicine or telehealth from an in-network participating provider.

Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue.

The MCO contract includes all requirements of 42 CFR 438.340 for assuring member access to care and availability of services. For monitoring member access to care and availability of services, the NH MCM Quality Program harmonizes with elements of NH's strategy for the CMS required Medicaid Fee for Service Access Report.

On a quarterly basis, the MCM Quality Program reviews a selection of performance measures designed to evaluate beneficiary needs as well as service utilization. Measures include but are not limited to:

- Grievances and Appeals;
- Services utilization (i.e., emergency department, office/clinic visits);
- Emergency department visits for conditions treatable in primary care;
- Beneficiary requests for primary care and specialist; and
- Member experience of care survey measures.

For each measure, control limits based on historical trends are employed in quarterly charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice[1]) from the mean based on historical data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that requires intensive analysis. For member experience of care survey measures, MCM rates will be evaluated to determine if they are at least equal to or better than the national average.

Annually, each MCO conducts a provider survey to determine compliance with the availability of services standards in the MCO contract and submits to the SMHA for review.

Annually, an External Quality Review Organization will conduct a secret shopper study for selected New Hampshire provider types. While each study will have a different focus, the core of the initiative will determine:

- New Hampshire providers accepting Medicaid;
- New Hampshire providers accepting Medicaid and accepting new patients; and
- Projected wait times for new appointments.

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[1] E.g., http://www.qualitydigest.com/aug/wheeler.html, http://www.isixsigma.com/dictionary/control-limits/

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?
Yes

6. Do the M/SUD providers screen and refer for:
a) Prevention and wellness education
Yes
b) Health risks such as
i) heart disease
Yes
ii) hypertension
Yes
viii) high cholesterol
Yes
ix) diabetes
Yes
c) Recovery supports
Yes

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?
Yes

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?
Yes

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The biggest parity concern was the requirement of prior approval for all MH and SUD services. The New Hampshire DHHS engaged with Milliman from 2017 and 2019 and found substantial disparity between payments for mental health and primary care services across the U.S. While this was a problem in most states, parity was a substantial problem in NH. NH Insurance Department therefore performed an evaluation of mental health parity in three private market health insurance companies. The evaluation results were published in February 14, 2020 and found that two of the three companies did not provide evidence to support parity, or the "comparability requirement." These companies are participating in compliance Assurance Plans and 2-year monitoring and reporting. The Department will continue to do parity exams in the coming years.

10. Does the state have any activities related to this section that you would like to highlight?

System Transformation and Integration

The SMHA has been working towards methods of integrating services for people with serious mental illness and serious emotional disturbances. The Department has been implementing regional integrated delivery networks for six years, and received support from the substance abuse and mental health services administration to co-locate and integrate primary care clinics into three community mental health clinics in 2018, as described above. In addition, seven community mental health centers independently developed integrated, co-located primary care, some with funding from SAMHSA. Thus, at present, all of the CMHCs in New Hampshire offer integrated primary care and community mental health services.

Currently, eight of New Hampshire's Community Mental Health Centers confirmed that they are providing integrated primary care on site. The extent of integrated care indicates a broad interest across the state.

NHCarePath

Initiatives for NH were put in place through **NHCarePath,** the state of New Hampshire's "No Wrong Door (NWD)" system overseen by DHHS, to increase access to long-term services and supports. "No Wrong Door" systems promote person- and family-centered practice to connect people of all ages, disabilities and income levels to information, assistance, or care they need.

As a result, NHCarePath Partners across the service spectrum meet quarterly for regional program updates, system partner cross training and practice discussions. In addition, there are Statewide NHCarePath leadership meetings where there are presentations and Department update provided. Goals of a NWD system include coordination and information sharing, developing plans to mirror the same information on how to streamline eligibility and access services across partner agencies regardless of what door the client/family enters. This group effort has connected partners locally and across regions, allowing the building of relationships to foster system improvements, and allows for dialog between providers and DHHS to discuss roadblocks and challenges for clients attempting to navigate the aging & disability system within NH and obtain eligibility to seek needed services.

This Partnership, with the institution of contracted Eligibility Coordinators, who work directly with NWD Partner organizations across the state, has led to process improvements within DHHS systems and warm hand-offs between providers/area agencies.

In addition to providing community mental health services, the Community Mental Health Centers will provide services by participating as agencies under the NHCarePath. Under the NHCarePath model, the CMHCs will operate as eligibility and referral partners for individuals who may inquire or may benefit from the community long terms supports and services.

AARP has released *No Wrong Door: Person- and Family-Centered Practices in Long-Term Services and Supports*, and spotlights NHCarePath, Featured in this report are services provided by NHCarePath and ServiceLink (see page 8 of the report) programs that assist New Hampshire's aging and disabled residents in connecting to services.

Consumer and Provider Guidance: Assisting with Behavioral Health Insurance Issues

The NH Insurance Department (NHID) has produced a document to assist NH citizens and providers with their access behavioral health care and parity concerns, titled, Provider Guidance: Assisting with Behavioral Health Insurance Issues, addressing issues a consumer or provider may encounter. This document provides information regarding filing for an internal appeal within an insurance carrier, filing for an external review by an independent review organization, and contacting the Consumer Services Unit using a 1-800 number. The NHID does not directly regulate carriers' treatment of providers, which is governed by the terms of the contract between the carrier and the provider. As a consequence, the NHID does not have the ability or the authority to intercede with carriers on behalf of specific providers as it does with policyholders. However, if the NHID discovers through an investigation or market conduct examination that a carrier is not meeting a particular legal standard, it can order the carrier to correct the violation, and may potentially take other enforcement action such as imposing administrative fines. These standards including promptly paying contracted providers for the services they provide, and complying with mental health parity requirements.

A Resource Guide For Addiction and Mental Health Care Consumers was produced in September 2016. The Guide, subtitled Answering Questions about Insurance Coverage and Parity for Addiction and Mental Health Care Services, provides consumers with A Quick Guide to Getting Help and Coverage for Addiction and Mental Health Care Services. With regard to the requirement that insurance enables access and pays for mental health and substance use treatment within 45 minutes from their home. The MH_SUD_FactSheet also provides a toll free number within the department through which consumers can get their questions answered.

Please indicate areas of technical assistance needed related to this section.

NA

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	◉ Yes ○ No
b) Ethnicity	◉ Yes ○ No
c) Gender	◉ Yes ○ No
d) Sexual orientation	◉ Yes ○ No
e) Gender identity	◉ Yes ○ No
f) Age	◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

1. The data system used by the State Mental Health Authority (SMHA), Phoenix, has the capacity to report and disaggregate data by race, ethnicity, gender, and age. Starting in the fall of 2020 through early 2021, the system was updated to allow for reporting of sexual orientation and gender identity. The quality of that data depends on the accuracy of data entry by the Community Mental Health Centers (CMHC), and supporting the CMHCs in an effort to ensure that the data points are updated and captured as clinically necessary.
2. The SMHA will continue to provide technical assistance to the CMHCs to ensure standardized responses and accuracy of information.
3. The Office of Health Equity (OHE) assures equitable access to effective, quality DHHS programs and services across all populations, with specialized focus on racial, ethnic, language, gender and sexual minorities, and individuals with disabilities. OHE provides coaching and TA to SMHA as well as external organizations to improve systems and practices for organizations to be able to serve all people with high quality care and services. These include effective strategies for communication access, cultural competence, data collection to identify disparities, community engagement, CLAS Standards implementation, gender identity 101, immigrant/refugee integration, and more.
4. The State Refugee Program in the Office of Health Equity partners with the SMHA as well as with contracted agencies to also provide service provider training as well as health case management, health education and orientation, and other supportive services to newly arriving and vulnerable New Hampshire refugees to build capacity to address identified health needs within refugee communities and to reduce barriers to achieving wellness.
5. The CMHCs are aware of their responsibility to provide qualified and meaningful communication access for consumers who require communication assistance. The CMHCs have access to spoken and signed language interpreters either onsite, and/or available through agencies such as Certified Languages International and the Language Bank. All CMHCs have additional capacity to provide culturally-tailored effective treatment by CMHC staff who are fluent in American Sign Language for consumers who are deaf or hard of hearing through the Deaf and Hard of Hearing Services Program which operates statewide out of the Greater Nashua Mental Health Center.

For the 2020 Community Mental Health Consumer Survey, administered by JSI Research & Training Institute through application of MHBG BHSIS funds, 1,718 adult clients were invited to participate in the Adult Survey, and 1,313 Family members of children receiving services were invited to participate in the Family Member Survey to enable assessment of satisfaction scores and behavioral outcomes. A total of 768 or 51% of the selected adult clients and 522 or 47% of the selected family members responded to the survey. The Surveys were provided in English and Spanish when indicated, and included a babble sheet with translations into 20 languages and contact information for interpretation services. The initial mail surveys also included a $5 upfront incentive. Phone follow up was provided to non-respondents and a web-based survey option was also provided.

The adult survey statewide findings are as follows:

• Generally, at least 70% of clients responded positively in four of the nine satisfaction domains. The highest scores were in the domains of quality and appropriateness (81%), access to services (80%), general satisfaction (78%), and self-determination (76%). Sixty-nine percent of clients were satisfied with their participation in treatment planning. The health and wellness (61%), social connectedness (61%), functioning (57%), and treatment outcomes (52%) domains were lower.

? Domain scores were compared across the last three years (2018-2020). The access domain was the only area to see statistically significant improvement from 2018 (73%) to 2020 (80%), all other domain scores remained relatively consistent.

• Overall females had statistically significantly higher satisfaction scores in the participation in treatment planning, social connectedness, functioning and self-determination domains compared to males.

• There were statistically significant differences in five of the nine domains by age group. Respondents age 22-44 had lower satisfaction in the access and social connectedness domains, Respondents age 45-65+ had higher satisfaction in health and wellness, and 70% of clients age 65+ were satisfied with functioning and outcomes, which is significantly higher than other age groups (range of 47%-56%).

• Clients receiving services for 1 year or more had statistically significantly higher satisfaction than those receiving services for less than 1 year in the health and wellness domain.

• Clients who were currently employed either full- or part-time had statistically significantly higher satisfaction in the functioning and either full- or part-time had statistically significantly higher satisfaction in the functioning or outcomes domains compared to those who were not employed.

The Family Survey statewide findings are as follows:

• Among family members of children receiving services, satisfaction scores were at least 70% or higher in five of the seven domains. The highest was in the area of cultural sensitivity of services (90%), followed by participation in treatment planning (83%), social connectedness (80%), access to services (78%), and General Satisfaction (73%).

? Domain scores were compared across the last three years (2018-2020). The access domain was the only area to see statistically significant improvement from 2018 (72%) to 2020 (80%), all other domain scores remained relatively consistent.

• There was no statically significant difference in satisfaction of family members of children receiving services between male and female children or between age group in any of the domains.

• There was no statistically significant difference in satisfaction of family members of children receiving services for children receiving services for more than one year compared to children receiving services for less than one year.

Please indicate areas of technical assistance needed related to this section

NA

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Footnotes:

Health Disparities

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Please respond to the following items:

1) Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, and age?

a) Race Yes

b) Ethnicity Yes

c) Gender Yes

d) Sexual orientation Yes

e) Gender identity Yes

f) Age Yes

2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation? Yes

3) Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers? Yes

4) Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes

5) If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes

6) Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes

7) Does the state have any activities related to this section that you would like to highlight?

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2. The SMHA will continue to provide technical assistance to the CMHCs to ensure standardized responses and accuracy of information.

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4. The State Refugee Program in the Office of Health Equity partners with the SMHA as well as with contracted agencies to also provide service provider training as well as health case management, health education and orientation, and other supportive services to newly arriving and vulnerable New Hampshire refugees to build capacity to address identified health needs within refugee communities and to reduce barriers to achieving wellness.

5. The CMHCs are aware of their responsibility to provide qualified and meaningful communication access for consumers who require communication assistance. The CMHCs have access to spoken and signed language interpreters either onsite, and/or available through agencies such as Certified Languages International and the Language Bank. All CMHCs have additional capacity to provide culturally-tailored effective treatment by CMHC staff who are fluent in American Sign Language for consumers who are deaf or hard of hearing through the Deaf and Hard of Hearing Services Program which operates statewide out of the Greater Nashua Mental Health Center.

For the 2020 Community Mental Health Consumer Survey, administered by JSI Research & Training Institute through application of MHBG BHSIS funds, 1,718 adult clients were invited to participate in the Adult Survey, and 1,313 Family members of children receiving services were invited to participate in the Family Member Survey to enable assessment of satisfaction scores and behavioral outcomes. A total of 768 or 51% of the selected adult clients and 522 or 47% of the selected family members responded to the survey. The Surveys were provided in English and Spanish when indicated, and included a babble sheet with translations into 20 languages and contact information for interpretation services. The initial mail surveys also included a $5 upfront incentive. Phone follow up was provided to non-respondents and a web-based survey option was also provided.

The adult survey statewide findings are as follows:

- Generally, at least 70% of clients responded positively in four of the nine satisfaction domains. The highest scores were in the domains of quality and appropriateness (81%), access to services (80%), general satisfaction (78%), and self-determination (76%). Sixty-nine percent of clients were satisfied with their participation in treatment planning. The health and wellness (61%), social connectedness (61%), functioning (57%), and treatment outcomes (52%) domains were lower.

    - Domain scores were compared across the last three years (2018-2020). The access domain was the only area to see statistically significant improvement from 2018 (73%) to 2020 (80%), all other domain scores remained relatively consistent.
- Overall females had statistically significantly higher satisfaction scores in the participation in treatment planning, social connectedness, functioning and self-determination domains compared to males.
- There were statistically significant differences in five of the nine domains by age group. Respondents age 22-44 had lower satisfaction in the access and social connectedness domains, Respondents age 45-65+ had higher satisfaction in health and wellness, and 70% of clients age 65+ were satisfied with functioning and outcomes, which is significantly higher than other age groups (range of 47%-56%).
- Clients receiving services for 1 year or more had statistically significantly higher satisfaction than those receiving services for less than 1 year in the health and wellness domain.
- Clients who were currently employed either full- or part-time had statistically significantly higher satisfaction in the functioning and either full- or part-time had statistically significantly higher satisfaction in the functioning or outcomes domains compared to those who were not employed.

The Family Survey statewide findings are as follows:

- Among family members of children receiving services, satisfaction scores were at least 70% or higher in five of the seven domains. The highest was in the area of cultural sensitivity of services (90%), followed by participation in treatment planning (83%), social connectedness (80%), access to services (78%), and General Satisfaction (73%).
    - Domain scores were compared across the last three years (2018-2020). The access domain was the only area to see statistically significant improvement from 2018 (72%) to 2020 (80%), all other domain scores remained relatively consistent.
- There was no statically significant difference in satisfaction of family members of children receiving services between male and female children or between age group in any of the domains.
- There was no statistically significant difference in satisfaction of family members of children receiving services for children receiving services for more than one year compared to children receiving services for less than one year.

Please indicate areas of technical assistance needed related to this section.

NA

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [x] Use of financial and non-financial incentives for providers or consumers.
- **d)** [x] Provider involvement in planning value-based purchasing.
- **e)** [x] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [x] Quality measures focused on consumer outcomes rather than care processes.
- **g)** [x] Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** [x] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Per Member Per Month Models
Starting in state fiscal year 2019, the state contracted with three Managed Care Organizations (MCOs) and within these contracts Per Member Per Month rates were required for all 10 of the regionally based CMHCs. These rates are based on the eligibility status of the individual, which can often align with the level of service utilization that the individual may need to be successful in their recovery. Through this model, CMHCs receive one payment per month that encompasses all Managed Care Program covered services provided to an individual in one rate.

Integration Services
Additionally, the three MCOs have also supported the integration for physical health services through promoting the values of whole person care and foster a coordinated continuum of care. The NH SAMHSA grant funded project, called ProHealth NH, aims to improve health and wellness for young people with serious emotional disturbance (SED), and serious mental illness (SMI). ProHealth NH was implemented utilizing partnerships between Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHC) that serve over one-third of the state. Primary care services are now co-located and integrated at three CMHCs with this project. The expectation is that integration can increase access to and receipt of recommended outpatient screening and treatment for both physical and mental health conditions, and that such treatment will reduce unnecessary emergency room visits and hospital stay.

Mental Health Medicaid Directed Payments
As authorized by the Centers for Medicare and Medicaid Services (CMS), the NH Department of Health and Human Services' (DHHS) – through its Medicaid Care Management agreements and contracted Managed Care Organizations (MCOs), have supported a multitude of directed payments models in the state. These model payments are specifically directed to improve mental health outcomes.

The directed payments include:
1. SFY 2020 – A $5M CMS approved plan that included directed payments for the period September 2019 through June 2020, as follows:

? Assertive Community Treatment (ACT) I – a payment, to promote fidelity, based upon the number of CMH system eligible individuals served.
? Assertive Community Treatment (ACT) II – a payment, to promote access, based on the number of ACT clients above the baseline count.
? Same Day/Next Day Follow-up – a payment for individuals receiving a face-to-face CMHC service within 24 hours of discharge from New Hampshire Hospital (NHH).
? Mobile Crisis Teams (MCT) – a payment for individuals seen face-to-face by Mobile Crisis Team, up to one time per month.
? Specialty Residential Placement – a payment for individuals dually diagnosed with a developmental disability and serious mental illness, discharged from New Hampshire Hospital or transitioning to a more independent living situation and receiving coordinated care from a multidisciplinary approach.

2. SFY 2021 – A $5M CMS approved plan that included directed payments for the period July 1, 2020 – June 30, 2021, as follows:

? ACT I and ACT II, as described above.
? Same Day/Next Day Follow-up – a payment for individuals receiving a face-to-face CMHC service within 24 hours of discharge from NHH or a designated receiving facility (DRF), and an additional payment for each subsequent, consecutive weekly face-to-face service, up to 180 days, to improve follow-up care and decrease readmission rates.
? Mobile Crisis Teams (MCT) – as described above.
? Special Residential Services – as described above.

3. SFY 2022 – A $5M plan, which is still pending CMS approval, for the period of July 1, 2021 – June 30, 2022, as follows:

? Same Day/Next Day Follow-up (NHH and DRFs) –as described above.
? Timely Prescriber – an enhanced uniform payment for all individuals (CMH eligible and non- eligible) who receive a prescriber appointment within 21 days of a new CMHC intake appointment.
? Illness Management and Recovery Services (IMR) – an enhanced uniform payment for individuals who receive at least 60 minutes of IMR services per week for a minimum of 10 weeks in a 13-week period.

Consolidation of Crisis Billing
To support the statewide behavioral health crisis response system transformation, the billing for acute crisis services, including mobile crisis response and stabilization services, has been consolidated and streamlined to help support a robust and sustainable crisis response system through the goals of:
• Responding to all individuals who require a face-to-face crisis intervention anywhere in the community.
• Deploying a two-person response team for the initial crisis intervention.
• Developing a reimbursement structure that supports two-person crisis response teams as well as instances when a one person response is allowed.
• Providing crisis stabilization services to individuals who need extra support following a crisis episode that resulted in contact with the mobile crisis response team.

Five specific billing codes were identified to cover crisis intervention services, psychotherapy for crisis, and crisis stabilization services. Each code was priced at levels based on the credentials of the staff providing the service whether it be a masters level clinical, bachelors level staff, or a peer support specialist. Crisis codes will be billed using a specialized modifier to access enhanced rates specifically developed to support these community-based crisis services.

CMHC EBP Incentive Funding
The CMHCs receive incentive funds via contracted state general funds to assist them with achieving higher fidelity and improve the quality of EBP's that is required by the CMHA and in their contracts. Each center can draw down money for achieving a score of "3" in the areas of frequency and intensity of services. A score of 3 for intensity is measured by individuals receiving 50-84 minutes of services per week by members of the ACT team. Frequency of service must occur between 2-3 times per week per individual to score a 3. By addressing both frequency and intensity of services, additional areas will also increase in efficacy such as the team approach within the ACT model. It is anticipated that the next contract year will increase the incentive requirement in these 2 areas to a score of 4 or 5, thus taking a step-wise approach to quality improvement.

Integrated Network Incentive Payment Program
New Hampshire just concluded its 5-year 1115(a) Medicaid Waiver, the Delivery System Reform Incentive Payment Program (DSRIP) on June 30, 2021. In the program, seven regional Integrated Delivery Networks (IDNs) were implemented across the state; each served approximately equal numbers of Medicaid beneficiaries. The work of the Integrated Delivery Networks (IDNs) was funded through the Delivery System Reform Incentive Payment (DSRIP) 1115(a) demonstration waiver. The 1115(a) waiver allowed the State of New Hampshire to draw federal financial participation (FFP) for Designated State Health Programs (DSHP) that are otherwise state-funded and use those funds to provide performance-based funding to the IDNs. The FFP that the State could receive for DSHP was capped at a certain amount for each year of the demonstration.

In the first year of the waiver IDNs received Project Design and Capacity Building funds. The remaining years the funds received were based on performance of the IDN in meeting process and performance metrics established in the standard terms and conditions of the waiver.

Challenges experienced, regarding gaps in service for individuals with co-occurring mental health and substance use disorders, were reported to the SMHA. Ongoing, collaborative work across DHHS mental health and substance use bureaus on care coordination, access, and development continues post-conclusion of the waiver program.

NH has been working to develop financial and programmatic procedures to address the continuum of care for these individuals. Cross walking of both Bureaus' rules and regulations, outlining service standards and access, has been a topic of discussion. By doing this, standards of care can be streamlined to ensure no wrong door access and innovative, sustainable payment models can be identified.

Great strides have been made through the ongoing communication and efforts between both the SMHA and the Bureau of Drug and Alcohol Services (BDAS) regarding statewide suicide prevention initiatives and critical time intervention strategies for those exiting a psychiatric stay. In early 2021, the Division for Behavioral Health, which houses both BDAS and the SMHA, hired its first statewide suicide prevention coordinator, linking the two Bureaus' efforts in this area. Both Bureaus are actively engaged together in managing the MCO contracts to ensure system of care coordination and support services for co-occurring diagnosed individuals. Staff from each Bureau meet regularly to discuss reporting provided by the MCOs to identify system needs for those with co-occurring issues. Ongoing management level work occur to ensure system wide financial and programmatic discussions are occurring and are an ongoing focus for the coming year.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

3. Innovation in Purchasing Decisions

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Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy

decisions?
Yes

2. Which value based purchasing strategies do you use in your state (check all that apply):

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Per Member Per Month Models

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NH has been working to develop financial and programmatic procedures to address the continuum of care for these individuals. Cross walking of both Bureaus' rules and regulations, outlining service standards and access, has been a topic of discussion. By doing this, standards of care can be streamlined to ensure no wrong door access and innovative, sustainable payment models can be identified.

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Please indicate areas of technical assistance needed related to this section.
NA

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

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Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ◉ Yes ○ No
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If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

For the last four years NH has had one First Episode Psychosis (FEP) treatment team at Greater Nashua Mental Health (GNMH), the HOPE (Helping Overcome Psychosis Early) team, who were trained in 2016-2019 in the NAVIGATE model. Greater Nashua Mental Health was part of the RAISE-Early Treatment Program (ETP) study and witnessed the positive impact on the lives of young adults and their families.

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4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ◉ Yes ○ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

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ESMI/FEP
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The State is fortunate to have a national expert on our staff. Mary Brunette, MD, who serves as NH's SMHA Medical Director, is a Professor of Psychiatry at Dartmouth-Hitchcock. Dr. Brunette has worked on the RAISE NAVIGATE research team since its inception. Dr. Brunette provides expertise to the ESMI/FEP SMHA project management team.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

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The expectation is to implement a Statewide Center of Excellence to bridge gaps between research, policies and practices for an evidence-based Coordinated Specialty Care (CSC) model for the treatment of First Episode Psychosis (FEP) through a collaborative and supportive effort with the Community Mental Health Centers (CMHCs) within New Hampshire. The Center of Excellence shall provide services to include training; consultation services; technical assistance; and program fidelity reviews. As of August 2021 this contract is still under negotiations and contract phasing.

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CMHCs will identify people with ESMI and provide MATCH and other EBPs tailored to the individual's needs.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

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10. Please list the diagnostic categories identified for your state's ESMI programs.

Individuals who are from the ages of 16 to 35 are served within the ESMI/FEP programs. If an individual outside of this age group is identified, the program may submit a request to serve this individual when clinically appropriate. Individuals who have experienced symptoms that demonstrate psychosis and/or symptoms that are highly likely to be the signs of an existing or emerging schizophrenia spectrum disorder are included. NH also includes those meeting the diagnostic criteria beyond existing or emerging Schizophrenia Spectrum Disorder to include additional ESMI diagnoses such as Major Depressive Disorder and Mood Disorders, and others that can cause serious impairment.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)-10 percent set aside

Much of the mainstream mental health treatment and recovery efforts traditionally focus on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

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Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?

○ Yes ◉ No

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If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI:

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ◉ Yes ○ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

NA

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The NH-DHHS supports, promotes, and even requires person-centered planning and the total involvement of individuals in their treatment decisions.

A person-centered system respects and responds to individual needs, goals and values. Within a person centered system, individuals and providers work in full partnership to guarantee that each person's values, experiences and knowledge drive the creation of a strength based individualized plan of care as well as the delivery of services. All persons have the right to have an individual support plan developed through a person-centered planning process regardless of age, disability need or residential setting.

4. Describe the person-centered planning process in your state.

New Hampshire's No Wrong Door (NWD) System represents a collaborative effort of the U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration (VHA), to support state efforts to streamline access to Long Term Services & Support (LTSS) options for all populations and all payers. In a "No Wrong Door" entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity.

A NWD System builds on the strength of existing entities such as State Units on Aging, Aging and Disability Resource Centers and Centers for Independent Living, by providing a single, more coordinated system of information and access for all persons seeking long-term support. This minimizes confusion, enhancing individual choice, and supporting informed decision-making. New Hampshire strives to create a person-centered, community-based environment that promotes independence, dignity and wellness for individuals. Person-centered planning establishes a process by which an individual support plan can be developed that is directed by the participant and their representative and is intended to identify their preferences, strength, capacities, needs and desired outcomes or goals.

All of NHs Community Mental Health Centers are required by NH State Rule to engage individuals in their treatment planning process. Each individual service plan focuses on the following items:
- Recovery;
- Strengths;
- Community integration and participation;
- Enhancing natural community supports and relationships, with particular emphasis on maintaining and improving family relationships;
- Employment, self-sufficiency, and other similar, socially valued roles;
- Identifying functional impairments which are a result of mental illness;
- Identifying treatment interventions to mitigate the functional impairments;
- Promoting access to generic services and resources;
- Establishing time-specific, sequentially-stated objectives for improved personal functioning;
- Establishing a crisis plan with individual strength and preferred responses to crisis; and
- Establishing an employment or educational plan, as appropriate.

These plans are reviewed with the individual or the individual and their care takers/natural supports/or family on a quarterly basis with the expectation that the services provided are reviewed to establish an ongoing need from both the provider and the individuals perspective.

NH SMHA also includes an Office of Consumer and Family Affairs (OCFA) which provides information, education, and support for children and youth, families, adults and older adults who are dealing with the challenges of mental illness. The goal of the OCFA is to facilitate individual and family input into all aspects of the state-funded mental health system as well as the SMHA's planning and policy development. By recruiting, organizing, and empowering individuals and families, the OCFA seeks to support them in establishing and maintaining strong input and mental health leadership on a local, regional, state, and national level.

NH also utilizes the CANS/ANSA collaborative tools that involves the individual and their natural supports in driving, prioritizing, and supporting treatment decisions. This tool allows for a collaborative conversation between the individual, provider, and necessary natural supports to identify the strengths and needs which further communicate into goals for the individual service plan.
In NH, Peer Support Agencies provide a place for individuals experiencing or recovering from SMI to receive support in a dignified and purposeful way. Peer support agencies provide services by and for people with a mental illness and are designed to assist people with their recovery through supportive interactions based on shared experience among people. The services and supports are intended to assist people to understand their potential to achieve their personal goals. Wellness Recovery Action Planning (WRAP), a group intervention helping individuals plan for all the steps needed for achieving recovery. WRAP is delivered in a self-help group context and used in PSAs to facilitate the recovery process. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. The WRAP process supports individuals to identify the tools that keep you well and create action plans to put them into practice in your everyday life. All along the way, WRAP helps individuals incorporate key recovery concepts and wellness tools into their wellness plans and life. The five key concepts of WRAP include hope, personal responsibility, education, self-advocacy and support.

Lastly, ensuring peer support specialists are part of the team that supports individuals during crisis is a focus in NH. Through the crisis response system transformation, NH intentionally included peer support specialists as core members of the two-person mobile crisis response deployment teams. Peers respond alongside master's level clinicians to an initial crisis and also remain part of the crisis stabilization team to deliver peer-oriented services once an individual's immediate crisis has stabilized. Peer support specialists are also required by contract with the SMHA to be employed at all transitional housing programs in order to support and facilitate person centered planning. These are examples of steps the NH SMHA is taking to support the lived and learned experiences model to allow for person centered approaches to drive recovery, wellness, and treatment planning.

Please indicate areas of technical assistance needed related to this section.

NA

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Footnotes:

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1. Does your state have policies related to person centered planning?
Yes

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Please indicate areas of technical assistance needed related to this section.

NA

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

New Hampshire understands the restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31. NH MHBG funds are allocated to support evidence-based, culturally competent programs, and activities for adults with SMI and children with SED. All programs funded by the MHBG are subject to this requirement.

Community-Based Programs and Confidentiality
We ensure that recipients of mental health services have full confidence in the confidentiality of their medical information. All CMHC clients receive notice of HIPAA privacy practices and State confidentiality protections at intake and annually thereafter. Members and staff of NH's Peer Support Agencies (PSAs) sign a Statement of Confidentiality detailing their rights and the obligation to protect the specific rights of their fellow members, and, in addition, PSAs and CMHC staff receive client rights training at the time of hire and on a recurring basis thereafter. All of these practices are monitored, reviewed, and reported on by an SMHA team, which includes the MHBG State Planner.

Community Mental Health Consumer Survey
The MHBG State Planner manages the annual Community Mental Health Consumer Survey and the BHSIS grant that, in association with the MHBG, supports the survey's execution and data collection efforts that inform the URS tables. The MHBG State Planner

ensures that MHPAC membership is informed of survey progress and they are offered opportunities to inform the process. The vendor, by contract, is required to present the survey findings and report to the MHPAC, the public, the CMHCs, and other state agency heads. In this way the quality findings stated in the survey report are presented as a source of suggested quality improvement efforts to be prioritized by the public and the SMHA.

The recipients of mental health services who comprise the random survey sample are clients served throughout the Community Mental Health system. The sample is derived from the NH-DHHS client-level services database. Survey recipients are advised that participation in the survey is voluntary and completely confidential. The survey is administered by a third-party vendor who is held to strict information security guidelines. In addition, survey participants are informed that their individually identifiable responses are not shared with DHHS.

Peer Support Agencies
In SFY 2020, 68% of New Hampshire's (NH) Mental Health Block Grant (MHBG) funds are directed to fund the NH-DHHS contracts with eight independent, non-profit, Peer Support Agencies (PSAs), assuring statewide access to standalone peer support programs for eligible adults. These services are not currently funded by insurance and/or Medicaid.

Because of the large proportion of MHBG funds allocated to them, the SMHA assists the PSAs in adopting policies and practices that promote compliance with program requirements, including quality and safety standards, as outlined in Administrative Rule and other state and federal requirements. This is achieved by providing continual and accessible oversight, technical assistance, and linkages to State and national resources.

The PSAs file budgets, monthly financial reports, and quarterly outcomes reports to the SMHA. PSAs undergo annual financial reviews conducted by outside auditors. Audit reports are submitted to the Division for Behavioral Health (DBH) Financial Management department; and are reviewed and reconciled by the DHHS Bureau of Program Integrity.

The Office of Consumer and Family Affairs conducts annual Mental Health Consumer Satisfaction Surveys of the PSA agencies. The survey can be completed by paper or via Survey Monkey. For the most recent survey, calendar year 2020, 225 responses were collected.

In 2018 – 2019, the SMHA conducted quality reviews of PSAs for contractual and administrative rule compliance. The review team consisted of several members from the Bureau of Mental Health Services (BMHS) and two staff members from Bureau of Program Integrity. PSAs were notified of the review in a detailed letter describing the review process and requesting initial programmatic, policy and financial information.

Post-review, program and financial findings were detailed in formal reports. The PSAs corrective action responses were evaluated and approved by the review team. Follow-up visits were conducted to verify corrective actions and other improvements recommended by the SMHA. Upon completion of all corrective actions, final reports approved and distributed. The process will be repeated on a biannual basis.

Other Programs Supported and Monitored by the SMHA

NH Mental Health Planning & Advisory Council (MHPAC)
The MHBG State Planner oversees the activities of, and provides support to, the NH Mental Health Planning & Advisory Council (MHPAC). The role of the MHBG State Planner within the MHPAC involves monitoring for the appropriate and effective use of MHBG dollars in support of the Council's activities. Conversely, the MHPAC reviews and provides feedback on the priorities to which BG funds are directed by the SMHA.

MHBG funds allocated for the support of the MHPAC are budgeted on a State Fiscal Year basis as a set dollar amount. Each expenditure request is properly invoiced, drawn down, and recorded by the DBH Finance Department. The MHBG State Planner reviews each invoice for approval prior to its being paid. Further review is conducted by both DBH and DHHS Finance departments before being paid.

MHPAC membership is unpaid; only peers (recipients of mental health services) and family members are eligible for mileage reimbursement. The MHPAC Chair, and subcommittee Chairs receive a small, token stipend for the extra time and assistance they provide to the support and well-being of the MHPAC. All funds are disbursed through a cost-effective and compliant process. Other reimbursements or stipends to MHPAC members for participation in stakeholder capacities provide the dual advantage of encouraging their participation and rewarding labor and time. For example, members are asked to spend time assisting with MHBG application research, and to participate in Steering Committees associated with BG-funded initiatives. Care is taken to follow and document DHHS protocol prohibiting conflicts of interest.

MATCH
Another CMHC program funded by the MHBG and subject to program integrity review includes training on the MATCH treatment protocol statewide. The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program that has been developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children

and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School). Once the training is completed, the CMHCs are able to continue utilizing the EBP by training peers at their own agency and maintaining their own certifications. MHBG funds are expended to assist each CMHC in the training of new clinicians, maintaining new and renewed certifications, and utilizing the TRAC-JBCC online platform. In New Hampshire there are approximately 60 trained clinicians maintaining their certification, and over 75 staff have been trained.

The CANS & ANSA in the NH System
The CANS & ANSA project is wide-ranging in its scope and goals. These two instruments are used to assess, direct, and monitor person-centered treatment for SED children and youth, via the CANS; and SMI adults, via the ANSA. The goals is to utilize these instruments as a standard assessment statewide throughout the youth and adult systems of care, and progress toward this goal is a priority of both the BMHS and the Bureau for Children's Behavioral Health (BCBH). Seven (7) out of the ten (10) CMHCs utilize the ANSA for screening and ongoing treatment planning. All ten (10) CMHCs utilize the CANS for assessment and ongoing treatment planning.

The State of New Hampshire provides technical assistance in the form of CANS and ANSA online training and certification of clinical staff employed by the CMHCs, and statewide partners throughout the children and youth System of Care, including participants in FAST FORWARD (a Wraparound program), and other community-based partnerships, since 2013. Annual CANS or ANSA certification from the Praed Foundation is required in order to preserve item rating reliability, and the State of New Hampshire covers the cost of this for CMHC staff. Program supervisory staff are encouraged to seek Trainer certification, allowing them to provide CANS/ANSA guidance consistently with SMHA and Praed Foundation expectations.

General Block Grant oversight allocations, program encumbrances, and expenditures are approved by the MHBG State Planner and accounting of the funds are managed by the DBH Finance Department. Status and balance reports are provided to the MHBG State Planner and SMHA leadership on a quarterly basis. The MHBG State Planner meets with the Finance Department frequently on an informal basis to track payments, determine vendor compliance, and fund balances. The MHBG State Planner oversees vendor compliance by managing project work plans that align program deliverables and invoices with costs, as budgeted and referenced in their contracts.

Please indicate areas of technical assistance needed related to this section

NA

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MATCH

Another CMHC program funded by the MHBG and subject to program integrity review includes training on the MATCH treatment protocol statewide. The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program that has been developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School). Once the training is completed, the CMHCs are able to continue utilizing the EBP by training peers at their own agency and maintaining their own certifications. MHBG funds are expended to assist each CMHC in the training of new clinicians, maintaining new and renewed certifications, and utilizing the TRAC-JBCC online platform. In New Hampshire there are approximately 60 trained clinicians maintaining their certification, and over 75 staff have been trained.

The CANS & ANSA in the NH System

The CANS & ANSA project is wide-ranging in its scope and goals. These two instruments are used to assess, direct, and monitor person-centered treatment for SED children and youth, via the CANS; and SMI adults, via the ANSA. The goals is to utilize these instruments as a standard assessment statewide throughout the youth and adult systems of care, and progress toward this goal is a priority of both the BMHS and the Bureau for Children's Behavioral Health (BCBH). Seven (7) out of the ten (10) CMHCs utilize the ANSA for screening and ongoing treatment planning. All ten (10) CMHCs utilize the CANS for assessment and ongoing treatment planning.

The State of New Hampshire provides technical assistance in the form of CANS and ANSA online training and certification of clinical staff employed by the CMHCs, and statewide partners throughout the children and youth System of Care, including participants in FAST FORWARD (a Wraparound program), and other community-based partnerships, since 2013. Annual CANS or ANSA certification from the Praed Foundation is required in order to preserve item rating reliability, and the State of New Hampshire covers the cost of this for CMHC staff. Program supervisory staff are encouraged to seek Trainer certification, allowing them to provide CANS/ANSA guidance consistently with SMHA and Praed Foundation expectations.

General Block Grant oversight allocations, program encumbrances, and expenditures are approved by the MHBG State Planner and accounting of the funds are managed by the DBH Finance Department. Status and balance reports are provided to the MHBG State Planner and SMHA leadership on a quarterly basis. The MHBG State Planner meets with the Finance Department frequently on an informal basis to track payments, determine vendor compliance, and fund balances. The MHBG State Planner oversees vendor compliance by managing project work plans that align program deliverables and invoices with costs, as budgeted and referenced in their contracts.

Please indicate areas of technical assistance needed related to this section

NA

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   NA

2. What specific concerns were raised during the consultation session(s) noted above?

   NA

3. Does the state have any activities related to this section that you would like to highlight?

   NA

   Please indicate areas of technical assistance needed related to this section.

   New Hampshire (NH) does not have any Federal or State recognized Tribes; there are no tribal governments or lands within its boundaries. However, this does not eliminate the possibility of the presence of American Indians and/or Alaska Natives within our state, or supports specific to their needs.

   In SFY 2020, there were 121 persons served in the NH public mental health system via the Community Mental Health Centers (CMHC) who report being Native Indian or Alaskan Native. (SOURCE: FY20 URS Table 14A).

   New Hampshire Intertribal Native American Council
   The mission of the New Hampshire Intertribal Native American Council is to create a culturally integrated organization to identify, unify, support, and service the cultural and non-cultural needs of the various Native American Indian people, their descendants, and organizations residing within the State of New Hampshire.

   The New Hampshire Intertribal Native American Council does not represent any one particular Native American Nation; but are

made up of many Nations, Tribes, Clans, and People whom reside in and around, the State of New Hampshire.

One of their stated purposes is to "provide services and resources to assist all Native American Peoples that have been assimilated into the general population of New Hampshire, so that they may live without hunger, be clothed, have proper housing, and experience the spiritual and cultural awareness that is part of the Native American Heritage."

Members of the MHPAC have identified the Council as a potential source of MHPAC members. In SFY 2022 a more detailed focus will be applied to council and subcommittee membership as a whole with more of a guiding force from the SMHA.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Tribes

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States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   N/A

2. What specific concerns were raised during the consultation session(s) noted above?
   N/A

3. Does the state have any activities related to this section that you would like to highlight?
   N/A

Please indicate areas of technical assistance needed related to this section.

New Hampshire (NH) does not have any Federal or State recognized Tribes; there are no tribal governments or lands within its boundaries. However, this does not eliminate the possibility of the presence of American Indians and/or Alaska Natives within our state, or supports specific to their needs.

In SFY 2020, there were 121 persons served in the NH public mental health system via the Community Mental Health Centers (CMHC) who report being Native Indian or Alaskan Native. (SOURCE: FY20 URS Table 14A).

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Members of the MHPAC have identified the Council as a potential source of MHPAC members. In SFY 2022 a more detailed focus will be applied to council and subcommittee membership as a whole with more of a guiding force from the SMHA.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The NH State Mental Health Authority, Bureau of Mental Health Services (BMHS), seeks to promote respect, recovery, and full community inclusion for adults, including older adults, who experience a mental illness. The BMHS provides oversight, guidance, technical assistance, training, and monitoring for mental health providers statewide to ensure that services are high quality, comprehensive and evidence-based.

The BMHS ensures the full continuum of recovery-oriented mental health services are available to State-eligible adults who experience a mental illness and/or a co-occurring mental illness and substance use disorder(s).

The state is divided into ten (10) designated community mental health regions. Each of the ten regions has a BMHS-contracted Community Mental Health Center and all ten of New Hampshire's Regions have Peer Support Agencies providing community-based services.

Administrative Rules for Community Mental Health Centers in the He-M 400 range detail the community-based psycho-rehabilitative services available in NH that are provided with SMHA oversight. The purpose of these services is to support and promote the ability of individuals to function in the community: outside of inpatient or residential institutions. The NH administrative rules governing community mental health program structure, services, and treatment programs may be found here: http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html.

NH contracts with three Medicaid Managed Care Organizations (MCOs). These contracts include provisions that MCOs maintain ongoing contracted relationships with the 10 Community Mental Health Centers (CMHCs) within NH ensuring services are reimbursable and supported. Each MCO submits a quarterly report that identifies cases that have been admitted to a psychiatric hospital and readmitted within a 30 or 180 day period after the initial readmission. The readmission report allows the MCO and DHHS to track the services each individual receives during the reporting period prior to the admission or re-admission identifying services or care or lack thereof. Ongoing work is being conducted to present these reports with the CMHCs and utilize them to engage in qualitative service discussions identifying what service gaps exist, how to respond to these gaps, and what service makeup is needed to fully support an individual within a community setting.

Transitional Housing Residential Services
The New Hampshire SMHA, through a contracted provider, offers Transitional Housing Programs (THP) to serve the clinical, medical, vocational and residential needs of adult men and women with mental health issues. The recovery model is to help individuals maintain their independence in the least restrictive environment possible, so they may successfully transition from New Hampshire Hospital into the community, where they will be able to manage their needs with the help of a Community Mental Health Center. In this way, support is titrated from intensive treatment to independence, preventing frequent hospital readmissions.

Currently there are a total of 87 transitional housing beds throughout New Hampshire, located in Concord, Manchester, Bethlehem, and Bradford. Natural and community support systems are engaged to increase community integration and connectedness for individuals. Transitional Housing offers the following services designed to be responsive to the unique needs of the individual:
• Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational and day treatment services.
• Support for community connectedness and family involvement.
• Open communication with families and individuals.

• A comprehensive approach to service delivery driven by consumer involvement.
• Evidence-based practice approaches that include Illness Management and Recovery and Supported Employment.

Comprehensive Crisis Response
Since 2015 New Hampshire has held contracts with three (3) agencies that employ distinct mobile crisis response teams within the greater Nashua region, the greater Manchester region, and the greater Concord region. Mobile Crisis Response Teams (MCRT) and beds are identified for individuals eighteen (18) years or older who are experiencing a mental health crisis, including those with a co-occurring substance use disorders. These current MCRTs each provide mobile crisis stabilization services 24 hours a day, 7 days a week, a central phone triage system where trained clinicians complete an initial risk assessment, provide crisis stabilizations services and interventions inclusive of peer support services, and provide mobile crisis apartments that serve as an alternative to hospitalization and/or institutionalization. MCRTs collaborate and coordinate with law enforcement where appropriate. MCRTs have the ability to respond to requests for crisis assessments and interventions within one (1) hour of receiving calls for mobilization of services. Once the MCRT is involved with a case, services and supports can be provided for up to thirty (30) days following the onset of the crisis to ensure individuals remain stable and in the community. Mobile Crisis Apartment stays are available for up to seven (7) days per episode or longer when warranted.

New Hampshire is currently in the process of expanding and transforming crisis services to include statewide and integrated (serving all ages with both mental health and substance use disorders) mobile crisis response. This expansion includes a single, statewide crisis access point that will serve as the primary call center equipped to provide phone based triage, assessment and de-escalation as well as the ability to deploy regional mobile crisis teams. The vision for statewide mobile crisis aligns with the national Crisis Now model and will be implemented incrementally over the next 2 years to include the full continuum of care including location-based crisis intervention.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	◉ Yes ○ No
b)	Mental Health	◉ Yes ○ No
c)	Rehabilitation services	◉ Yes ○ No
d)	Employment services	◉ Yes ○ No
e)	Housing services	◉ Yes ○ No
f)	Educational Services	◉ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	◉ Yes ○ No
h)	Medical and dental services	◉ Yes ○ No
i)	Support services	◉ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	◉ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	◉ Yes ○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The BMHS works closely with the Bureau of Drug and Alcohol Services (BDAS); both agencies serve the NH-DHHS under the umbrella of the Division for Behavioral Health (DBH). DBH leadership reinforce the coordination of Behavioral Health treatment and care services for SUD, Mental Illness, Developmental Disorders and Co-Occurring disorders.

Comprehensive psycho-rehabilitative services (inclusive of education, employment, housing, peer support, and physical health services) for individuals with mental illness and services for persons with co-occurring disorders are provided by all ten CMHCs. Several CMHCs additionally offer SUD treatment services, or refer to close partners in SUD treatment. Gaps in services for those individuals with co-occurring mental health and substance use disorders have been identified. Current and future work has started and will continue to increase collaboration across DHHS's BMHS and BDAS. Detailed financial and programmatic strategies require ongoing development to address the continuum of care. Cross walking of both BMHS and BDAS rules and regulations outlining service standards and access has been a topic of discussion. Once completed, standards of care will be established with best practices to ensure No Wrong Door access. The BDAS and BMHS work together to oversee the behavioral health components of the Managed Care Organization contracts to ensure contract terms, performance metrics, and quality improvement efforts meet the expectations and needs for all individuals with behavioral health needs.

New Hampshire's 1115(a) Medicaid Waiver, the Delivery System Reform Incentive Payment Program (DSRIP) is implemented regionally through seven Integrated Delivery Networks (IDNs) across the state, each serving approximately equal numbers of Medicaid recipients. Each IDN is implementing three community-driven projects. At least one community driven project in each region must focus on treatment of SUDs and most emphasize care coordination. The IDNs represent increasingly

collaborative networks of mental health and substance use disorder treatment organizations and a growing infrastructure of supports (i.e., integrated care, workforce development, enhanced technology) that align with the goals and strategies of this Plan.

Integrating the MH/SUD Portal and its regional hub and spokes within the IDN structure, while simultaneously extending the reach of the IDNs beyond the Medicaid population makes sense, as the IDNs seek sustainability beyond the current period of grant funding.

3. Describe your state's case management services

Community Mental Health Case Management
The philosophy of case management stems from the concept of wellness, and when an individual reaches their optimum level of wellness and functional capability, everyone benefits: the individual being served, their support system, the health care delivery system and the various reimbursement sources. Case management aims to meet the needs of an individual and address their social determinants of health. This is achieved through a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy.

The foundation of the community mental health system in NH is built on case management. The Administrative Rules set the standard for NH community mental health programs. These Rules outline case management, and case managers act as core treatment constituents throughout service delivery while providing person-centered services. For example, case management is offered, at intake, to all eligible individuals, including those with SMI and SED. The person-driven treatment planning process is facilitated by the case manager; they are the primary contact for the client. CMHC programs may serve as the sole case management entity for individuals with SMI or SED, or the CMHCs may serve as the linkage point for mental health services for clients whose cases are coordinated by another entity, including schools, developmental services agencies, or nursing homes. The Targeted Case Management (TCM) requirement limiting case management billing to one entity per client encourages communication across the service spectrum and a client-centered experience. Individuals involved across the system have the option to select the agency to manage their case.

Supported housing programs in the State of New Hampshire, for individuals with SMI/SPMI who qualify, provide case management as a basic support. The program shall provide case management services if the individual does not otherwise have a case manager. If the individual is a Community Mental Health Center client, that center continues to serve as their case manager across the service spectrum. For clients residing in staffed residences, there shall be regular communication between residential staff and each resident's case manager to ensure that services are provided in accordance with an ISP and that there is no duplication of service.

Supporting individuals diagnosed with SED and SMI to integrate into their community of choice is a key case management activity. An annual case management assessment and care plan, pursuant to He-M 426, includes documentation of the following:
• Information gathered from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual;
• An assessment of the individual's strengths;
• Identification of the consumer's case management needs; and
• The individual's preferences for needs to be addressed.

All assessment needs including; referrals, linkage and monitoring activities are documented in an individual's care plan. Needs are reviewed on a mutually agreed upon frequency (at least quarterly) with an annual review and revisions to the assessment on an as needed basis.

The development and periodic revision of a specific and comprehensive care plan relates to information collected through the assessment or reassessment that indicates goals for medical, social, educational, and other needs. An individual may decline to receive services that are suggested in the care plan. The care plan, and the CANS or ANSA are used in creation with the Individual Service Plan (ISP) to inform goals and objectives.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Our community mental health system is designed to provide high quality services at every level from low to high intensity, and hospitalization for people who need that level of care. Timely effective outpatient services help many people with SMI and SPMI avoid illness exacerbations to the degree that hospitalization is needed. Some of the most effective community-based services the SMHA supports (through contractual arrangements) are Functional Support Services, Assertive Community Treatment, Supported Employment, Supported Housing, Mobile Crisis Response Teams, First Episode Psychosis early intervention, Case Management, and Peer Support Center services, including day programs, step up step down beds, and Crisis Respite.

Functional Support Services (FSS) are core rehabilitative services. Providers help rebuild functional skills that may have been lost during challenging periods. FSS workers assist to support clients with community integration as needed. These services may be prescribed for up to 8 hours per day, per client; with a high range of 7 days per week for clients in Assertive Community Treatment. This frequent, routine contact can provide a level of support to keep clients from falling through the multitude of social and functional "cracks" that can trigger relapses and hospitalization.

Assertive Community Treatment (ACT) is an evidence-based comprehensive community-based model for delivering treatment, support, and rehabilitation services for individuals with severe mental illness. ACT team members include Functional Support Specialists.

Community Mental Health Center Services: Unique Count of Adult Assertive Community Treatment Clients from reporting ending in March of 2021.

Community Mental Health Center

January
2021

February
2021

March 2021
Unique Clients in Quarter Unique Clients in
Prior
Quarter
01 Northern Human Services 120 121 124 133 133
02 West Central Behavioral Health 43 44 60 66
03 Lakes Region Mental Health Center 56 56 59 60 58
04 Riverbend Community Mental Health Center 92 99 94 109 109
05 Monadnock Family Services 46 46 45 47 45
06 Greater Nashua Mental Health 121 126 130 152 133
07 Mental Health Center of Greater Manchester 262 256 254 274 276
08 Seacoast Mental Health Center 80 81 80 86 81
09 Community Partners 65 70 73 79 73
10 Center for Life Management 45 45 45 47 47
Total Unique Clients 929 943 963 1,051 1,007
Unique Clients Receiving ACT Services 4/1/2020 to 3/31/2021: 1,234

Individual Placement and Support - Supported Employment for people with severe mental illness is an evidence-based practice that has been implemented New Hampshire. Supported employment is a well-defined approach to helping people with disabilities participate in the competitive labor market, working in jobs of their choice that fit their skills, abilities, and interests, with competitive rates of pay. Supported Employment specialists are included on every ACT team, as well as in freestanding Supported Employment programs in all ten CMHCs.

Community Mental Health Center Services: Annual Adult Supported Employment Penetration Rates for Prior 12-Month Period for reporting ending March of 2021.

Community Mental Health Center 12 Month Period Ending March 2021 Penetration Rate for Period
Ending
December 2020
Supported Employment
Clients
Total Eligible
Clients
Penetration
Rate
01 Northern Human Services 159 1,326 12.0% 12.0%
02 West Central Behavioral Health 100 539 18.6% 22.5%
03 Lakes Region Mental Health Center 624 1,599 39.0% 32.7%
04 Riverbend Community Mental Health Center 259 1,903 13.6% 14.1%
05 Monadnock Family Services 47 1,109 4.2% 3.7%
06 Greater Nashua Mental Health 313 2,777 11.3% 12.3%
07 Mental Health Center of Greater Manchester 1,462 3,605 40.6% 40.1%
08 Seacoast Mental Health Center 844 2,137 39.5% 37.0%
09 Community Partners 109 838 13.0% 13.2%
10 Center for Life Management 232 1,474 15.7% 14.3%
Total Unique Clients 4,137 17,062 24.2% 23.7%

Mobile Crisis Response Teams (MCRT)
Mobile crisis response teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and other community-based settings outside of a traditional clinical office. Crisis intervention teams work

with law enforcement officials to recognize a person who is in crisis and safely direct them to treatment appropriate for their condition, thus reducing the rate of arrest, incarceration or unnecessary emergency room visits.

Over 1,400 individuals were served by Mobile Crisis Services and Apartments in the first quarter of 2021 by three mobile crisis teams located in the population centers of Nashua, Manchester, and Concord. These teams were structured through contractual agreements with the SMHA. Starting in SFY 2022 mobile crisis response services will be available statewide as a result of NH's crisis transformation work.

Supportive housing and housing supports
The availability of safe and affordable housing is often a core social determinant of health for those diagnosed with severe mental illness. The cascading effects of mental illness can put a strain on the individual's ability to acquire and maintain housing. Having a safe and secure place to live is a critical part of stabilization and recovery, along with access to services that enable those with mental health conditions to live as independently after hospitalization.

There are currently several successful housing programs managed by the Bureau of Mental Health Services assisting individuals experiencing homelessness due to disabling symptoms of mental illness. The Housing Bridge Subsidy Program (HBSP) is a supportive housing program currently funded to serve up to 500 individuals across New Hampshire. HBSP services include a Housing Specialist assigned to each individual in the program. The Housing Specialist will assist the individual in finding an appropriate unit, signing and understanding their lease, and ensuring they are connected to any community supports and services the individual requests or requires. Individuals on HBSP are expected to transition onto a Housing Choice Voucher through HUD within 2 to 3 years of entering HBSP. The Housing Specialist will assist them with the transition of vouchers, and remain available to the individual should they require any further housing assistance. BMHS has partnered with New Hampshire Housing Finance Authority to manage the Project Rental Assistance Section 811 Program (PRA811). This is a permanent housing program, and recipients have access to the full array of support services provided by the CMHCs. PRA811 provides the individual with a safe, affordable place to live, and the availability to have support services in the community to keep them safely housed and connected with their health care providers.
Supported Housing Subsidy Summary for data ending in March of 2021.

Subsidy January – March
2021 October – December
2020
Total subsidies by end of quarter Total subsidies by end of quarter

Housing Bridge Subsidy: Units Currently Active 306 300
Individuals Enrolled and Seeking Unit for Bridge
Lease 104 96
Section 8 Voucher
(NHHFA): Transitioned from Housing Bridge* 233 212
Not Previously Receiving Housing Bridge 0 0
811 Units: PRA* 121 114
Mainstream* 74 74
Other Permanent Housing Vouchers (HUD, Public Housing, VA)* 8 2
Total Supported Housing Subsidies 846 798

Peer Support Agencies (PSA) provide an alternative to traditional clinical treatment. Among PSA programming, individuals can receive support from individuals with lived experience with mental illness. PSA's offer support groups, resources, warm line services, community connection, on-site activities and educational events, and Peer Respite. Peer Respite provides an alternative to psychiatric ED or inpatient hospitalization. 148 out of 161 peer program participants responding to an anonymous survey reported that day support programs for peers, provided by Peer Support Agencies, helped to keep them out of the hospital (Source: PSA Satisfaction Survey 2020).

Peer Respite services are operated by people who have experience living with a mental illness (i.e., peers), and are designed as calming homelike environment with supports for individuals in crisis twenty-four (24) hours a day. Peer Respite is offered in three of NH's Peer Support Agencies. Peer Respite stays are seven days or less, but may be extended through approval by the BMHS, if needed. Peer Respite services are generally shorter term than crisis residential services.

SFY 21 PSA Crisis Respite Utilization

Peer Support Agency
# of days person occupied bed
# of persons served
Total number of admissions
HEARTS (2 beds)
SFY 20 468 70 79
SFY21 Q1 61 10 10

SFY21 Q2 71 11 13
SFY21 Q3 68 11 11
SFY21 Q4 83 10 10
Total for SFY 21 283 112 44

MPASA (1 bed)
SFY 20 145 27 27
SFY21 Q1 71 11 11
SFY21 Q2 21 3 3
SFY21 Q3
12 4 4
SFY21 Q4 0 0 0
Total for SFY 21 104 18 18

Stepping Stone (2 beds)
SFY 20 60 10 15
SFY21 Q1 0 0 0
SFY21 Q2 0 0 0
SFY21 Q3
2 1 1
SFY21 Q4 2 1 1
Total for SFY 21 4 2 2

Peer Support Agencies maintain warm lines: "a direct service delivered via telephone by a [peer] that provides a person in distress with a confidential venue to discuss their current status and/or needs SAMHSA, 2012).

NH Mental Health Client Peer Support Agencies: Census Summary for reporting ending in March of 2021.

Peer Support Agency January – March 2021 October – December 2020
Total Members Average Daily Visits Total Members Average Daily Visits

Alternative Life Center Total
622
25
614
28
Conway 271 5 271 6
Berlin 143 6 137 7
Littleton 90 6 89 6
Colebrook 118 8 117 9

Stepping Stone Total
368
6
366
7
Claremont 249 5 248 6
Lebanon 119 1 118 1

Cornerbridge Total
368
6
141
11
Laconia 249 5 53 5
Concord 119 1 73 3
Plymouth Outreach 15 0 15 3

MAPSA Keene Total
340
19
339
14

HEARTS Nashua Total

391
36
386
50
On the Road to Recovery Total 165 12 149 10
Manchester 93 5 83 4
Derry 72 7 66 6
Connections Portsmouth Total 108 7 101 5
TriCity Coop Rochester Total 282 7 277 8

Total
2,644
106
2,373
123

First Episode Psychosis
For the last four years NH has operated one FEP treatment team at Greater Nashua Mental Health (GNMH), the HOPE (Helping Overcome Psychosis Early) team, who were trained in 2016-2019 in the NAVIGATE coordinated specialty care model that was developed and tested through the NIMH RAISE-ETP program. Greater Nashua Mental Health was part of the RAISE-ETP study and witnessed the positive impact on the lives of young adults and their families.

The Coordinated Specialty Care team from Greater Nashua Mental Health is composed of a Program Director, Family Education (FE) Clinician, Prescriber, Individual Resiliency Trainer (IRT), and Supported Employment and Education (SEE) Specialist. Additionally, case management and functional support services are offered.

The HOPE Program Director was involved in the original RAISE study and has been trained as an IRT therapist and trainer. The HOPE Program SEE specialist was also part of the original RAISE study and has significant training and experience as an SEE provider. We are fortunate to have both of these staff working on the FEP team. BG funds will continue to support the HOPE program with implementation costs and reimbursement for uncompensated HOPE program services.

New Hampshire has expanded efforts to increase awareness and reduce stigma related to mental illness in young people generally, and first episode psychosis specifically. We have implemented learning and education models such as Mental Health First Aid statewide. These programs have planted the seeds of awareness about mental illness and how to recognize early signs. Stigma reduction, we have found, plays a large part in the ability of the general public to recognize early symptoms, refer to appropriate services, and engage in treatment. As part of NH's 10-year mental health plan, early treatment models, including FEP were highlighted and identified by stakeholders as foundational recommendations.

. During SFY 2019-21, the State carried out a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide ESMI or FEP treatment model using funds provide by the 10% set-aside of the BG. The initiative included two components; first, proposing a treatment model that we can scale to provide ESMI/FEP services statewide, and the second, a public awareness campaign that focuses on the importance and availability of early interventions. New Hampshire has been working to expand FEP services statewide. In July 2021, three new FEP sites were implemented in the state, bringing the total number of FEP programs to four programs statewide. These programs are in the process of developing implementation models.

Criterion 2: Mental Health System Data Epidemiology
Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.
Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED Target Population (A) Statewide prevalence (B) Statewide incidence (C)

1. Adults with SMI

5.4% (59,261)
5.4% (59,261)

2. Children with SED

3.4% (8,691)
3.4% (8,691)

** Note the above estimated population rates are a direct calculation utilizing the SAMHSA identified population percentages of 5.4% for adults with SMI and 3.4% of children with SED. Percentages were used to calculate against 2021 census population rates.

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

NH utilizes the Uniform Reporting System (URS) tables for planning and reporting purposes. Information from the NH-DHHS Phoenix client service and demographic database is sorted and analyzed to produce the URS reports as well as various other reports, including Adult Assertive Community program utilization, waitlist, and staffing; and Supported Employment program utilization, waitlist, staffing, and aggregate count reports of clients by employment status.

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New Hampshire Hospital: Adult Census Summary for reporting ending in March of 2021.

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Discharges 173 191
Median Length of Stay in Days for Discharges 35 32
Deaths 2 0

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?
a) Social Services Yes
b) Educational services, including services provided under IDE Yes
c) Juvenile justice services Yes
d) Substance misuse prevention and SUD treatment services Yes
e) Health and mental health services Yes
f) Establishes defined geographic area for the provision of services of such system Yes

Criterion 4
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Describe your state's targeted services to rural and homeless populations and to older adult.
All ten community mental health centers are required to provide care to individuals in rural settings within their regions. Specific regions with high rural settings include Norther Human Services, West Central Behavioral Health, and Monadnock Family Services. Within these regions CMHCs work to provide care on telehealth platforms, within the community or clients living location, and provide support in transportation where needed. Often times the local Peer Support Agencies will provide transportation to attend support through their services. The Department further supports the following services through rural care venues.

Targeted Services to Rural and Homeless Populations and to Older Adults
Rural Populations
The State of NH, Department of Health and Human Service, Division of Public Health Services, Bureau of Community Health Services Rural Health and Primary Care section includes the Primary Care Office, the State Office of Rural Health, and Workforce Development. The mission and function of the Rural Health and Primary Care section is to support communities and stakeholders that provide innovative and effective access to quality health care services with a focus on the low income, uninsured, and Medicaid populations of New Hampshire.

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Workforce Development
Workforce Development works with each of the above program areas to increase or retain the supply of health professionals serving New Hampshire. There is a particular focus on those professionals whose service will meet the needs of rural and underserved populations. Workforce Development administers New Hampshire's State Loan Repayment Program, the J1 Visa Waiver (Conrad 30) program, and the National Interest Waiver program.

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The Division of Public Health Services, Rural Health and Primary Care Section, has the responsibility within the State of New Hampshire to provide a Letter of Attestation in support of a foreign physician's request for a National Interest Waiver from the US Citizenship and Immigration Services (USCIS). The foreign physicians' work must be in an area that has been designated as having a shortage of health care providers by the Secretary of Health and Human Services, and must be deemed by the Division of Public Health Services to be in the public interest.

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The New Hampshire State Loan Repayment Program (SLRP) provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time). The allotment of funds is contingent on the availability of specified SLRP funding in the State budget for any given fiscal year. These medically underserved areas; identified as Health Care Professional Shortage Areas (HPSAs), Mental Health Professional Shortage Areas (MHPSAs), Dental Health Professional Shortage Areas (DHPSAs), Medically Underserved Areas/Populations (MUA/Ps), and Governor's Exceptional Medically Underserved Populations (E-MUP) are indicators that a shortage of primary healthcare providers exist, posing a barrier to access to primary health care services for the residents of these areas.

Table: NH Health Professional Shortage Areas (HPSAs) – Mental Health

HPSA Name Designation Type HPSA Score
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Eastern Coos High Needs Geographic HPSA 17
Littleton Service Area High Needs Geographic HPSA 12
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Weeks Medical Center - Groveton Rural Health Clinic 18
Weeks Medical Center - Whitefield Rural Health Clinic 18
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Rowe Health Center Rural Health Clinic 19
Weeks Medical Center - Lancaster Rural Health Clinic 14

Describe your state’s targeted services to the homeless population.
CMHC PATH Programs

Six out of the ten CMHCs provide PATH homeless outreach services. These PATH programs are in compliance with the Federal Public Health Services Act, Section 522(b)(10), Part C to individuals who are homeless or at imminent risk of being homeless and who are believed to have Severe Mental Illness (SMI), or SMI and a co-occurring substance use disorder. The CMHCs provide outreach, screening, diagnostic treatment, and case management services. Services are targeted to Assisting eligible homeless individuals with obtaining and coordinating services, including referrals for primary health care. The designated PATH workers assess the individual immediacy of needs and continues to focus and work with the individual to enhance treatment and housing readiness.

Homelessness

The State of Homelessness in New Hampshire 2018 examines homelessness in the state between 2018 and 2020. Homeless census data during this time period reveals that the overall number of those experiencing homelessness rose by 21 percent from 2019 - 2020. The poverty rate in New Hampshire continues to fall, and remains well below the national rate of 15.1 percent. Moreover, at the same time that unemployment remains relatively low in New Hampshire, median income of renters has shown slight increases. At the same time, however, data also show increasing rents compounded by extremely low vacancy rates across the state, two key factors which significantly hinder the state's progress in ending homelessness. The 2020 NH Residential Rental Cost Survey reports that the median rent for a 2 bedroom apartment in NH is $1,413 per month, and the vacancy rate for rental units is 1.8%. A 5% vacancy rate is considered a balance rental market.

• Between 2018 and 2020, the overall number of people experiencing homelessness rose by 21 percent.
• There were 1,577people in families (including children) that were experiencing homelessness in SFY 2020.
• The number of individuals living unsheltered in SFY 2020 was 411.
• For the 2019-2020 school year, the statewide number of students experiencing homelessness was 3,216. This is believed to be an underrepresentation of student homelessness. The COVID-19 pandemic created several limitations in identifying students experiencing homelessness.

"When we became homeless we ended up in a tent by the railroad tracks. We have a limited, fixed income. Most landlords told us we didn't make enough to afford a studio. We spent 11 months in the tent until we were able to get into a shelter."
- Emergency shelter guest

The US Department of Housing and Urban Development (HUD) defines someone who is homeless as:
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

• Has a primary nighttime residence that is a public or private place not meant for human habitation;
• Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
• Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Homelessness and housing instability are known to negatively impact the other Social Determinants of Health. By increasing access to safe, affordable housing, and improving housing stability, other health outcomes improve. This includes physical and mental health, as well as other SDOH like education and employment. The COVID-19 pandemic has made it clear that lack of housing is a public health crisis. There are many studies that link housing with improved health outcomes. "Housing is healthcare" is a common phrase, with new studies showing the importance of linking housing with public health in order to achieve the greatest outcomes.

The State of New Hampshire Bureau of Housing Supports (BHS) provides an array of statewide services, which act as a safety net for some of New Hampshire's most vulnerable citizens. Services are provided through five Community Action Agencies and other non-profit service providers across the state and provide interventions that have a direct and positive impact on individuals and families, preventing them from becoming homeless or assisting the homeless in moving on to permanent housing. Examples of services provided include:

• Assists people who are experiencing housing instability or homelessness to access housing, shelter, and/ or other services to assist in achieving or maintaining housing stability and independence.
• Provide short and medium term rental assistance and Permanent Supportive Housing to individuals, youth, and/ or families, along with supportive services to maintain housing stability.
• Provide outreach services to those who are considered "hard to reach," such as those residing on the streets, or other places not meant for human habitation to increase their transitions to housing stability.
• Provide intensive case management services to connect individuals and families to appropriate services including medical and mental health care, TANF/SNAP benefits, SSI/SSDI, and any other services necessary.

Services provided through the Bureau of Housing Supports follow the Housing First approach. Housing First is a homeless assistance approach that is guided on the belief that housing is a basic need for people that should be met as quickly as possible, without any prerequisites or conditions beyond those of a typical renter. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and participating in supportive services, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life. Traditional homelessness programs have been based upon the assumption that people should not be placed into housing until they have resolved personal issues, such as diagnosis and treatment of a disability or training in independent living skills. Conversely, a Housing First approach assumes that people should start with stable permanent housing. They may then choose to address other life issues that may have contributed to their homelessness experience to maintain their ongoing housing stability. Supportive services (such as recovery resources or mental

health treatment) are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.

The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. Individuals using a Housing First model have been shown to access housing faster and are more likely to remain stably housed. Each individualized POC will use the above approach to create a strengths based, individualized, community-based, culturally and linguistically informed action plan to obtain, or retain housing.
• State Funded Emergency and Transitional Shelters

• HUD Continuum of Care funding

Describe your state's targeted services to the older adult population.

New Hampshire is Aging
As of 2019, NH's population over 65 increased 2.7%. It is clear that a need exists for services and programs targeted to our aging population, 2.2% greater than the rate of increase in the US.
(SOURCE: US Census)

New Hampshire Referral, Education, Assistance, & Prevention Program (REAP)
The New Hampshire Referral, Education, Assistance, & Prevention Program is a partnership between the BMHS, BDAS, Bureau of Elderly and Adult Services, and the CMHCs. The Program is available to all older adults, 60 years or older, who are residents of New Hampshire Senior Housing, or caregivers or family members of an older adult in NH. The program is designed to assist those adults in taking control of their life, and to live a happy, healthy, and independent lifestyle. REAP counselors are available to provide support, education, information, and resources on how to deal with life changes and encounters. REAP also focuses on ensuring individuals can improve their quality of life and maintain their independence.

Community Based Care
The Bureau of Elderly and Adult Services (BEAS) and supports are intended to assist people to live as independently as possible in safety and with dignity. Services range from home care, meals on wheels, care management, transportation assistance and assisted living to nursing home care.

A variety of social and long-term services and supports can be accessed through the ServiceLink Resource Centers and the NH DHHS District Offices. Services and supports are intended to assist people to live as independently as possible in safety and with dignity. Examples include:
• Home care
• Meals on wheels
• Transportation assistance
• Long Term Care-Nursing home and community based care
• Information and assistance regarding Medicare and Medicaid
• Information about volunteer opportunities
• Investigation of reports of abuse, neglect or exploitation of incapacitated adults
Long-Term Care Rehabilitative Services
The Glencliff Home serves Adults with SMI 60 years of age or older who meet the requirements for Long-Term Care that identifies GHE as the least restrictive environment and providing the level of medical care the person requires.

Criterion 5: Management Systems
States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Describe your state's management systems.
MHBG-Funded Staff and Training Management Systems
I. Adults: PEER SUPPORT AGENCIES – STAFFING, TRAINING, and OVERSIGHT
In New Hampshire the largest of recovery support services is through our network of Peer Support Agencies that are subsidized by the MHBG and State general funds. To maintain professionalism, expand implementation, support individuals with mental illness and in compliance with contract provisions of services, the PSA system in New Hampshire remains heavily reliant on ongoing training and leadership development. NH has fourteen Peer Support Agencies that are employed by individuals whom identify with having lived experience with mental illness. They are peer-led, peer-driven in programming (e.g., community meetings, team-building meetings, support groups, educational events) and agency policy making through mutuality and consensus of members. Some Peer Support Agencies also offer Peer Respite. Peer Respite provides a short-term place to stay with 24/7 peer support available on-site in a homelike environment with the goal being to divert an individual entering a higher level of care.

Staff members must be trained in Intentional Peer Support (IPS), Whole Health Action Management and Recovery Action Planning (materials developed by Mary Ellen Copeland, PhD and SAMHSA). At this time, NH has one certified IPS trainer and is in the process

of evaluating the peer training infrastructure/modalities and increasing the number of state trainers to support the peer workforce statewide. Three individuals have been identified to attend the national IPS train-the-trainer event in calendar year 2021. These additional IPS state trainers will allow for greater flexibility, support for and expansion of the peer workforce. Additionally we are developing training components such as boundaries and ethics training as this is an important aspect of peer support and service delivery.

All Warm Line staff also receive Warm Line Training to create expertise in this vital use of Peer Support.
The MHBG FFY 2019-2021 supplemental award, granted in September 2019, supported over ten trainings for PSAs designed to strengthen governance, management, technical and leadership skills, and nonprofit best-practices, including customized board of directors trainings for each agency, "Deepening Community Awareness and Fundraising", "Board Recruitment and Retention", and "Nonprofit Financials", among others.

The Supplemental award also allowed NH to receive consultation from national trainer and peer leader, Eduardo Vega, to develop the Peer Workforce Advancement Plan. The purpose of the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) is to present actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector. The New Hampshire Peer Workforce Development plan is the result of the 10-Year Mental Health Plan's Recommendation #7, which seeks to expand the availability of peers in practice settings and to integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas such as training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies, while other factors are specific to the roles, challenges, and opportunities of people with lived experience in the role of a peer support specialist. Preparation of the Advancement Plan included stakeholder input at three (3) public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the Bureau of Mental Health Services (BMHS), National Alliance on Mental Illness of New Hampshire (NAMI-NH) and Eduardo Vega, Humannovations. Participating stakeholders included individuals representing peer support agencies (PSA), community mental health centers (CMHCs), community and system advocates, and many individuals with lived experience.

On-Site monitoring visits occurred in SFY 20-21of all of the PSAs. Interviews and file review based on a customized review tool gave the BMHS a clear impression of needs and strengths to guide PSA oversight. Corrective Action Plans were requested, approved, and monitoring continues.

Improvements in the contracting process ensure that funds and programs are operating efficiently and in accordance with best practices.

Mental health training for criminal justice staff was made available through SAMHSA's supplemental training and technical assistance mental health block grant funds. In FY2021, grant funds supported New Hampshire's workforce development goals to increase mental health training for individuals working in the criminal justice system. Through a partnership with the NH Department of Corrections (DOC), a series of training sessions for personnel working with individuals with mental illness who are involved with the justice system took place. Attendees included more than 275 staff from the NH DOC and court system, and law enforcement personnel. The series of trainings included Building Trauma-Responsive Correctional Settings; Mental Health First Aid/Awareness Training; Suicide Prevention Training; Responding to People with Mental Illness; and Crisis Intervention Training. Trainings were targeted to directly address recommendations within New Hampshire's 10 Year Mental Health Plan.

II. Children: MATCH
The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program that has been developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School), The Judge Baker Children's Center (JBCC) employs the Learning Collaborative model, and includes rigorous implementation strategies for evidence-based practices, including conducting continuous quality improvement review and assessment, and developing and implementing data systems to collect, analyze, and report outcomes and implementation data. Over sixty (60) CMHC clinicians were trained in the MATCH protocol by JBCC, and over 130 additional staff have been trained by CMHC MATCH-certified trainers. A rigorous reporting structure, and an online clinical component provides the CMHCs and the SMHA with management reports, provide guarantees of program integrity.

Clinical Staff Participants by Cohort
Learning Collaborative Cohorts CMHC Participation and Clinical Staff Training
Training Cohort 1 Planned: 4 CMHCs with 5-8 clinical staff each for a total of up to 32 clinical staff.
(At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Training Cohort 2 Planned: 6 CMHCs with 5-8 clinical staff each for a total of up to 48 clinical staff.
(At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Total Learning Collaborative Actual: 64 clinical staff have been trained across 10 CMHCs.

The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projected have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract. Actual and projected SFY costs are as follows:

SFY 2018: SFY 2019: SFY 2020
$270,000 $215,000 $175,000

First Episode Psychosis: PROGRAM SUPPORT AND STAFF TRAINING COSTS
Each year since the inception of the requirement for 10% of the block grant required set aside for First Episode Psychosis (FEP) programming, these MHBG funds have used for continued training and support in the NAVIGATE Coordinated Specialty Care model to the HOPE FEP program team at Greater Nashua Mental Health.

In July of 2021 the CMHC contracts were updated to include start up training funds of a total of $51,000 each to four CMHCs beginning to implement FEP/ESMI programs to cover initial costs associated with training and consultation in the NAVIGATE model. Funds also include a total of $60,000 each to four CMHCs to support non billable programing costs and staff time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	18	18
2.Children with SED	11	11

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

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b)	Educational services, including services provided under IDE	◉ Yes ○ No
c)	Juvenile justice services	◉ Yes ○ No
d)	Substance misuse preventiion and SUD treatment services	◉ Yes ○ No
e)	Health and mental health services	◉ Yes ○ No
f)	Establishes defined geographic area for the provision of services of such system	◉ Yes ○ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

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b. Describe your state's targeted services to the homeless population.

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- Emergency shelter guest

The US Department of Housing and Urban Development (HUD) defines someone who is homeless as:
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
• Has a primary nighttime residence that is a public or private place not meant for human habitation;
• Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
• Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Homelessness and housing instability are known to negatively impact the other Social Determinants of Health. By increasing access to safe, affordable housing, and improving housing stability, other health outcomes improve. This includes physical and mental health, as well as other SDOH like education and employment. The COVID-19 pandemic has made it clear that lack of housing is a public health crisis. There are many studies that link housing with improved health outcomes. “Housing is healthcare” is a common phrase, with new studies showing the importance of linking housing with public health in order to achieve the greatest outcomes.

The State of New Hampshire Bureau of Housing Supports (BHS) provides an array of statewide services, which act as a safety net for some of New Hampshire's most vulnerable citizens. Services are provided through five Community Action Agencies and other non-profit service providers across the state and provide interventions that have a direct and positive impact on individuals and families, preventing them from becoming homeless or assisting the homeless in moving on to permanent housing. Examples of services provided include:
• Assists people who are experiencing housing instability or homelessness to access housing, shelter, and/ or other services to assist in achieving or maintaining housing stability and independence.
• Provide short and medium term rental assistance and Permanent Supportive Housing to individuals, youth, and/ or families, along with supportive services to maintain housing stability.
• Provide outreach services to those who are considered “hard to reach,” such as those residing on the streets, or other places not meant for human habitation to increase their transitions to housing stability.
• Provide intensive case management services to connect individuals and families to appropriate services including medical and mental health care, TANF/SNAP benefits, SSI/SSDI, and any other services necessary.

Services provided through the Bureau of Housing Supports follow the Housing First approach. Housing First is a homeless assistance approach that is guided on the belief that housing is a basic need for people that should be met as quickly as possible, without any prerequisites or conditions beyond those of a typical renter. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and participating in supportive services, and that exercising that choice is likely to

make a client more successful in remaining housed and improving their life. Traditional homelessness programs have been based upon the assumption that people should not be placed into housing until they have resolved personal issues, such as diagnosis and treatment of a disability or training in independent living skills. Conversely, a Housing First approach assumes that people should start with stable permanent housing. They may then choose to address other life issues that may have contributed to their homelessness experience to maintain their ongoing housing stability. Supportive services (such as recovery resources or mental health treatment) are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.

The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. Individuals using a Housing First model have been shown to access housing faster and are more likely to remain stably housed. Each individualized POC will use the above approach to create a strengths based, individualized, community-based, culturally and linguistically informed action plan to obtain, or retain housing.

c. Describe your state's targeted services to the older adult population.

As of July 2019, NH's population over 65 increased 2.7%. It is clear that a need exists for services and programs targeted to our aging population, 2.2% greater than the rate of increase in the US.
(SOURCE: SAMHSA URS tables)

Community Based Care
The Bureau of Elderly and Adult Services (BEAS) and supports are intended to assist people to live as independently as possible in safety and with dignity. Services range from home care, meals on wheels, care management, transportation assistance and assisted living to nursing home care.

A variety of social and long-term services and supports can be accessed through the ServiceLink Resource Centers and the NH DHHS District Offices. Services and supports are intended to assist people to live as independently as possible in safety and with dignity. Examples include:
• Home care
• Meals on wheels
• Transportation assistance
• Long Term Care-Nursing home and community based care
• Information and assistance regarding Medicare and Medicaid
• Information about volunteer opportunities
• Investigation of reports of abuse, neglect or exploitation of incapacitated adults

Long-Term Care Rehabilitative Services
The Glencliff Home serves Adults with SMI 60 years of age or older who meet the requirements for Long-Term Care that identifies GHE as the least restrictive environment and providing the level of medical care the person requires.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

I. Adults: PEER SUPPORT AGENCIES – STAFFING, TRAINING, and OVERSIGHT

In New Hampshire the largest of recovery support services is through our network of Peer Support Agencies that are subsidized by the MHBG and State general funds. To maintain professionalism, expand implementation, support individuals with mental illness and in compliance with contract provisions of services, the PSA system in New Hampshire remains heavily reliant on ongoing training and leadership development. NH has fourteen Peer Support Agencies that are employed by individuals whom identify with having lived experience with mental illness. They are peer-led, peer-driven in programming (e.g., community meetings, team-building meetings, support groups, educational events) and agency policy making through mutuality and consensus of members. Some Peer Support Agencies also offer Peer Respite. Peer Respite provides a short-term place to stay with 24/7 peer support available on-site in a homelike environment with the goal being to divert an individual entering a higher level of care.

Staff members must be trained in Intentional Peer Support (IPS), Whole Health Action Management and Recovery Action Planning (materials developed by Mary Ellen Copeland, PhD and SAMHSA). At this time, NH has one certified IPS trainer and is in the process of evaluating the peer training infrastructure/modalities and increasing the number of state trainers to support the peer workforce statewide. Three individuals have been identified to attend the national IPS train-the-trainer event in calendar year 2021. These additional IPS state trainers will allow for greater flexibility, support for and expansion of the peer workforce. Additionally we are developing training components such as boundaries and ethics training as this is an important aspect of peer support and service delivery. All Warm Line staff also receive Warm Line Training to create expertise in this vital use of Peer Support.

The MHBG FFY 2019-2021 supplemental award, granted in September 2019, supported over ten trainings for PSAs designed to strengthen governance, management, technical and leadership skills, and nonprofit best-practices, including customized board of directors trainings for each agency, "Deepening Community Awareness and Fundraising", "Board Recruitment and Retention", and "Nonprofit Financials", among others.

The Supplemental award also allowed NH to receive consultation from national trainer and peer leader, Eduardo Vega, to develop the Peer Workforce Advancement Plan. The purpose of the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) is to present actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector. The New Hampshire Peer Workforce Development plan is the result of the 10-Year Mental Health Plan's Recommendation #7, which seeks to expand the availability of peers in practice settings and to integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas such as training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies, while other factors are specific to the roles, challenges, and opportunities of people with lived experience in the role of a peer support specialist. Preparation of the Advancement Plan included stakeholder input at three (3) public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the NH Department of Health and Human Services, Bureau of Mental Health Services (BMHS), National Alliance on Mental Illness of New Hampshire (NAMI-NH) and Eduardo Vega, Humannovations. Participating stakeholders included individuals representing peer support agencies (PSA), community mental health centers (CMHCs), community and system advocates, and many individuals with lived experience.

On-Site monitoring visits occurred in SFY 20-21of all of the PSAs. Interviews and file review based on a customized review tool gave the BMHS a clear impression of needs and strengths to guide PSA oversight. Corrective Action Plans were requested, approved, and monitoring continues. Improvements in the contracting process ensure that funds and programs are operating efficiently and in accordance with best practices.

II. Children: MATCH

The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program that has been developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School), The Judge Baker Children's Center (JBCC) employs the Learning Collaborative model, and includes rigorous implementation strategies for evidence-based practices, including conducting continuous quality improvement review and assessment, and developing and implementing data systems to collect, analyze, and report outcomes and implementation data. Over sixty (60) CMHC clinicians were trained in the MATCH protocol by JBCC, and over 130 additional staff have been trained by CMHC MATCH-certified trainers. A rigorous reporting structure, and an online clinical component provides the CMHCs and the

SMHA with management reports, provide guarantees of program integrity.
Clinical Staff Participants by Cohort Learning Collaborative Cohorts CMHC Participation and Clinical Staff Training

Training Cohort 1 Planned: 4 CMHCs with 5-8 clinical staff each for a total of up to 32 clinical staff.
(At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Training Cohort 2 Planned: 6 CMHCs with 5-8 clinical staff each for a total of up to 48 clinical staff.
(At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Total Learning Collaborative Actual: 64 clinical staff have been trained across 10 CMHCs.

The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projected have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract. Actual and projected SFY costs are as follows:

SFY 2018: SFY 2019: SFY 2020
$270,000 $215,000 $175,000

First Episode Psychosis: PROGRAM SUPPORT AND STAFF TRAINING COSTS
Each year since the inception of the requirement for 10% of the block grant required set aside for First Episode Psychosis (FEP) programming, these MHBG funds have used for continued training and support in the NAVIGATE Coordinated Specialty Care model to the HOPE FEP program team at Greater Nashua Mental Health.

In July of 2021 the CMHC contracts were updated to include start up training funds of a total of $51,000 each to four CMHCs beginning to implement FEP/ESMI programs. Funds also include a total of $60,000 each to four CMHCs to support non billable programing costs and staff time.

Footnotes:

Statutory Criterion for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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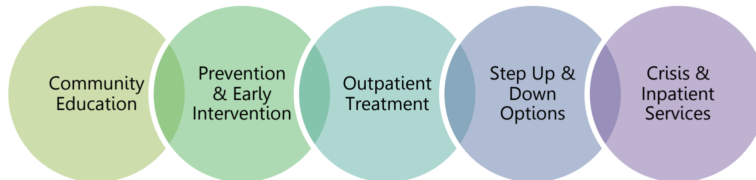
1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The NH State Mental Health Authority, Bureau of Mental Health Services (BMHS), seeks to promote respect, recovery, and full community inclusion for adults, including older adults, who experience a mental illness. The BMHS provides oversight, guidance, technical assistance, training, and monitoring for mental health providers statewide to ensure that services are high quality, comprehensive and evidence-based.

The BMHS ensures the full continuum of recovery-oriented mental health services are available to State-eligible adults who experience a mental illness and/or a co-occurring mental illness and substance use disorder(s).



The state is divided into ten (10) designated community mental health regions. Each of the ten regions has a BMHS-contracted Community Mental Health Center and all ten of New Hampshire's Regions have Peer Support Agencies providing community-based services.

Administrative Rules for Community Mental Health Centers in the He-M 400 range detail the community-based psycho-rehabilitative services available in NH that are provided with SMHA oversight. The purpose of these services is to support and promote the ability of individuals to function in the community: outside of inpatient or residential institutions. The NH administrative rules governing community mental health program structure, services, and treatment programs may be found here: http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html.

NH contracts with three Medicaid Managed Care Organizations (MCOs). These contracts include provisions that MCOs maintain ongoing contracted relationships with the 10 Community Mental Health Centers (CMHCs) within NH ensuring services are reimbursable and supported. Each MCO submits a quarterly report that identifies cases that have been admitted to a psychiatric hospital and readmitted within a 30 or 180 day period after the initial readmission. The readmission report allows the MCO and DHHS to track the services each individual receives during the reporting period prior to the admission or re-admission identifying services or care or lack thereof. Ongoing work is being conducted to present these reports with the CMHCs and utilize them to engage in qualitative service discussions identifying what service gaps exist, how to respond to these gaps, and what service makeup is needed to fully support an individual within a community setting.

Transitional Housing Residential Services

The New Hampshire SMHA, through a contracted provider, offers Transitional Housing Programs (THP) to serve the clinical, medical, vocational and residential needs of adult men and women with mental health issues. The recovery model is to help individuals maintain their independence in the least restrictive environment possible, so they may successfully transition from New Hampshire Hospital into the community, where they will be able to manage their needs with the help of a Community Mental Health Center. In this way, support is titrated from intensive treatment to independence, preventing frequent hospital readmissions.

Currently there are a total of 87 transitional housing beds throughout New Hampshire, located in Concord, Manchester, Bethlehem, and Bradford. Natural and community support systems are engaged to increase community integration and connectedness for individuals. Transitional Housing offers the following services designed to be responsive to the unique needs of the individual:

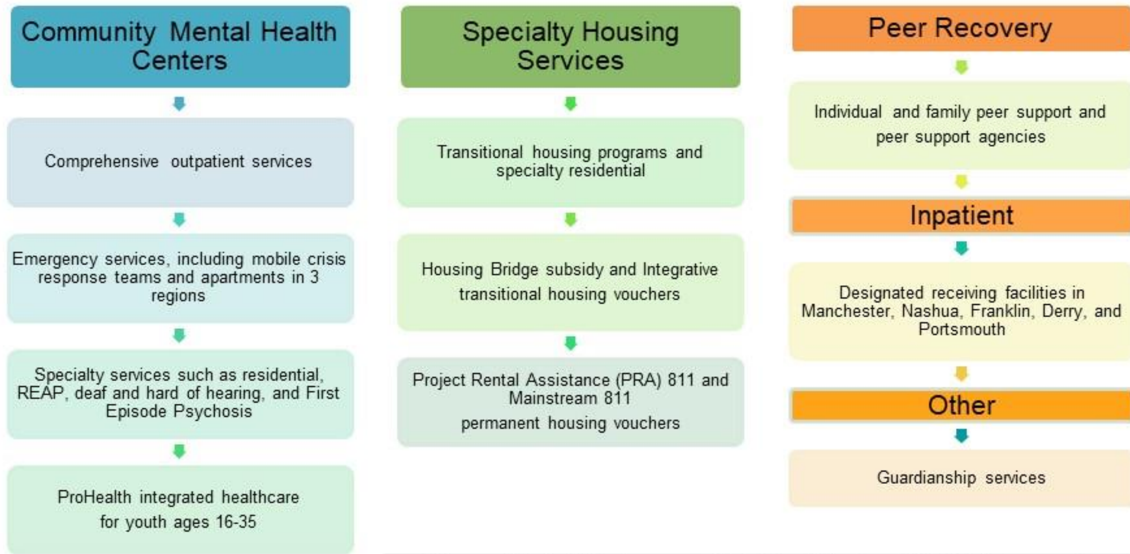
- Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational and day treatment services.
- Support for community connectedness and family involvement.
- Open communication with families and individuals.
- A comprehensive approach to service delivery driven by consumer involvement.
- Evidence-based practice approaches that include Illness Management and Recovery and Supported Employment.

Comprehensive Crisis Response

Since 2015 New Hampshire has held contracts with three (3) agencies that employ distinct mobile crisis response teams within the greater Nashua region, the greater Manchester region, and the greater Concord region. Mobile Crisis Response Teams (MCRT) and beds are identified for individuals eighteen (18) years or older who are experiencing a mental health crisis, including those with a co-occurring substance use disorders. These current MCRTs each provide mobile crisis stabilization services 24 hours a day, 7

days a week, a central phone triage system where trained clinicians complete an initial risk assessment, provide crisis stabilizations services and interventions inclusive of peer support services, and provide mobile crisis apartments that serve as an alternative to hospitalization and/or institutionalization. MCRTs collaborate and coordinate with law enforcement where appropriate. MCRTs have the ability to respond to requests for crisis assessments and interventions within one (1) hour of receiving calls for mobilization of services. Once the MCRT is involved with a case, services and supports can be provided for up to thirty (30) days following the onset of the crisis to ensure individuals remain stable and in the community. Mobile Crisis Apartment stays are available for up to seven (7) days per episode or longer when warranted.

New Hampshire is currently in the process of expanding and transforming crisis services to include statewide and integrated (serving all ages with both mental health and substance use disorders) mobile crisis response. This expansion includes a single, statewide crisis access point that will serve as the primary call center equipped to provide phone based triage, assessment and de-escalation as well as the ability to deploy regional mobile crisis teams. The vision for statewide mobile crisis aligns with the national Crisis Now model and will be implemented incrementally over the next 2 years to include the full continuum of care including location-based crisis intervention.



2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a) Physical health
Yes
b) Mental Health
Yes
c) Rehabilitation services
Yes
d) Employment services
Yes
e) Housing services
Yes
f) Educational services

No
g) Substance misuse prevention and SUD treatment services
Yes
h) Medical and dental services
Yes
i) Support services
Yes
j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
Yes
k) Services for persons with co-occurring M/SUDs
Yes

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The BMHS works closely with the Bureau of Drug and Alcohol Services (BDAS); both agencies serve the NH-DHHS under the umbrella of the Division for Behavioral Health (DBH). DBH leadership reinforce the coordination of Behavioral Health treatment and care services for SUD, Mental Illness, Developmental Disorders and Co-Occurring disorders.

Comprehensive psycho-rehabilitative services (inclusive of education, employment, housing, peer support, and physical health services) for individuals with mental illness and services for persons with co-occurring disorders are provided by all ten CMHCs. Several CMHCs additionally offer SUD treatment services, or refer to close partners in SUD treatment. Gaps in services for those individuals with co-occurring mental health and substance use disorders have been identified. Current and future work has started and will continue to increase collaboration across DHHS's BMHS and BDAS. Detailed financial and programmatic strategies require ongoing development to address the continuum of care. Cross walking of both BMHS and BDAS rules and regulations outlining service standards and access has been a topic of discussion. Once completed, standards of care will be established with best practices to ensure No Wrong Door access. The BDAS and BMHS work together to oversee the behavioral health components of the Managed Care Organization contracts to ensure contract terms, performance metrics, and quality improvement efforts meet the expectations and needs for all individuals with behavioral health needs.

New Hampshire's 1115(a) Medicaid Waiver, the Delivery System Reform Incentive Payment Program (DSRIP) is implemented regionally through seven Integrated Delivery Networks (IDNs) across the state, each serving approximately equal numbers of Medicaid recipients. Each IDN is implementing three community-driven projects. At least one community driven project in each region must focus on treatment

of SUDs and most emphasize care coordination. The IDNs represent increasingly collaborative networks of mental health and substance use disorder treatment organizations and a growing infrastructure of supports (i.e., integrated care, workforce development, enhanced technology) that align with the goals and strategies of this Plan.

Integrating the MH/SUD Portal and its regional hub and spokes within the IDN structure, while simultaneously extending the reach of the IDNs beyond the Medicaid population makes sense, as the IDNs seek sustainability beyond the current period of grant funding.

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3. Describe your state's case management services

Community Mental Health Case Management

The philosophy of case management stems from the concept of wellness, and when an individual reaches their optimum level of wellness and functional capability, everyone benefits: the individual being served, their support system, the health care delivery system and the various reimbursement sources. Case management aims to meet the needs of an individual and address their social determinants of health. This is achieved through a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy.

The foundation of the community mental health system in NH is built on case management. The Administrative Rules set the standard for NH community mental health programs. These Rules outline case management, and case managers act as core treatment constituents throughout service delivery while providing person-centered services. For example, case management is offered, at intake, to all eligible individuals, including those with SMI and SED. The person-driven treatment planning process is facilitated by the case manager; they are the primary contact for the client. CMHC programs may serve as the sole case management entity for individuals with SMI or SED, or the CMHCs may serve as the linkage point for mental health services for clients whose cases are coordinated by another entity, including schools, developmental services agencies, or nursing homes. The Targeted Case Management (TCM) requirement limiting case management billing to one entity per client encourages communication across the service spectrum and a client-centered experience. Individuals involved across the system have the option to select the agency to manage their case.

Supported housing programs in the State of New Hampshire, for individuals with SMI/SPMI who qualify, provide case management as a basic support. The program shall provide case management services if the individual does not otherwise have a case manager. If the individual is a Community Mental Health Center client, that center continues to serve as their case manager across the service spectrum. For clients residing in staffed residences, there shall be regular communication between residential staff and each resident's

case manager to ensure that services are provided in accordance with an ISP and that there is no duplication of service.

As defined in NH Administrative Rule He-M 426, Case management shall:
(1) Assist individuals eligible under the state plan in gaining access to needed medical, social, educational, and other services, on a one to one basis only;
(2) Be a covered CMHP service;
(3) Consist of at least one direct contact, either face-to-face or by telephone, with the individual or guardian within every 90 days;
(4) Be documented in the clinical record, including:
a. Whether the goals specified in the care plan have been achieved;
b. Whether the individual has declined services in the care plan;
c. Timelines for providing services and reassessment; and
d. The need for, and occurrences of, coordination with case managers of other programs.

Supporting individuals diagnosed with SED and SMI to integrate into their community of choice is a key case management activity. An annual **case management assessment and care plan,** pursuant to He-M 426, includes documentation of the following:

- Information gathered from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual;
- An assessment of the individual's strengths;
- Identification of the consumer's case management needs; and
- The individual's preferences for needs to be addressed.

The assessment shall determine the need for the following services:

a. Medical services including, but not limited to, primary care, dental care, home health care, and assistance with activities of daily living (ADL);
b. Substance misuse prevention, treatment, and recovery services in the Community Mental Health Centers or their communities;
c. Educational services including, but not limited to, obtaining high school or advanced degrees, skill-building classes, parenting education, and other support groups;
d. Social services including, but not limited to, employment, housing, and transportation; and
e. Other services, including but not limited to, opportunities for personal development, maintenance and support of social and familial relationships and the pursuit of hobbies and interests such as spiritual development.

All assessment needs including; referrals, linkage and monitoring activities are documented in an individual's care plan. Needs are reviewed on a mutually agreed upon frequency (at least quarterly) with an annual review and revisions to the assessment on an as needed basis.

The development and periodic revision of a specific and comprehensive care plan relates to information collected through the assessment or reassessment that indicates goals for medical, social, educational, and other needs. An individual may decline to receive services that are suggested in the care plan. The care

plan, and the CANS or ANSA are used in creation with the Individual Service Plan (ISP) to inform goals and objectives.

***4.** Describe activities intended to reduce hospitalizations and hospital stays.*

Our community mental health system is designed to provide high quality services at every level from low to high intensity, and hospitalization for people who need that level of care. Timely effective outpatient services help many people with SMI and SPMI avoid illness exacerbations to the degree that hospitalization is needed. Some of the most effective community-based services the SMHA supports (through contractual arrangements) are Functional Support Services, Assertive Community Treatment, Supported Employment, Supported Housing, Mobile Crisis Response Teams, First Episode Psychosis early intervention, Case Management, and Peer Support Center services, including day programs, step up step down beds, and Crisis Respite.

Functional Support Services (FSS) are core rehabilitative services. Providers help rebuild functional skills that may have been lost during challenging periods. FSS workers assist to support clients with community integration as needed. These services may be prescribed for up to 8 hours per day, per client; with a high range of 7 days per week for clients in Assertive Community Treatment. This frequent, routine contact can provide a level of support to keep clients from falling through the multitude of social and functional "cracks" that can trigger relapses and hospitalization.

Assertive Community Treatment (ACT) is an evidence-based comprehensive community-based model for delivering treatment, support, and rehabilitation services for individuals with severe mental illness. ACT team members include Functional Support Specialists.

Community Mental Health Center Services: Unique Count of Adult Assertive Community Treatment Clients from reporting ending in March of 2021.

Community Mental Health Center	January 2021	February 2021	March 2021	Unique Clients in Quarter	Unique Clients in Prior Quarter
01 Northern Human Services	120	121	124	133	133
02 West Central Behavioral Health	43	44	60	66	
03 Lakes Region Mental Health Center	56	56	59	60	58
04 Riverbend Community Mental Health Center	92	99	94	109	109
05 Monadnock Family Services	46	46	45	47	45
06 Greater Nashua Mental Health	121	126	130	152	133

07 Mental Health Center of Greater Manchester	262	256	254	274	276
08 Seacoast Mental Health Center	80	81	80	86	81
09 Community Partners	65	70	73	79	73
10 Center for Life Management	45	45	45	47	47
Total Unique Clients	**929**	**943**	**963**	**1,051**	**1,007**
Unique Clients Receiving ACT Services 4/1/2020 to 3/31/2021: 1,234					

Individual Placement and Support - Supported Employment for people with severe mental illness is an evidence-based practice that has been implemented New Hampshire. Supported employment is a well-defined approach to helping people with disabilities participate in the competitive labor market, working in jobs of their choice that fit their skills, abilities, and interests, with competitive rates of pay. Supported Employment specialists are included on every ACT team, as well as in freestanding Supported Employment programs in all ten CMHCs.

Community Mental Health Center Services: Annual Adult Supported Employment Penetration Rates for Prior 12-Month Period for reporting ending March of 2021.

	12 Month Period Ending March 2021			
Community Mental Health Center	**Supported Employment Clients**	**Total Eligible Clients**	**Penetration Rate**	**Penetration Rate for Period Ending December 2020**
01 Northern Human Services	159	1,326	12.0%	12.0%
02 West Central Behavioral Health	100	539	18.6%	22.5%
03 Lakes Region Mental Health Center	624	1,599	39.0%	32.7%
04 Riverbend Community Mental Health Center	259	1,903	13.6%	14.1%
05 Monadnock Family Services	47	1,109	4.2%	3.7%
06 Greater Nashua Mental Health	313	2,777	11.3%	12.3%
07 Mental Health Center of Greater Manchester	1,462	3,605	40.6%	40.1%
08 Seacoast Mental Health Center	844	2,137	39.5%	37.0%
09 Community Partners	109	838	13.0%	13.2%
10 Center for Life Management	232	1,474	15.7%	14.3%
Total Unique Clients	**4,137**	**17,062**	**24.2%**	**23.7%**

Mobile Crisis Response Teams (MCRT)

Mobile crisis response teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and other community-based settings outside of a traditional clinical office. Crisis intervention teams work with law enforcement officials to recognize a person who is in crisis and safely direct them to treatment appropriate for their condition, thus reducing the rate of arrest, incarceration or unnecessary emergency room visits.

Over 1,400 individuals were served by Mobile Crisis Services and Apartments in the first quarter of 2021 by three mobile crisis teams located in the population centers of Nashua, Manchester, and Concord. These teams were structured through contractual agreements with the SMHA. Starting in SFY 2022 mobile crisis response services will be available statewide as a result of NH's crisis transformation work.

Supportive housing and housing supports

The availability of safe and affordable housing is often a core social determinant of health for those diagnosed with severe mental illness. The cascading effects of mental illness can put a strain on the individual's ability to acquire and maintain housing. Having a safe and secure place to live is a critical part of stabilization and recovery, along with access to services that enable those with mental health conditions to live as independently after hospitalization.

There are currently several successful housing programs managed by the Bureau of Mental Health Services assisting individuals experiencing homelessness due to disabling symptoms of mental illness. The Housing Bridge Subsidy Program (HBSP) is a supportive housing program currently funded to serve up to 500 individuals across New Hampshire. HBSP services include a Housing Specialist assigned to each individual in the program. The Housing Specialist will assist the individual in finding an appropriate unit, signing and understanding their lease, and ensuring they are connected to any community supports and services the individual requests or requires. Individuals on HBSP are expected to transition onto a Housing Choice Voucher through HUD within 2 to 3 years of entering HBSP. The Housing Specialist will assist them with the transition of vouchers, and remain available to the individual should they require any further housing assistance. BMHS has partnered with New Hampshire Housing Finance Authority to manage the Project Rental Assistance Section 811 Program (PRA811). This is a permanent housing program, and recipients have access to the full array of support services provided by the CMHCs. PRA811 provides the individual with a safe, affordable place to live, and the availability to have support services in the community to keep them safely housed and connected with their health care providers.

Supported Housing Subsidy Summary for data ending in March of 2021.

Subsidy		January – March 2021 Total subsidies by end of quarter	October – December 2020 Total subsidies by end of quarter
Housing Bridge Subsidy:	Units Currently Active	306	300
	Individuals Enrolled and Seeking Unit for Bridge Lease	104	96
Section 8 Voucher (NHHFA):	Transitioned from Housing Bridge*	233	212
	Not Previously Receiving Housing Bridge	0	0
811 Units:	PRA*	121	114
	Mainstream*	74	74

Other Permanent Housing Vouchers (HUD, Public Housing, VA)*	8	2
Total Supported Housing Subsidies	**846**	**798**

Peer Support Agencies (PSA) provide an alternative to traditional clinical treatment. Among PSA programming, individuals can receive support from individuals with lived experience with mental illness. PSA's offer support groups, resources, warm line services, community connection, on-site activities and educational events, and Peer Respite. Peer Respite provides an alternative to psychiatric ED or inpatient hospitalization. 148 out of 161 peer program participants responding to an anonymous survey reported that day support programs for peers, provided by Peer Support Agencies, helped to keep them out of the hospital (Source: PSA Satisfaction Survey 2020).

Peer Respite services are operated by people who have experience living with a mental illness (i.e., peers), and are designed as calming homelike environment with supports for individuals in crisis twenty-four (24) hours a day. Peer Respite is offered in three of NH's Peer Support Agencies. Peer Respite stays are seven days or less, but may be extended through approval by the BMHS, if needed. Peer Respite services are generally shorter term than crisis residential services.

SFY 21 PSA Crisis Respite Utilization			
Peer Support Agency	**# of days person occupied bed**	**# of persons served**	**Total number of admissions**
HEARTS (2 beds)			
SFY 20	468	70	79
SFY21 Q1	61	10	10
SFY21 Q2	71	11	13
SFY21 Q3	68	11	11
SFY21 Q4	83	10	10
Total for SFY 21	283	112	44
MPASA (1 bed)			

SFY 20	145	27	27
SFY21 Q1	71	11	11
SFY21 Q2	21	3	3
SFY21 Q3	12	4	4
SFY21 Q4	0	0	0
Total for SFY 21	104	18	18
Stepping Stone (2 beds)			
SFY 20	60	10	15
SFY21 Q1	0	0	0
SFY21 Q2	0	0	0
SFY21 Q3	2	1	1
SFY21 Q4	2	1	1
Total for SFY 21	4	2	2

Peer Support Agencies maintain warm lines: “a direct service delivered via telephone by a [peer] that provides a person in distress with a confidential venue to discuss their current status and/or needs SAMHSA, 2012).

NH Mental Health Client Peer Support Agencies: Census Summary for reporting ending in March of 2021.

	January – March 2021		October – December 2020	
Peer Support Agency	**Total Members**	**Average Daily Visits**	**Total Members**	**Average Daily Visits**
Alternative Life Center Total	**622**	**25**	**614**	**28**
Conway	271	5	271	6
Berlin	143	6	137	7
Littleton	90	6	89	6

Colebrook	118	8	117	9
Stepping Stone Total	**368**	**6**	**366**	**7**
Claremont	249	5	248	6
Lebanon	119	1	118	1
Cornerbridge Total	**368**	**6**	**141**	**11**
Laconia	249	5	53	5
Concord	119	1	73	3
Plymouth Outreach	15	0	15	3
MAPSA Keene Total	**340**	**19**	**339**	**14**
HEARTS Nashua Total	**391**	**36**	**386**	**50**
On the Road to Recovery Total	**165**	**12**	**149**	**10**
Manchester	93	5	83	4
Derry	72	7	66	6
Connections Portsmouth Total	**108**	**7**	**101**	**5**
TriCity Coop Rochester Total	**282**	**7**	**277**	**8**
Total	**2,644**	**106**	**2,373**	**123**

First Episode Psychosis

For the last four years NH has operated one FEP treatment team at Greater Nashua Mental Health (GNMH), the HOPE (Helping Overcome Psychosis Early) team, who were trained in 2016-2019 in the NAVIGATE coordinated specialty care model that was developed and tested through the NIMH RAISE-ETP program. Greater Nashua Mental Health was part of the RAISE-ETP study and witnessed the positive impact on the lives of young adults and their families.

The Coordinated Specialty Care team from Greater Nashua Mental Health is composed of a Program Director, Family Education (FE) Clinician, Prescriber, Individual Resiliency Trainer (IRT), and Supported Employment and Education (SEE) Specialist. Additionally, case management and functional support services are offered.

The HOPE Program Director was involved in the original RAISE study and has been trained as an IRT therapist and trainer. The HOPE Program SEE specialist was also part of the original RAISE study and has

significant training and experience as an SEE provider. We are fortunate to have both of these staff working on the FEP team. BG funds will continue to support the HOPE program with implementation costs and reimbursement for uncompensated HOPE program services.

New Hampshire has expanded efforts to increase awareness and reduce stigma related to mental illness in young people generally, and first episode psychosis specifically. We have implemented learning and education models such as Mental Health First Aid statewide. These programs have planted the seeds of awareness about mental illness and how to recognize early signs. Stigma reduction, we have found, plays a large part in the ability of the general public to recognize early symptoms, refer to appropriate services, and engage in treatment. As part of NH's 10-year mental health plan, early treatment models, including FEP were highlighted and identified by stakeholders as foundational recommendations.

. During SFY 2019-21, the State carried out a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide ESMI or FEP treatment model using funds provide by the 10% set-aside of the BG. The initiative included two components; first, proposing a treatment model that we can scale to provide ESMI/FEP services statewide, and the second, a public awareness campaign that focuses on the importance and availability of early interventions. New Hampshire has been working to expand FEP services statewide. In July 2021, three new FEP sites were implemented in the state, bringing the total number of FEP programs to four programs statewide. These programs are in the process of developing implementation models.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.
Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	5.4% (59,261)	5.4% (59,261)

2. Children with SED	3.4% (8,691)	3.4% (8,691)

*** Note the above estimated population rates are a direct calculation utilizing the SAMHSA identified population percentages of 5.4% for adults with SMI and 3.4% of children with SED. Percentages were used to calculate against 2021 census population rates.*

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

NH utilizes the Uniform Reporting System (URS) tables for planning and reporting purposes. Information from the NH-DHHS Phoenix client service and demographic database is sorted and analyzed to produce the URS reports as well as various other reports, including Adult Assertive Community program utilization, waitlist, and staffing; and Supported Employment program utilization, waitlist, staffing, and aggregate count reports of clients by employment status.

NH-DHHS also utilizes data from the New Hampshire [Psychiatric] Avatar hospital electronic system to produce reports on admissions, daily census, readmissions, and discharge.

These reports are utilized for program planning and budgeting, as well as for target-setting for program utilization and client outcomes.

New Hampshire Hospital: Adult Census Summary for reporting ending in March of 2021.

Measure	January – March 2021	October – December 2020
Admissions	165	187
Mean Daily Census	173	173
Discharges	173	191
Median Length of Stay in Days for Discharges	35	32
Deaths	2	0

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?
a) Social Services Yes
b) Educational services, including services provided under IDE Yes
c) Juvenile justice services Yes
d) Substance misuse prevention and SUD treatment services Yes
e) Health and mental health services Yes
f) Establishes defined geographic area for the provision of services of such system Yes

Criterion 4

Narrative Question
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Describe your state's targeted services to rural and homeless populations and to older adult.

All ten community mental health centers are required to provide care to individuals in rural settings within their regions. Specific regions with high rural settings include Norther Human Services, West Central Behavioral Health, and Monadnock Family Services. Within these regions CMHCs work to provide care on telehealth platforms, within the community or clients living location, and provide support in transportation where needed. Often times the local Peer Support Agencies will provide transportation to attend support through their services. The Department further supports the following services through rural care venues.

Targeted Services to Rural and Homeless Populations and to Older Adults

Rural Populations

The State of NH, Department of Health and Human Service, Division of Public Health Services, Bureau of Community Health Services Rural Health and Primary Care section includes the Primary Care Office, the State Office of Rural Health, and Workforce Development. The mission and function of the Rural Health and Primary Care section is to support communities and stakeholders that provide innovative and effective access to quality health care services with a focus on the low income, uninsured, and Medicaid populations of New Hampshire.

Primary Care

The Primary Care Office (PCO) works with other NH partners statewide to improve access to quality health care services especially for uninsured residents. The PCO is the location of the NH Health Professions Data

Center and is responsible for federal health care shortage designations. The PCO also provides technical assistance for National Health Service Corps sites.

Rural Health Care

The State Office of Rural Health (SORH) offers technical assistance to rural health care providers and organizations and provides healthcare-related information to rural healthcare stakeholders. SORH serves as a liaison between rural healthcare organizations and many DHHS programs. It also includes the Medicare Rural Hospital Flexibility Program, which supports the Critical Access Hospitals and the Small Rural Hospital Improvement Program.

Workforce Development

Workforce Development works with each of the above program areas to increase or retain the supply of health professionals serving New Hampshire. There is a particular focus on those professionals whose service will meet the needs of rural and underserved populations. Workforce Development administers New Hampshire's State Loan Repayment Program, the J1 Visa Waiver (Conrad 30) program, and the National Interest Waiver program.

National Interest Waiver Program

The Division of Public Health Services, Rural Health and Primary Care Section, has the responsibility within the State of New Hampshire to provide a Letter of Attestation in support of a foreign physician's request for a National Interest Waiver from the US Citizenship and Immigration Services (USCIS). The foreign physicians' work must be in an area that has been designated as having a shortage of health care providers by the Secretary of Health and Human Services, and must be deemed by the Division of Public Health Services to be in the public interest.

State Loan Repayment Program

The New Hampshire State Loan Repayment Program (SLRP) provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time). The allotment of funds is contingent on the availability of specified SLRP funding in the State budget for any given fiscal year. These medically underserved areas; identified as Health Care Professional Shortage Areas (HPSAs), Mental Health Professional Shortage Areas (MHPSAs), Dental Health Professional Shortage Areas (DHPSAs), Medically Underserved Areas/Populations (MUA/Ps), and Governor's Exceptional Medically Underserved Populations (E-MUP) are indicators that a shortage of primary healthcare providers exist, posing a barrier to access to primary health care services for the residents of these areas.

Table: NH Health Professional Shortage Areas (HPSAs) – Mental Health

HPSA Name	Designation Type	HPSA Score
FCI-Berlin	**Correctional Facility**	**21**
Northern New Hampshire Correctional Facility	**Correctional Facility**	**21**
Ammonoosuc Community Health Services Inc.	**Federally Qualified Health Center**	**21**
Coos County Family Health Services, Inc.	**Federally Qualified Health Center**	**16**
Greater Seacoast Community Health	**Federally Qualified Health Center**	**21**
Harbor Homes, Inc.	**Federally Qualified Health Center**	**19**
Healthfirst Family Care Center, Inc.	**Federally Qualified Health Center**	**21**
Indian Stream Health Center	**Federally Qualified Health Center**	**14**
Lamprey Health Care, Inc.	**Federally Qualified Health Center**	**22**
Mid-State Health Center	**Federally Qualified Health Center**	**16**
Manchester, City of	**Federally Qualified Health Center**	**19**
Springfield Medical Care System, Inc.	**Federally Qualified Health Center**	**20**
Manchester Community Health Center	**Federally Qualified Health Center**	**23**
White Mountain Community Health Center	**Federally Qualified Health Center Look-alike**	**14**
Eastern Grafton	**Geographic HPSA**	**11**
Eastern Coos	**High Needs Geographic HPSA**	**17**
Littleton Service Area	**High Needs Geographic HPSA**	**12**
North Country Primary Care	**Rural Health Clinic**	**18**
Weeks Medical Center - Groveton	**Rural Health Clinic**	**18**
Weeks Medical Center - Whitefield	**Rural Health Clinic**	**18**
Mount Washington Valley Rural Health	**Rural Health Clinic**	**10**
Rowe Health Center	**Rural Health Clinic**	**19**
Weeks Medical Center - Lancaster	**Rural Health Clinic**	**14**

Describe your state's targeted services to the homeless population.

CMHC PATH Programs

Six out of the ten CMHCs provide PATH homeless outreach services. These PATH programs are in compliance with the Federal Public Health Services Act, Section 522(b)(10), Part C to individuals who are homeless or at imminent risk of being homeless and who are believed to have Severe Mental Illness (SMI), or SMI and a co-occurring substance use disorder. The CMHCs provide outreach, screening, diagnostic treatment, and case management services. Services are targeted to Assisting eligible homeless individuals with obtaining and coordinating services, including referrals for primary health care. The designated PATH workers assess the

individual immediacy of needs and continues to focus and work with the individual to enhance treatment and housing readiness.

Homelessness

The State of Homelessness in New Hampshire 2018 examines homelessness in the state between 2018 and 2020. Homeless census data during this time period reveals that the overall number of those experiencing homelessness rose by 21 percent from 2019 - 2020. The poverty rate in New Hampshire continues to fall, and remains well below the national rate of 15.1 percent. Moreover, at the same time that unemployment remains relatively low in New Hampshire, median income of renters has shown slight increases. At the same time, however, data also show increasing rents compounded by extremely low vacancy rates across the state, two key factors which significantly hinder the state's progress in ending homelessness. The 2020 NH Residential Rental Cost Survey reports that the median rent for a 2 bedroom apartment in NH is $1,413 per month, and the vacancy rate for rental units is 1.8%. A 5% vacancy rate is considered a balance rental market.

• Between 2018 and 2020, the overall number of people experiencing homelessness rose by 21 percent.

• There were 1,577people in families (including children) that were experiencing homelessness in SFY 2020.

• The number of individuals living unsheltered in SFY 2020 was 411.

• For the 2019-2020 school year, the statewide number of students experiencing homelessness was 3,216. This is believed to be an underrepresentation of student homelessness. The COVID-19 pandemic created several limitations in identifying students experiencing homelessness.

"When we became homeless we ended up in a tent by the railroad tracks. We have a limited, fixed income. Most landlords told us we didn't make enough to afford a studio. We spent 11 months in the tent until we were able to get into a shelter."

- Emergency shelter guest

The US Department of Housing and Urban Development (HUD) defines someone who is homeless as:

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Has a primary nighttime residence that is a public or private place not meant for human habitation;
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
- Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Homelessness and housing instability are known to negatively impact the other Social Determinants of Health. By increasing access to safe, affordable housing, and improving housing stability, other health outcomes improve. This includes physical and mental health, as well as other SDOH like education and employment. The COVID-19 pandemic has made it clear that lack of housing is a public health crisis. There are many studies that link housing with improved health outcomes. "Housing is healthcare" is a common

phrase, with new studies showing the importance of linking housing with public health in order to achieve the greatest outcomes.

The State of New Hampshire Bureau of Housing Supports (BHS) provides an array of statewide services, which act as a safety net for some of New Hampshire's most vulnerable citizens. Services are provided through five Community Action Agencies and other non-profit service providers across the state and provide interventions that have a direct and positive impact on individuals and families, preventing them from becoming homeless or assisting the homeless in moving on to permanent housing. Examples of services provided include:

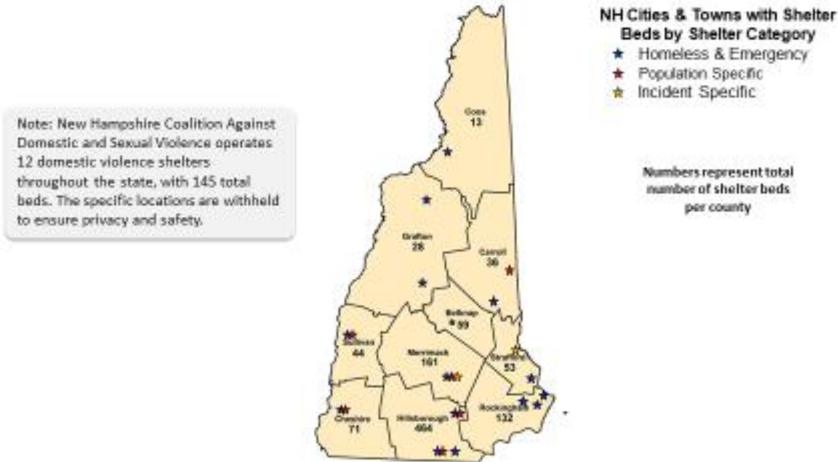
- Assists people who are experiencing housing instability or homelessness to access housing, shelter, and/ or other services to assist in achieving or maintaining housing stability and independence.
- Provide short and medium term rental assistance and Permanent Supportive Housing to individuals, youth, and/ or families, along with supportive services to maintain housing stability.
- Provide outreach services to those who are considered “hard to reach,” such as those residing on the streets, or other places not meant for human habitation to increase their transitions to housing stability.
- Provide intensive case management services to connect individuals and families to appropriate services including medical and mental health care, TANF/SNAP benefits, SSI/SSDI, and any other services necessary.

Services provided through the Bureau of Housing Supports follow the Housing First approach. Housing First is a homeless assistance approach that is guided on the belief that housing is a basic need for people that should be met as quickly as possible, without any prerequisites or conditions beyond those of a typical renter. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and participating in supportive services, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life. Traditional homelessness programs have been based upon the assumption that people should not be placed into housing until they have resolved personal issues, such as diagnosis and treatment of a disability or training in independent living skills. Conversely, a Housing First approach assumes that people should start with stable permanent housing. They may then choose to address other life issues that may have contributed to their homelessness experience to maintain their ongoing housing stability. Supportive services (such as recovery resources or mental health treatment) are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.

The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. Individuals using a Housing First model have been shown to access housing faster and are more likely to remain stably housed. Each individualized POC will use the above approach to create a strengths based,

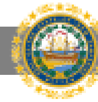
individualized, community-based, culturally and linguistically informed action plan to obtain, or retain housing.

- **State Funded Emergency and Transitional Shelters**



State Funded Programs

- In addition to state funded shelter programs, the Bureau of Housing Supports funds the following with state general funds:
- Homeless Housing and Access Revolving Loan Fund (HHARLF) and eviction prevention
- Housing Security Guarantee Program (HSGP)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Projects for Assistance in Transition from Homelessness (PATH)
- Emergency Solutions Grants (ESG)
- Homeless Management Information System (HMIS)



- **HUD Continuum of Care funding**

HUD and Continuum of Care (CoC)

The CoC Program is designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing, with the goal of long-term stability.

NH has 3 CoC:

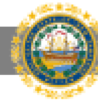
- Greater Nashua- Harbor Homes
- Manchester- Families in Transition (FIT)
- Balance of State- Bureau of Housing Supports (BHS)

HUD contracts directly with the CoC to:

- Promote community-wide planning and strategic use of resources to address homelessness;
- Improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; improve data collection and performance measurement; and
- Allow each community to tailor its program to the particular strengths and challenges within that community.
- Funds and programs cannot cross CoC with CoC funding.

FY 2020 funding for each CoC, used to promote a community-wide commitment to the goal of ending homelessness

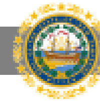
- Balance of State: $4,775,549
- Greater Nashua: $2,091,092
- Manchester: $1,561,039



Project Balance of State – New CoC Projects

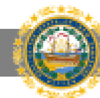
As a response to community needs within the BoS, BHS was funded for new programs in the FY 2018 and FY 2019 Continuum of Care Program application

- Rapid Re-Housing for survivors of domestic violence
- Rapid Re-Housing for youth (ages 18-24 as defined by HUD)
- Rapid Re-Housing program in Strafford County, which had been unserved by this type of programing
- Coordinated Entry System for Domestic Violence survivors
- Permanent Supportive Housing expansion in the North Country through Tri-County CAP
- New Projects are awarded based on points.



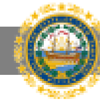
Other Federal Funding

- HUD Emergency Solutions Grant- Provides Rapid Re-Housing, Prevention and Housing Stability Case Management.
- Projects are available statewide and DHHS contracts with the 5 Community Action Agencies, Easter Seals, The Front Door Agency, and The Way Home.
- HUD Housing Opportunities for People with HIV/AIDS (HOPWA). This supports people who have HIV/AIDS to maintain housing.
  - BHS holds the grant for the Balance of State CoC and Manchester CoC, which is administered by the Merrimack Valley Assistance Program.
  - Harbor Homes administers the HOPWA grant for the Greater Nashua CoC.



Other Federal Funding

- SAMHSA Projects for Assistance in Transition for Homeless (PATH) provides homeless street outreach for individuals experiencing homelessness who have a diagnosis of a severe mental illness.
- PATH is administered by Tri-County Community Action, Monadnock Family Services, Riverbend, Seacoast Mental Health, Greater Manchester Mental Health, Nashua Mental Health, and Center for Life Management.
- Under the State Opioid Response funding from SAMHSA, housing vouchers and respite housing for individuals with an opioid use disorder are available through the 9 Doorway programs throughout the State.



Describe your state's targeted services to the older adult population.

New Hampshire is Aging

As of 2019, NH's population over 65 increased 2.7%. It is clear that a need exists for services and programs targeted to our aging population, 2.2% greater than the rate of increase in the US.
(SOURCE: US Census)

New Hampshire Referral, Education, Assistance, & Prevention Program (REAP)

The New Hampshire Referral, Education, Assistance, & Prevention Program is a partnership between the BMHS, BDAS, Bureau of Elderly and Adult Services, and the CMHCs. The Program is available to all older adults, 60 years or older, who are residents of New Hampshire Senior Housing, or caregivers or family members of an older adult in NH. The program is designed to assist those adults in taking control of their life, and to live a happy, healthy, and independent lifestyle. REAP counselors are available to provide support, education, information, and resources on how to deal with life changes and encounters. REAP also focuses on ensuring individuals can improve their quality of life and maintain their independence.

Community Based Care

The Bureau of Elderly and Adult Services (BEAS) and supports are intended to assist people to live as independently as possible in safety and with dignity. Services range from home care, meals on wheels, care management, transportation assistance and assisted living to nursing home care.

A variety of social and long-term services and supports can be accessed through the ServiceLink Resource Centers and the NH DHHS District Offices. Services and supports are intended to assist people to live as independently as possible in safety and with dignity. Examples include:

- Home care
- Meals on wheels
- Transportation assistance
- Long Term Care-Nursing home and community based care
- Information and assistance regarding Medicare and Medicaid
- Information about volunteer opportunities
- Investigation of reports of abuse, neglect or exploitation of incapacitated adults

Long-Term Care Rehabilitative Services
The Glencliff Home serves Adults with SMI 60 years of age or older who meet the requirements for Long-Term Care that identifies GHE as the least restrictive environment and providing the level of medical care the person requires.

Criterion 5: Management Systems
States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Describe your state's management systems.

MHBG-Funded Staff and Training Management Systems

I. Adults: PEER SUPPORT AGENCIES – STAFFING, TRAINING, and OVERSIGHT

In New Hampshire the largest of recovery support services is through our network of Peer Support Agencies that are subsidized by the MHBG and State general funds. To maintain professionalism, expand implementation, support individuals with mental illness and in compliance with contract provisions of services, the PSA system in New Hampshire remains heavily reliant on ongoing training and leadership development. NH has fourteen Peer Support Agencies that are employed by individuals whom identify

with having lived experience with mental illness. They are peer-led, peer-driven in programming (e.g., community meetings, team-building meetings, support groups, educational events) and agency policy making through mutuality and consensus of members. Some Peer Support Agencies also offer Peer Respite. Peer Respite provides a short-term place to stay with 24/7 peer support available on-site in a homelike environment with the goal being to divert an individual entering a higher level of care.

Staff members must be trained in Intentional Peer Support (IPS), Whole Health Action Management and Recovery Action Planning (materials developed by Mary Ellen Copeland, PhD and SAMHSA). At this time, NH has one certified IPS trainer and is in the process of evaluating the peer training infrastructure/modalities and increasing the number of state trainers to support the peer workforce statewide. Three individuals have been identified to attend the national IPS train-the-trainer event in calendar year 2021. These additional IPS state trainers will allow for greater flexibility, support for and expansion of the peer workforce. Additionally we are developing training components such as boundaries and ethics training as this is an important aspect of peer support and service delivery.

All Warm Line staff also receive Warm Line Training to create expertise in this vital use of Peer Support.

The MHBG FFY 2019-2021 supplemental award, granted in September 2019, supported over ten trainings for PSAs designed to strengthen governance, management, technical and leadership skills, and nonprofit best-practices, including customized board of directors trainings for each agency, “Deepening Community Awareness and Fundraising”, “Board Recruitment and Retention”, and “Nonprofit Financials”, among others.

The Supplemental award also allowed NH to receive consultation from national trainer and peer leader, Eduardo Vega, to develop the Peer Workforce Advancement Plan. The purpose of the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) is to present actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire’s mental health services sector. The New Hampshire Peer Workforce Development plan is the result of the 10-Year Mental Health Plan’s Recommendation #7, which seeks to expand the availability of peers in practice settings and to integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas such as training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies, while other factors are specific to the roles, challenges, and opportunities of people with lived experience in the role of a peer support specialist. Preparation of the Advancement Plan included stakeholder input at three (3) public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the Bureau of Mental Health Services (BMHS), National Alliance on Mental Illness of New Hampshire (NAMI-NH) and Eduardo Vega, Humannovations. Participating stakeholders included individuals representing peer support agencies (PSA), community mental health centers (CMHCs), community and system advocates, and many individuals with lived experience.

On-Site monitoring visits occurred in SFY 20-21of all of the PSAs. Interviews and file review based on a customized review tool gave the BMHS a clear impression of needs and strengths to guide PSA oversight. Corrective Action Plans were requested, approved, and monitoring continues.

Improvements in the contracting process ensure that funds and programs are operating efficiently and in accordance with best practices.

Mental health training for criminal justice staff was made available through SAMHSA's supplemental training and technical assistance mental health block grant funds. In FY2021, grant funds supported New Hampshire's workforce development goals to increase mental health training for individuals working in the criminal justice system. Through a partnership with the NH Department of Corrections (DOC), a series of training sessions for personnel working with individuals with mental illness who are involved with the justice system took place. Attendees included more than 275 staff from the NH DOC and court system, and law enforcement personnel. The series of trainings included Building Trauma-Responsive Correctional Settings; Mental Health First Aid/Awareness Training; Suicide Prevention Training; Responding to People with Mental Illness; and Crisis Intervention Training. Trainings were targeted to directly address recommendations within New Hampshire's 10 Year Mental Health Plan.

II. Children: *MATCH*

The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program that has been developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School), The Judge Baker Children's Center (JBCC) employs the Learning Collaborative model, and includes rigorous implementation strategies for evidence-based practices, including conducting continuous quality improvement review and assessment, and developing and implementing data systems to collect, analyze, and report outcomes and implementation data. Over sixty (60) CMHC clinicians were trained in the MATCH protocol by JBCC, and over 130 additional staff have been trained by CMHC MATCH-certified trainers. A rigorous reporting structure, and an online clinical component provides the CMHCs and the SMHA with management reports, provide guarantees of program integrity.

Clinical Staff Participants by Cohort

Learning Collaborative Cohorts	CMHC Participation and Clinical Staff Training
Training Cohort 1	Planned: 4 CMHCs with 5-8 clinical staff each for a total of up to 32 clinical staff. (At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)

Training Cohort 2	Planned: 6 CMHCs with 5-8 clinical staff each for a total of up to 48 clinical staff. (At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Total Learning Collaborative	**Actual: 64 clinical staff have been trained across 10 CMHCs.**

The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projected have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract.

Actual and projected SFY costs are as follows:

SFY 2018:	SFY 2019:	SFY 2020
$270,000	$215,000	$175,000

First Episode Psychosis: PROGRAM SUPPORT AND STAFF TRAINING COSTS

Each year since the inception of the requirement for 10% of the block grant required set aside for First Episode Psychosis (FEP) programming, these MHBG funds have used for continued training and support in the NAVIGATE Coordinated Specialty Care model to the HOPE FEP program team at Greater Nashua Mental Health.

In July of 2021 the CMHC contracts were updated to include start up training funds of a total of $51,000 each to four CMHCs beginning to implement FEP/ESMI programs to cover initial costs associated with training and consultation in the NAVIGATE model. Funds also include a total of $60,000 each to four CMHCs to support non billable programing costs and staff time.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

The past two years have seen continuous progress made in the redesign of the DHHS behavioral health oversight function. Some quality improvement efforts are managed centrally, by the DHHS Bureau of Program Quality (BPQ) office. The BPQ implements and monitors Quality Service Reviews (QSRs) required by the State Mental Health Authority (SMHA). Each Community Mental Health Center (CMHC) is reviewed annually by the BPQ unit, and the resulting reports are published on the DHHS website. The QSRs result in a quality improvement plan that is developed by the CMHC and closely monitored jointly by BPQ and the SMHA. QSRs continued through the pandemic with minor adjustments made to include provisions for reviewing telehealth services and to conduct the reviews remotely.

Fidelity reviews are intended to assess the quality of any given evidence based practice. Each CMHC participates in two fidelity reviews each year; one for Assertive Community Treatment (ACT) and another for Individual Placement and Support - Supported Employment (IPS-SE). Dartmouth-Hitchcock (DH) consultants conduct independent reviews for each center and produce a fidelity report with recommendations for improvement. The fidelity reports are published on the DHHS website. Based on the feedback and recommendations of the consultants, the CMHCs are required to develop a quality improvement plan and work closely with the SMHA throughout the year to monitor progress. Annual training is provided to CMHCs to ensure they remain up to date on evidence based practices and technical assistance is provided by experts from DH.

During the pandemic full fidelity reviews were cancelled. Mini-consults were adapted for both ACT and IPS-SE to assess quality indicators that were most affected by the public health emergency. Following each consult, the DH consultants provided CMHC teams with a detailed consultation report that addressed observations, feedback, strengths and recommendations. Previous quality improvement plans were extended into the pandemic year and each center had the choice to continue to work on items, adjust or modify action plans or close out the quality improvement indicator where progress was made and high fidelity achieved.

Each CMHC participates in a re-approval review in order to maintain their status as a community mental health provider. Each review period covers a five-year review cycle. The re-approval process reviews all noted tools (QSR, Fidelity Reports, MCO audits, Satisfaction surveys, etc.) and reviews the adherence to administrative rule He-M 403, Approval and Operations of a Community Mental Health Program. Reports are written, distributed to agencies and published on the NH DHHS website. Corrective action plans are submitted to the SMHA, and reviewed and approved prior to reapproval being granted. These corrective action plans are monitored by the SMHA to ensure steps are taken to address gaps or needs.

The SMHA will continue to be responsible for program reviews of the Peer Support Agencies. Over the last 2 years review tools were further refined based on administrative rules He-M 402 Peer Support Agencies (PSA), He-M 315 Rights of Persons Receiving Peer Support Services, BMHS contract compliance, and state nonprofit regulations. In SFY19, monitoring visits and reports were completed and in SFY20, follow-up was done to support corrective action on findings. PSA bi-annual quality reviews include site visits, a member interview, a staff interview, an Executive Director interview, a Board of Directors interview; and program, policy and financial review. Individual agency reports include findings, implementation timeframes, corrective action plans, and ongoing monitoring of corrective action plans as part of the review process.

The SMHA also partners with the three MCOs in NH around monthly CMHC chart audits. This tools was designed to review items outlined in contracts or NH rules that other reviews do not capture. Each month one MCO is assigned to review all ten CMHCs. This schedule is on rotation throughout the year allowing for each MCO to review all ten CMHCs four times throughout the year. These reports are provided to the CMHCs and discussed with their quality departments in a supportive nature to identify further TA needed. The reports are also provided to the SMHA in which they are consolidated on a quarterly basis and discussed with the CMHC QI directors.

The SMHA continues to participate in the DHHS Sentinel Event Reporting Systems, Mortality Reporting Summaries (quarterly and annually), and participation in the DHHS Division of Community Based Care Services (DCBCS) monthly Sentinel Event Reviews.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Quality Improvement Plan

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and 73 performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

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1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
a) No

The past two years have seen continuous progress made in the redesign of the DHHS behavioral health oversight function. Some quality improvement efforts are managed centrally, by the DHHS Bureau of Program Quality (BPQ) office. The BPQ implements and monitors Quality Service Reviews (QSRs) required by the State Mental Health Authority (SMHA). Each Community Mental Health Center (CMHC) is reviewed annually by the BPQ unit, and the resulting reports are published on the DHHS website. The QSRs result in a quality improvement plan that is developed by the CMHC and closely monitored jointly by BPQ and the SMHA. QSRs continued through the pandemic with minor adjustments made to include provisions for reviewing telehealth services and to conduct the reviews remotely.

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Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ◉ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ◉ Yes ○ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ◉ Yes ○ No
5. Does the state have any activities related to this section that you would like to highlight.

   The State Mental Health Authority's (SMHA) administrative rules require the community mental health centers (CMHC) to screen for and document a client's trauma history, including domestic violence, upon initial assessment and intake. The Child & Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA), administered at intake and at least annually thereafter, each contain prompts specific to trauma. Seven out of the ten CMHCs utilize the ANSA and all ten CMHCs utilize the CANS. While the prompts do exist, the detailed module is not included as the CMHCs conduct further trauma screening upon a therapeutic relationship being built to ensure the individual feels safe to openly discuss.

Formal policies directing providers on how to screen for personal history of trauma are not currently in place; however, the CMHCs use trauma assessment tools when history of, or current trauma, are indicated.

Non-clinical recovery supports that include trauma-informed practices are available to participants in the block grant-funded Peer Support Agencies. Specifically, Intentional Peer Support (IPS), Whole Health Action Management (WHAM) and the EBP Wellness Recovery Action Plan (WRAP).

The CMHA has mandated the inclusion of Peer Support Specialists on CMHC Assertive Community Treatment (ACT) teams, crisis response teams, and transitional housing programs. Individuals who have experienced trauma have a higher success rate in engaging individuals who have experienced trauma. Peer Support Specialists are individuals who have lived experience with mental illness, some of whom have experienced homelessness, multiple traumatic experiences associated with, resulting from, or causing homelessness, substance use, and other traumatic events or experiences.

All NH's Community Mental Health Centers have successfully employed Peer Support Specialists for outreach, support and empathize with individuals with SPMI who have a history of trauma. Youth M.O.V.E NH and NAMI NH offer youth peer support and family support programs. These avenues of cooperation will be explored for sources of peer support in NH's evolving FEP treatment program, based on the NAVIGATE model.

The Seacoast Vet-to-Vet program works with individuals who have trauma histories every time they meet (bimonthly). Their three facilitators are Peer Support Specialists with combat experience, which is important to many veterans.
On September 24th and 25th 2020, NHs three managed Care Organizations (MCOs) participated in a BH Symposium which offered ten (10) courses. The symposium consisted of courses within the following BH topics:
• Evidence-Based Practices
• Substance Use Disorders (SUD)
• Trauma-Informed Care and Integration
• Zero Suicide
• Overdose Prevention and Naloxone Administration

In SFY 20 and SFY 21, all three MCOs offered trainings in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. These trainings, specifically offered for providers, enabled providers to earn a certificate in TF-CBT, crisis intervention, and how to integrate trauma informed care models into practice. Trainings were offered in person at agencies, via a tele-network platform, and some are recorded for user access and self-paced trainings.

In SFY 2020 the SMHA partnered with the NH Department of Corrections and NAMI NH to host a series of trainings inclusive of a workshop titled "Building Trauma-Responsive Correctional Setting." Three trainings were offered and in sum, 110 professionals within criminal justice settings were trained. There is substantial evidence that trauma plays a role in problematic behaviors exhibited in correctional facilities such as rule violations and violence. To combat such behaviors, there is a need to adopt "universal precautions" i.e. "trauma-informed care" when working with justice-involved individuals is the best practice for those working in the criminal justice system. This training provided attendees with information to increase understanding of significant prevalence of traumatic exposure, appreciation of the trauma, psychosocial and system impacts of exposure to adversity and post-traumatic growth; Recognition of the signs of trauma; and Development of approaches and interventions to put knowledge into practice.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Trauma

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

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Please consider the following items as a guide when preparing the description of the state’s system:

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1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?

No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?

Yes

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
Yes

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
Yes

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5) Does the state have any activities related to this section that you would like to highlight.

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Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ◉ Yes ○ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ◉ Yes ○ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ◉ Yes ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

   BMHS Housing Pilot Program
   Beginning in Fiscal Year 2020, the SMHA began a pilot program, the Integrative Housing Voucher Program (IHVP), for individuals who have a criminal background that would otherwise prevent them from entering into HUD housing. According to HUD regulations, individuals with convicted violent criminal offenses such as burglary or assault; or individuals with drug related convictions including the intent to manufacture, sell, or distribute a controlled substance will be denied a HUD voucher. The Integrative Housing Voucher Program, is a temporary supportive housing program that provides a housing voucher coupled with a designated housing specialist who will work with the individual to ensure they remain safely housed. The housing specialist also works closely with the individual's treatment team at the community mental health program, in an effort to create a true network of wrap around supports while the individual is in IHVP. The individual is expected to pay 30% of their income in rent, and comply with the requirements of IHVP, which include ongoing communication with their housing specialist and CMHC treatment team, annual income recertification and criminal background checks, annual apartment inspections to ensure unit safety, and to work with the housing specialist to become eligible for HUD housing vouchers. Individuals entering this program may be coming out of the New Hampshire prison system, a local New Hampshire jail, or may be homeless on the streets.

IDNs and Community Reentry Programs
Using a Medicaid 1115 waiver, the State of New Hampshire funds networks of providers who meet metrics demonstrating improved patient outcomes and promoting delivery system reform.

By providing funding to support delivery system transformation—rather than to cover the costs of specific services rendered by providers—the waiver enables health care providers and community partners within a region to form relationships focused on transforming care. This funding also provides prompt resources for combatting the opioid crisis and strengthening the state's strained mental health delivery system.

Regionally-based networks of providers called Integrated Delivery Networks ('IDNs') are driving system transformation by designing and implementing projects in a geographic region.

One goal of IDN projects is to support beneficiaries transitioning from institutional settings to the community and within organizations in the community.

Research indicates that significant numbers of adults in correctional facilities and youth in juvenile justice residential facilities have diagnosed and undiagnosed mental illness and/or substance use disorders. Community re-entry is a time-limited program to assist those individuals with behavioral health conditions to safely transition back into community life. The program is initiated pre- discharge and continues for 12 months post discharge.

The program's objectives are to:
• Support adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues (mental health and/or substance misuse or substance use disorders) in maintaining their health and recovery as they return to the community.
• Prevent unnecessary hospitalizations and ED usage among these individuals by connecting them with integrated primary and behavioral health services, care coordination and social and family supports.

The project approach will blend after-care planning efforts that occur within corrections with enhanced case management, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

Participating Organizations/ Implementation Framework
County Corrections facilities
Local shelters
Peer Recovery Centers
Community Colleges
Developmental Disability Area Agencies
University of New Hampshire Cooperative Extension
Diversion/Restorative Justice Programs
Public Health Regional Networks
Community Mental Health Clinics
Community Health Services Network
Primary Care Services
Housing Services

NH Department of Corrections
Typical mental health treatment services available within the State correctional system are dependent upon the inmate's location in the system. At the state level the Department of Corrections (DOC) operates a full array of mental health services in what DOC terms the "outpatient" unit inside the state prison. For inmates requiring inpatient care, referral is made to the Secure Psychiatric Unit (SPU), located within the State Prison for Men in Concord, NH. The SPU is a 40-bed unit established by state statute to house and treat a mixed population of severely mentally ill persons. The residents include mentally ill prison inmates, mentally ill jail inmates, criminal and civil commitments.

The New Hampshire DHHS contracts for sex offender treatment at Transitional Housing Services for the Mentally Ill and NHH Acute Psychiatric Services. Inmates that require sub-acute residential treatment can now reside in the Residential Treatment Unit (RTU), a 20-bed unit housed next to the SPU.

At the county level each of the ten county jail facilities are independently operated and vary in the level of mental health services provided. Some, but not all, contract with the CMHCs for mental health treatment. Others contract with private practitioners.
Juvenile Justice Services (JJS)

Juvenile Justice Services (JJS) is a unit administered by the Division of Children, Youth, & Families (DCYF), and is responsible for

providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as Children In Need of Services (CHINS). JJS provides supervision, case management, and an array of rehabilitative services through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community-based providers who are licensed and/or certified by DHHS. All community-based services, both residential and non-residential, are administered by JJS institutional and field staff in cooperation with the NH court system. The services are then delivered by local organizations and providers. These services include home-based therapeutic services, substance misuse assessment and counseling, mental health services and an array of residential services, (foster homes, group homes, and intensive treatment facilities).

Mental Health Courts
Mental Health and Drug Courts are specialty court programs for offenders with substance use or mental health diagnoses. These treatment courts combine community based treatment programs with strict court supervision and progressive incentives and sanctions. By linking offenders to treatment services, the program aims to address offender's substance abuse and mental health diagnoses that led to criminal behavior, thereby reducing recidivism, and protecting public safety. These treatment court programs are designed to promote compliance with treatment programs as an alternative to jail time. The Mental Health Courts in NH operate at the District Court level in Nashua, Keene, Rochester, Exeter, Portsmouth, Manchester, Milford, Concord, Goffstown and Haverhill. The review tiers, as well as the specifics of pleading, convictions, dismissal and so forth, varies among the court programs. There is current discussion of adding Veterans' Courts to the Mental Health courts to specifically address veteran's issues when they become involved with the judicial system.

The Mental health and Drug Courts are extremely successful in rehabilitating participants who graduate from the 12 to 24 month programs. The recidivism rate at which offenders get sent back to jail, for Drug Court graduates in Grafton and Strafford counties is around 22% as compared to prisoners statewide with a recidivism rate of close to 40% and nearly 60% nationally.

Crisis Intervention Team (CIT) Training
Many towns and cities in NH have adopted a crisis intervention team (CIT) strategy. The CIT initiative includes policy, practice, and protocol changes and officers specially trained to effectively respond to calls that involve individuals experiencing a mental health crisis. Officers receive intensive training in recognition of mental illness, de-escalation techniques, and resources available to those experiencing a mental health crisis. NH Police Departments annually respond to thousands of calls for service involving individuals experiencing a mental health crisis.

In state fiscal year 2019, NAMI-NH was awarded a SAMHSA Mental Health Awareness Training Grant to expand CIT statewide for NH state police, EMS and other first responders. The SMHA serves with other stakeholders on the advisory committee to implement the goals of the three-year grant.

Training, Technical Assistance, and Education
Governor Sununu's Executive Order 2019-02 established the Governor's Advisory Commission on Mental Illness and the Corrections System to identify solutions and recommendations for how to reduce incarceration and improve services for such individuals, and to support individuals with mental illness who are transitioning from jail back to their communities. The commission posted a report in November 2020.

Recommendations outlined in the commission report use the 10-Year Mental Health Plan as a framework and call for targeted recommendations to address education, prevention, intervention, diversion, incarceration, and transition/reintegration. Expanding training opportunities for staff working within the criminal justice system was an identified objective of the Advisory Commission on Mental Illness and Corrections

In 2021, the SMHA provided funds from the NH mental health block grant TA/training supplemental award to the Department of Corrections for a series of training sessions to be conducted by the National Alliance on Mental Illness-New Hampshire (NAMI NH) to offer training sessions to those who work closely with justice-involved individuals with mental illness to include administrative, correctional officer and probation and parole staff from the NH Department of Corrections and community stakeholders to include but not limited to Judicial Branch and law enforcement. As of July 2021, 278 individuals were trained.
The trainings offered included:
Building Trauma-Responsive Correctional Setting – 3 trainings, 110 professionals trained
There is substantial evidence that trauma plays a role in problematic behaviors exhibited in correctional facilities such as rule violations and violence. To combat such behaviors, there is a need to adopt "universal precautions" i.e. "trauma-informed care" when working with justice-involved individuals is the best practice for those working in the criminal justice system. This training provided attendees with information to increase understanding of significant prevalence of traumatic exposure, appreciation of the trauma, psychosocial and system impacts of exposure to adversity and post-traumatic growth; Recognition of the signs of trauma; and Development of approaches and interventions to put knowledge into practice.

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The Connect Suicide Prevention Program (Connect), developed by NAMI NH, is a national and international suicide prevention

program. Connect gatekeeper training is designed to teach participants about suicide data, identification of risk and protective factors, and responding to warning signs, intervention strategies, suicide as a public health issue and its impact on communities, families, and friends, confidentiality and reporting requirements, best practices around safe messaging, and self-care skills.

Responding to People with Mental Illness – 29 professionals trained
In order to safely and effectively resolve situations involving mental illness, emotional crises, and volatile circumstances, law enforcement and correctional personnel should understand best approaches, related laws and available resources that can affect a constructive disposition. This training provides an overview of mental illness, behaviors and risks, protocols for intervening with a person who is suicidal, safely de-escalate situations, understand the impact of stigma and trauma, relevant laws, and understand the impact of trauma on law enforcement and recognize risk of suicide and resources to reduce risk and promote healthy and productive management of stress.

Crisis Intervention Team (CIT) Training – 26 professionals trained
CIT training is comprised of a comprehensive curriculum taught by local specialists from law enforcement, Emergency Medical Services (EMS), mental health and the peer/advocate field. CIT highlights best practices, improves community partnerships and helps communities develop processes to serve people affected by mental illness with respect and dignity. The 5-day training increases participant's knowledge of mental illness, suicide prevention, and signs and symptoms of a crisis situation and incorporates skills training on engagement and de-escalation.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Criminal and Juvenile Justice

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment

Please respond to the following items:

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1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?
Yes

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?
Yes

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?
Yes

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-

governmental entities to address M/SUD and other essential domains such as employment, education, and finances?
No

5. Does the state have any activities related to this section that you would like to highlight?

BMHS Housing Pilot Program
Beginning in Fiscal Year 2020, the SMHA began a pilot program, the Integrative Housing Voucher Program (IHVP), for individuals who have a criminal background that would otherwise prevent them from entering into HUD housing. According to HUD regulations, individuals with convicted violent criminal offenses such as burglary or assault; or individuals with drug related convictions including the intent to manufacture, sell, or distribute a controlled substance will be denied a HUD voucher. The Integrative Housing Voucher Program, is a temporary supportive housing program that provides a housing voucher coupled with a designated housing specialist who will work with the individual to ensure they remain safely housed. The housing specialist also works closely with the individual's treatment team at the community mental health program, in an effort to create a true network of wrap around supports while the individual is in IHVP. The individual is expected to pay 30% of their income in rent, and comply with the requirements of IHVP, which include ongoing communication with their housing specialist and CMHC treatment team, annual income recertification and criminal background checks, annual apartment inspections to ensure unit safety, and to work with the housing specialist to become eligible for HUD housing vouchers. Individuals entering this program may be coming out of the New Hampshire prison system, a local New Hampshire jail, or may be homeless on the streets.

IDNs and Community Reentry Programs
Using a Medicaid 1115 waiver, the State of New Hampshire funds networks of providers who meet metrics demonstrating improved patient outcomes and promoting delivery system reform.

By providing funding to support delivery system transformation—rather than to cover the costs of specific services rendered by providers—the waiver enables health care providers and community partners within a region to form relationships focused on transforming care. This funding also provides prompt resources for combatting the opioid crisis and strengthening the state's strained mental health delivery system.

Regionally-based networks of providers called Integrated Delivery Networks ('IDNs') are driving system transformation by designing and implementing projects in a geographic region.

One goal of IDN projects is to support beneficiaries transitioning from institutional settings to the community and within organizations in the community.

Research indicates that significant numbers of adults in correctional facilities and youth in juvenile justice residential facilities have diagnosed and undiagnosed mental illness and/or substance use disorders. Community re-entry is a time-limited program to assist those individuals with behavioral health conditions to safely transition back into community life. The program is initiated pre- discharge and continues for 12 months post discharge.

The program's objectives are to:

- Support adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues (mental health and/or substance misuse or substance use disorders) in maintaining their health and recovery as they return to the community.
- Prevent unnecessary hospitalizations and ED usage among these individuals by connecting them with integrated primary and behavioral health services, care coordination and social and family supports.

The project approach will blend after-care planning efforts that occur within corrections with enhanced case management, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

Participating Organizations/ Implementation Framework	
County Corrections facilities	Local shelters
Peer Recovery Centers	Community Colleges
Developmental Disability Area Agencies	University of New Hampshire Cooperative Extension
Diversion/Restorative Justice Programs	Public Health Regional Networks
Community Mental Health Clinics	Community Health Services Network
Primary Care Services	Housing Services

NH Department of Corrections

Typical mental health treatment services available within the State correctional system are dependent upon the inmate's location in the system. At the state level the Department of Corrections (DOC) operates a full array of mental health services in what DOC terms the "outpatient" unit inside the state prison. For inmates requiring inpatient care, referral is made to the Secure Psychiatric Unit (SPU), located within the State Prison for Men in Concord, NH. The SPU is a 40-bed unit established by state statute to house and treat a mixed population of severely mentally ill persons. The residents include mentally ill prison inmates, mentally ill jail inmates, criminal and civil commitments.

The New Hampshire DHHS contracts for sex offender treatment at Transitional Housing Services for the Mentally Ill and NHH Acute Psychiatric Services. Inmates that require sub-acute residential treatment can now reside in the Residential Treatment Unit (RTU), a 20-bed unit housed next to the SPU.

At the county level each of the ten county jail facilities are independently operated and vary in the level of mental health services provided. Some, but not all, contract with the CMHCs for mental health treatment. Others contract with private practitioners.

Juvenile Justice Services (JJS)

Juvenile Justice Services (JJS) is a unit administered by the Division of Children, Youth, & Families (DCYF), and is responsible for providing supervision and rehabilitative services to youth adjudicated under

state law as delinquent or as Children In Need of Services (CHINS). JJS provides supervision, case management, and an array of rehabilitative services through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community-based providers who are licensed and/or certified by DHHS.

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Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

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[61] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Community Mental Health Centers Emergency Services
Each of the ten (10) Community Mental Health Centers offers access to Emergency Services 24 hours a day, 7 days a week, that provide clinical/psychiatric evaluation and treatment, and medication services, with availability in the office, community, and in the Emergency Departments at most local hospitals. All emergency services teams are required by contract with the SMHA to employ certified peer support specialists.

If warranted, CMHC clinicians also outreach and attempt to connect with patients seen in emergency departments after discharge. In addition, the three (3) Managed Care Organizations (MCOs) employ behavioral health care specialists who outreach MCO-enrolled individuals and confirm that after- care appointments were scheduled and kept and provide supportive services, such as transportation services, to ensure individuals can attend appointments. This trend is also emerging with commercial insurance payers.

Crisis Intervention and Stabilization Unit
Designated Receiving Facilities (DRF): In accordance with New Hampshire State Rule, He-M 405, DRFs are hospital-based psychiatric units or non-hospital-based residential treatment programs that are designated by the NH-DHHS commissioner to provide care, custody, and treatment to persons involuntary admitted to the state mental health services system.

NH has recently implemented a process to ensure that individuals who receive outpatient services from a community mental health center (CMHC) receive a follow-up service the same/ next day of discharge from a DRF. The CMHCs, DRFs, and MCOs are working to implement an electronic event notification system to facilitate the transfer of discharge information to facilitate timely follow-up.

In 2020, NH transitioned youth DRF beds from New Hampshire Hospital to Hampstead Hospital which now operates sixteen (16) youth DRF beds. An additional eight (8) adults beds were also added to the system in late 2019.

The bed totals are listed below:
247 total adult beds
16 total youth beds

The breakdown of these beds is as follows:
Adult DRF Beds
Cypress Center (16 adult beds)
Elliot Regional Hospital (14 adult beds)
Concord Hospital - Franklin (10 adult beds)
Portsmouth Regional Hospital (16 adult beds)
Parkland Medical Center (4 adult beds)
New Hampshire Hospital (187 Adult Beds)
Youth DRF Beds
Hampstead Regional Hospital (16 youth beds).

Mobile Crisis Response Teams
Since 2015 New Hampshire has held contracts with three (3) agencies that employ distinct mobile crisis response teams within the greater Nashua region, the greater Manchester region, and the greater Concord region. Mobile Crisis Response Teams (MCRT) and beds are identified for individuals eighteen (18) years or older who are experiencing a mental health crisis, including those with a co-occurring substance use disorders. These current MCRTs each provide mobile crisis stabilization services 24 hours a day, 7 days a week, a central phone triage system where trained clinicians complete an initial risk assessment, provide crisis stabilizations services and interventions inclusive of peer support services, and provide mobile crisis apartments that serve as an alternative to hospitalization and/or institutionalization. MCRTs collaborate and coordinate with law enforcement where appropriate. MCRTs have the ability to respond to requests for crisis assessments and interventions within one (1) hour of receiving calls for mobilization of services. Once the MCRT is involved with a case, services and supports can be provided for up to thirty (30) days following the onset of the crisis to ensure individuals remain stable and in the community. Mobile Crisis Apartment stays are available for up to seven (7) days per episode or longer when warranted.

New Hampshire has seen success in establishing mobile crisis services in targeted regions of the state. A core goal of NH’s 10 Year Mental Health Plan is to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to transform and expand New Hampshire’s crisis services to include mobile response statewide and integrated (serving all ages with both mental health and substance use disorders). NH’s behavioral health crisis response model, the NH Rapid Response, is in the early implementation phase and contracts have been awarded. The Rapid Response model will require a system transformation. The below graphic illustrates the current and future state of crisis services in NH. The model has three parts; First is the centralized, 24/7 statewide access point where all behavioral health crisis

calls/texts/chats with be answered, triaged, and, in many cases, de-escalated altogether. The access point is contracted to Beacon Health. Second, if the access point cannot be de-escalate the situation, a mobile Rapid Response team will be deployed. The mobile Rapid Response teams will be staffed by all 10 CMHC's and teams will be available to deploy to the location of the person in crisis. Options for same day in-office appointments and telehealth visits will also be offered to callers. Third, once stabilized, all individuals who engage with the Rapid Response system will have access to short-term stabilization services through the CMHCs.

The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention.

The goal of the Rapid Response system is to provide easy access to behavioral health care for children, youth, adults, and families in crisis. The system is intended to ensure individuals receive the clinically appropriate level of care in the modality and environment of their choice (phone, text, chat, community, office, telehealth). A core outcome of this system will be to engage people early and divert people from entering emergency departments to access behavioral health care. The below graphic illustrates the projected number of encounters expected statewide. As depicted, approximately 80% of individuals who reach out to the access point will be resolved and not require a higher level of intervention.

On the June 30, 2021 the New Hampshire Governor and Executive Council approved a new contract with Beacon Health for the NH Rapid Response Access Point. This agreement will provide the centralized crisis call center that will also dispatch and deploy Mobile Crisis Teams statewide; the population served includes individuals across the age continuum who experience a behavioral health crisis including individuals with SMI and SED. It is also anticipated that the Access Point will connect with the new national 9-8-8-crisis line and include phone, text and chat functionality. Also on June 30, 2021 Governor and Executive Council approved contracts with all 10 community mental health centers to begin implementation of mobile crisis in all 10 regions. This will integrate crisis services for the general population and individuals with SMI/SPMI/SED currently served through the community mental health system. New Hampshire's 9-8-8 planning coalition is also working to address access and collaboration efforts between the Access Point and Department of Safety.

The SMHA in partnership with the CMHCs and Beacon Health will also be engaging in community education and outreach. The expectation is launch a broad public awareness campaign to blanket the state in educational materials and announcements regarding access to crisis services. The goal being to inform NH citizens about the availability of crisis services in their community and how to easy access care while experiencing a behavioral health crisis.

Behavioral Health Crisis Treatment Center
The BHCTC, located in the greater Concord region, provides intensive, short-term stabilization treatment services for individuals eighteen (18) years of age and older who are experiencing a mental health crisis, including those with a co-occurring substance use disorder. The BHCTC staff collaborate with the individual's existing treatment providers, if any, other community resources, and appropriate Integrated Delivery Network (IDN) providers to rapidly coordinate needed services to support the individual post-discharge. The BHCTC fills an existing gap in the behavioral health treatment and service continuum by expanding system capacity to treat individuals experiencing a mental health crisis. Individuals are able to access the BHCTC on a walk-in basis and if transported by first responders or from other treatment sites, such as emergency departments. The model offers a peer living room, clinical, and medical services. BHCTC staff provide treatment services to de-escalate, stabilize and successfully transition the individual back to the community or to a step-down treatment site. The BHCTC triages, assesses, treats, and completes discharge planning - inclusive of completing a warm hand-off of the individual with community providers when needed within 24 hours.

If appropriate, individuals may step down to a mobile crisis apartment bed, a peer respite bed, or other existing community residence or treatment site.

Critical Time Intervention (CTI) Statewide Implementation
CTI is a time-limited, evidence- and community-based practice that mobilizes support for adults with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships.

CTI is broken into four discrete phases, as the table below shows:
Phase Description
Pre-CTI CTI provider meets with client and establishes personal relationships (prior to discharge).
Phase 1 CTI provider connects client to people and agencies ("linkages") that will assume the primary roles of support (e.g., food, housing, health care, employment, family, etc.).
Phase 2 CTI provider observes operation of client's new support network; mediates any conflict between client and caregivers; and encourages client to take increasing responsibility.
Phase 3 CTI provider and client develop plan for long-term goals; plan for and execute final transfer of care to linkages. CTI provider ensures client can function independently of CTI.

The State anticipates that its Community Mental Health Services Block Grant funding will enable the initial implementation of a statewide CTI program, with the near-term goal of mitigating the overflowing demand on the State hospital system. Sustainable

funding for CTI over the long term will be provided by other sources, such as State General Funds, Medicaid reimbursement, or third-party grants.

The State intends to follow its implementation of CTI with a rigorous, empirical study of the program's effectiveness in New Hampshire, particularly with regard to its impact on hospital readmissions.

State general funds are included in the proposed State fiscal year 2022-2023 budget in order to implement CTI in targeted regions of the state. These supplemental funds will enable New Hampshire to fully implement the program statewide to meet the increased needs of individuals who seek services in hospital settings.

Peer-Run Respite Apartments
A peer operated, respite provides early intervention for individuals (18) years of age and older who have a mental illness and are experiencing a crisis in the community. Applications for respite stays are submitted by self-referral or through other formal or informal support networks. Peer Respite shall be available for peers to stay a maximum of seven (7) days per episode. The State of New Hampshire contracts with three (3) agencies for a total of six (6) beds.

Peer Respite beds are available 365 days a year, are available to any individual in New Hampshire regardless of where they live or work, and provide the following supports:
• A form of temporary housing such as an apartment adjacent to or attached to the peer support agency that include amenities and private living space for the individual while experiencing a mental health crisis
• Provide interventions using a model of Intentional Peer Support (IPS), that focus on individual's strengths and assists in personal recovery and wellness
• Provide individualized supports with a focus on wellness and recovery that may include Wellness Recovery Action Plan (WRAP) and/or Whole Health action Management (WHAM), if applicable
• Offer other peer support services and supports during the course of stay at the program
• Assist the individual to identify and obtain benefits such as but not limited to food stamps, heating assistance, as appropriate
• Support the individual to return to participation in community activities, services and supports
• Ensure the individual's health needs if they become ill or injured are addressed during the course of their stay in the peer respite program

Peer Operated Warm Lines
Currently all eight (8) of NH's contracted Peer Support Agencies provide peer operated warm line services. The warm lines offer evening (5-10pm) telephone peer support to anyone who lives or works in New Hampshire. Trained peers provide callers with information, resources, referrals, and phone-based peer support services to assist with crisis resolution and/or access to treatment.

Recovery-Oriented Step-Up/Step-Down Beds
In December of 2020, New Hampshire entered into contract with four (4) Peer Support Agencies, each to operate 3-bed Recovery-Oriented Step Up/Step Down programs. These programs offer a new level of crisis care in NH. Step-Up/Step-Down Programs provide short-term recovery based transition services for adults (18 years of older) who are transitioning from inpatient or institutional settings into the community or who require a more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer supports with access to peer staff 24 hours a day 7 days per week. Stays are limited to ninety (90) days per episode of need. Staff focus on recovery oriented peer support services that also work to coordinate and engage with outpatient community based clinical treatment providers. Programs are operated in accordance with the SAMHSA Core Competencies for Peer Support Workers in the behavioral health system and accept referrals from a multitude of community based treatment providers.

Programs support recovery and resiliency oriented interventions through:
• Facilitating connections to natural supports
• Developing and supporting individual discharge plans
• Providing access to at least one SAMHSA recognized peer support model
• Providing opportunities for engagement in structured, daily activities
• Development of individual recovery and wellness plans
Programs also facilitate connections with service providers including, but not limited to, family support services, social security, food stamps, housing supports, health support services and other community based resources. If an individual is in need of a higher level of care while staying in a Step Up/Step Down bed, the program shall deploy necessary referrals to engage the individual in accessing this level of care.

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Headrest participates as a crisis intervention center within the National Suicide Prevention Lifeline Network, funded through the

Substance Abuse and Mental Health Services Administration (SAMHSA). In 2020 Headrest had an 80% answer rate for instate calls; supporting 5,292 NH callers total.

Crisis Intervention Team (CIT) Training
Many towns and cities in NH have adopted a crisis intervention team (CIT) strategy. The CIT initiative includes policy, practice, and protocol changes and officers receive specialized training to effectively respond to calls that involve individuals experiencing a mental health crisis. Officers receive intensive training in recognition of mental illness, de-escalation techniques, and resources available to those experiencing a mental health crisis. NH Police Departments annually respond to thousands of calls for service involving individuals experiencing a mental health crisis.

In state fiscal year 2019, NAMI-NH was awarded a SAMHSA Mental Health Awareness Training Grant to expand CIT statewide for NH state police, EMS and other first responders. The SMHA serves with other stakeholders on the advisory committee to implement the goals of the three-year grant.

Other Noteworthy Work
• In April 2020 New Hampshire was awarded a SAMHSA grant to support implementation of "Rapid Response to Behavioral Health Needs During Covid-19". This grant expanded emergency services teams by hiring ten (10) additional master's clinicians and ten (10) additional peer support specialists statewide. These staff provide crisis services and supports to healthcare providers and individuals who are uninsured and underinsured seeking crisis support services.
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Proposed and planned activities utilizing the 5% set aside for FY 21
The 5% Crisis Services Set Aside shall be utilized by the centralized access point to support start-up and implementation outlined above. Funds will be targeted to support the clinical staff needed to provide telephonic crisis intervention services to all callers and to coordinate deployment and warm hand-off referrals, including deployment of mobile response teams, as clinically determined.

Please indicate areas of technical assistance needed related to this section.

Strategies to effectively integrate peers into crisis response systems.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Crisis Services

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
    - Wellness Recovery Action Plan (WRAP) Crisis Planning? Yes
    - Psychiatric Advance Directives? No
    - Family Engagement? Yes
    - Safety Planning? Yes
    - Peer-Operated Warm Lines? Yes
    - Peer-Run Crisis Respite Programs? Yes
    - Suicide Prevention? Yes

2. Crisis Intervention/Stabilization:
    - Assessment/Triage (Living Room Model)? Yes
    - Open Dialogue? Yes
    - Crisis Residential/Respite? Yes
    - Crisis Intervention Team/ Law Enforcement? Yes
    - Mobile Crisis Outreach? Yes
    - Collaboration with Hospital Emergency Departments and Urgent Care Systems? Yes

3. Post Crisis Intervention/Support:
    - Peer Support/Peer Bridges? Yes
    - Follow-Up Outreach and Support? Yes
    - Family-to-Family engagement? Yes

- Connection to care coordination and follow-up clinical care for individuals in crisis? Yes
- Follow-up crisis engagement with families and involved community members: Yes
- Recovery community coaches/peer recovery coaches? Yes
- Recovery community organization? Yes

4. Does the state have any activities related to this section that you would like to highlight?

Community Mental Health Centers Emergency Services

Each of the ten (10) Community Mental Health Centers offers access to Emergency Services 24 hours a day, 7 days a week, that provide clinical/psychiatric evaluation and treatment, and medication services, with availability in the office, community, and in the Emergency Departments at most local hospitals. All emergency services teams are required by contract with the SMHA to employ certified peer support specialists.

If warranted, CMHC clinicians also outreach and attempt to connect with patients seen in emergency departments after discharge. In addition, the three (3) Managed Care Organizations (MCOs) employ behavioral health care specialists who outreach MCO-enrolled individuals and confirm that after- care appointments were scheduled and kept and provide supportive services, such as transportation services, to ensure individuals can attend appointments. This trend is also emerging with commercial insurance payers.

Crisis Intervention and Stabilization Unit

Designated Receiving Facilities (DRF): In accordance with New Hampshire State Rule, He-M 405, DRFs are hospital-based psychiatric units or non-hospital-based residential treatment programs that are designated by the NH-DHHS commissioner to provide care, custody, and treatment to persons involuntary admitted to the state mental health services system.

NH has recently implemented a process to ensure that individuals who receive outpatient services from a community mental health center (CMHC) receive a follow-up service the same/ next day of discharge from a DRF. The CMHCs, DRFs, and MCOs are working to implement an electronic event notification system to facilitate the transfer of discharge information to facilitate timely follow-up.

In 2020, NH transitioned youth DRF beds from New Hampshire Hospital to Hampstead Hospital which now operates sixteen (16) youth DRF beds. An additional eight (8) adults beds were also added to the system in late 2019.

The bed totals are listed below:

247 total adult beds
16 total youth beds

The breakdown of these beds is as follows:

<u>Adult DRF Beds</u>
Cypress Center (16 adult beds)
Elliot Regional Hospital (14 adult beds)
Concord Hospital - Franklin (10 adult beds)
Portsmouth Regional Hospital (16 adult beds)
Parkland Medical Center (4 adult beds)
New Hampshire Hospital (187 Adult Beds)
<u>Youth DRF Beds</u>
Hampstead Regional Hospital (16 youth beds).

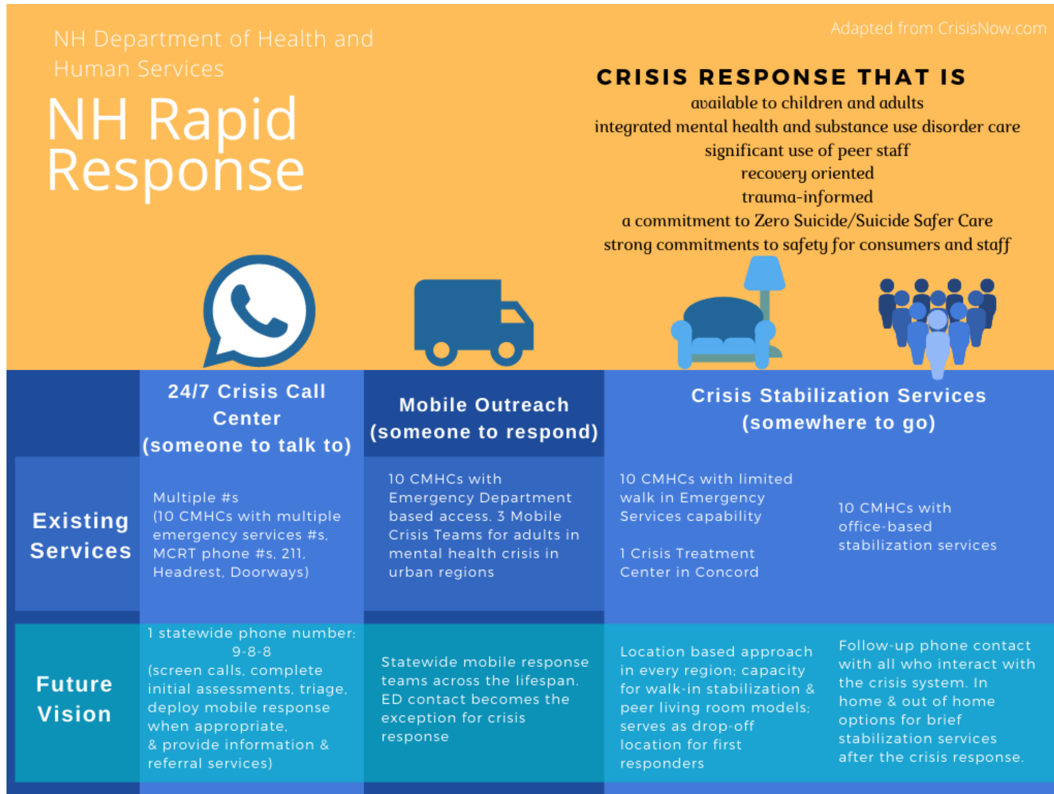
Mobile Crisis Response Teams

Since 2015 New Hampshire has held contracts with three (3) agencies that employ distinct mobile crisis response teams within the greater Nashua region, the greater Manchester region, and the greater Concord region. Mobile Crisis Response Teams (MCRT) and beds are identified for individuals eighteen (18) years or older who are experiencing a mental health crisis, including those with a co-occurring substance use disorders. These current MCRTs each provide mobile crisis stabilization services 24 hours a day, 7 days a week, a central phone triage system where trained clinicians complete an initial risk assessment, provide crisis stabilizations services and interventions inclusive of peer support services, and provide mobile crisis apartments that serve as an alternative to hospitalization and/or institutionalization. MCRTs collaborate and coordinate with law enforcement where appropriate. MCRTs have the ability to respond to requests for crisis assessments and interventions within one (1) hour of receiving calls for mobilization of services. Once the MCRT is involved with a case, services and supports can be provided for up to thirty (30) days following the onset of the crisis to ensure individuals remain stable and in the community. Mobile Crisis Apartment stays are available for up to seven (7) days per episode or longer when warranted.

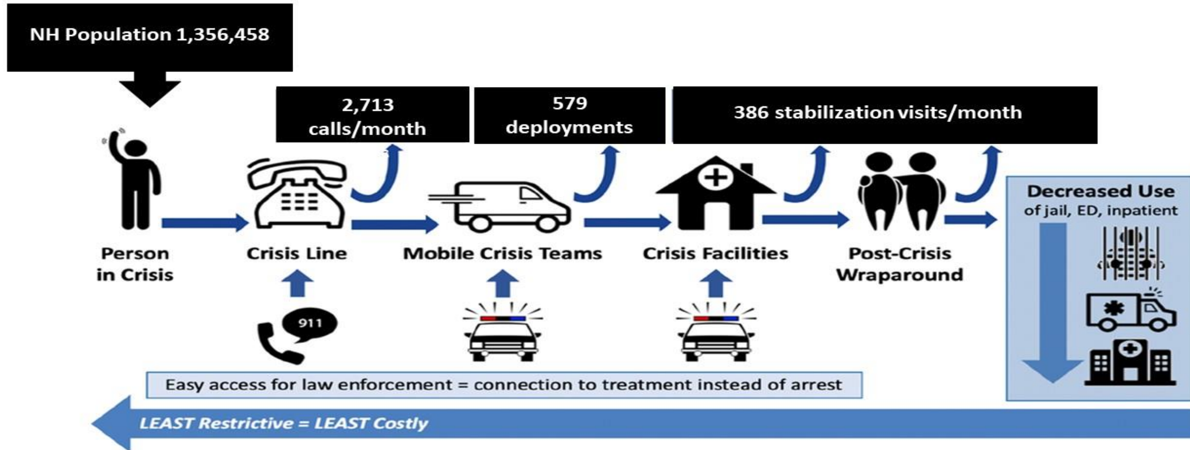
New Hampshire has seen success in establishing mobile crisis services in targeted regions of the state. A core goal of NH's 10 Year Mental Health Plan is to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to transform and expand New Hampshire's crisis services to include mobile response statewide and integrated (serving all ages with both mental health and substance use disorders). NH's behavioral health crisis response model, the NH Rapid Response, is in the early implementation phase and contracts have been awarded. The Rapid Response model will require a system transformation. The below graphic illustrates the current and future state of crisis services in NH. The model has three parts; First is the centralized, 24/7 statewide access point where all behavioral health crisis calls/texts/chats with be answered, triaged, and, in many cases, de-escalated altogether. The access point is contracted to Beacon Health. Second, if the access point cannot be de-escalate the situation, a mobile Rapid Response team will be deployed. The mobile Rapid Response teams will be staffed by all 10 CMHC's and teams will be available to deploy to the location of the person in crisis. Options for same day in-office appointments and telehealth visits will also be offered to callers.

Third, once stabilized, all individuals who engage with the Rapid Response system will have access to short-term stabilization services through the CMHCs.

The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention.



The goal of the Rapid Response system is to provide easy access to behavioral health care for children, youth, adults, and families in crisis. The system is intended to ensure individuals receive the clinically appropriate level of care in the modality and environment of their choice (phone, text, chat, community, office, telehealth). A core outcome of this system will be to engage people early and divert people from entering emergency departments to access behavioral health care. The below graphic illustrates the projected number of encounters expected statewide. As depicted, approximately 80% of individuals who reach out to the access point will be resolved and not require a higher level of intervention.



On the June 30, 2021 the New Hampshire Governor and Executive Council approved a new contract with Beacon Health for the NH Rapid Response Access Point. This agreement will provide the centralized crisis call center that will also dispatch and deploy Mobile Crisis Teams statewide; the population served includes individuals across the age continuum who experience a behavioral health crisis including individuals with SMI and SED. It is also anticipated that the Access Point will connect with the new national 9-8-8-crisis line and include phone, text and chat functionality. Also on June 30, 2021 Governor and Executive Council approved contracts with all 10 community mental health centers to begin implementation of mobile crisis in all 10 regions. This will integrate crisis services for the general population and individuals with SMI/SPMI/SED currently served through the community mental health system. New Hampshire's 9-8-8 planning coalition is also working to address access and collaboration efforts between the Access Point and Department of Safety.

The SMHA in partnership with the CMHCs and Beacon Health will also be engaging in community education and outreach. The expectation is launch a broad public awareness campaign to blanket the state in educational materials and announcements regarding access to crisis services. The goal being to inform NH citizens about the availability of crisis services in their community and how to easy access care while experiencing a behavioral health crisis.

Behavioral Health Crisis Treatment Center

The BHCTC, located in the greater Concord region, provides intensive, short-term stabilization treatment services for individuals eighteen (18) years of age and older who are experiencing a mental health crisis, including those with a co-occurring substance use disorder. The BHCTC staff collaborate with the individual's existing treatment providers, if any, other community resources, and appropriate Integrated Delivery Network (IDN) providers to rapidly coordinate needed services to support the individual post-discharge. The BHCTC fills an existing gap in the behavioral health treatment and service continuum by expanding system capacity to treat individuals experiencing a mental health crisis. Individuals are able to access the BHCTC on a walk-in basis and if transported by first responders or from other treatment sites,

such as emergency departments. The model offers a peer living room, clinical, and medical services. BHCTC staff provide treatment services to de-escalate, stabilize and successfully transition the individual back to the community or to a step-down treatment site. The BHCTC triages, assesses, treats, and completes discharge planning - inclusive of completing a warm hand-off of the individual with community providers when needed within 24 hours.

If appropriate, individuals may step down to a mobile crisis apartment bed, a peer respite bed, or other existing community residence or treatment site.

Critical Time Intervention (CTI) Statewide Implementation

CTI is a time-limited, evidence- and community-based practice that mobilizes support for adults with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships.

CTI is broken into four discrete phases, as the table below shows:

Phase	Description
Pre-CTI	CTI provider meets with client and establishes personal relationships (prior to discharge).
Phase 1	CTI provider connects client to people and agencies ("linkages") that will assume the primary roles of support (e.g., food, housing, health care, employment, family, etc.).
Phase 2	CTI provider observes operation of client's new support network; mediates any conflict between client and caregivers; and encourages client to take increasing responsibility.
Phase 3	CTI provider and client develop plan for long-term goals; plan for and execute final transfer of care to linkages. CTI provider ensures client can function independently of CTI.

The State anticipates that its Community Mental Health Services Block Grant funding will enable the initial implementation of a statewide CTI program, with the near-term goal of mitigating the overflowing demand on the State hospital system. Sustainable funding for CTI over the long term will be provided by other sources, such as State General Funds, Medicaid reimbursement, or third-party grants.

The State intends to follow its implementation of CTI with a rigorous, empirical study of the program's effectiveness in New Hampshire, particularly with regard to its impact on hospital readmissions.

State general funds are included in the proposed State fiscal year 2022-2023 budget in order to implement CTI in targeted regions of the state. These supplemental funds will enable New Hampshire to fully implement the program statewide to meet the increased needs of individuals who seek services in hospital settings.

Peer-Run Respite Apartments

A peer operated, respite provides early intervention for individuals (18) years of age and older who have a mental illness and are experiencing a crisis in the community. Applications for respite stays are submitted by self-referral or through other formal or informal support networks. Peer Respite shall be available for peers to stay a maximum of seven (7) days per episode. The State of New Hampshire contracts with three (3) agencies for a total of six (6) beds.

Peer Respite beds are available 365 days a year, are available to any individual in New Hampshire regardless of where they live or work, and provide the following supports:

- A form of temporary housing such as an apartment adjacent to or attached to the peer support agency that include amenities and private living space for the individual while experiencing a mental health crisis
- Provide interventions using a model of Intentional Peer Support (IPS), that focus on individual’s strengths and assists in personal recovery and wellness
- Provide individualized supports with a focus on wellness and recovery that may include Wellness Recovery Action Plan (WRAP) and/or Whole Health action Management (WHAM), if applicable
- Offer other peer support services and supports during the course of stay at the program
- Assist the individual to identify and obtain benefits such as but not limited to food stamps, heating assistance, as appropriate
- Support the individual to return to participation in community activities, services and supports
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Proposed and planned activities utilizing the 5% set aside for FY 21

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Please indicate areas of technical assistance needed related to this section.

Strategies to effectively integrate peers into crisis response systems.

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ◉ Yes ○ No

b) Required peer accreditation or certification? ◉ Yes ○ No

c) Block grant funding of recovery support services. ◉ Yes ○ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

NH subscribes to the definition of recovery developed by people in the recovery community and set forth by SAMHSA: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their potential. The 4 major dimensions that support a life in recovery are Health, Home, Community and Purpose. We also promote the 10 Guiding Principles of Recovery.

Peer Support Agencies
Individuals in recovery and family members have access to Peer Support Agencies (PSAs) throughout the state. The SMHA contracts with 8 PSAs (14 locations) statewide, to ensure at least one agency is headquartered in each of the 10 designated community mental health regions. PSAs offer peer support, education, connectedness to the community, activities, training, and employment opportunities among other services. Some of these peer agencies also provide Peer Respite and Recovery Orientated Step Up/Step Down beds. The SMHA and the PSA's continue to work toward expansion of services and integration of services throughout the system. Peer support has been proven successful and has shown to divert individuals from psychiatric hospitalizations, increase the likelihood of employment, reduce suicidality, and lead to better quality of life.

Recovery Oriented Step-up/Step-down programs
In December of 2020, New Hampshire entered into contract with four (4) Peer Support Agencies, each to operate 3-bed Recovery-Oriented Step Up/Step Down programs. These programs offer a new level of crisis care in NH. Step-Up/Step-Down Programs provide short-term recovery based transition services for adults (18 years of older) who are transitioning from inpatient or institutional settings into the community or who require a more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer supports with access to peer staff 24 hours a day 7 days per week. Stays are limited to ninety (90) days per episode of need. Staff focus on recovery oriented peer support services that also work to coordinate and engage with outpatient community based clinical treatment providers. Programs are operated in accordance with the SAMHSA Core Competencies for Peer Support Workers in the behavioral health system and accept referrals from a multitude of community based treatment providers.

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Programs also facilitate connections with service providers including, but not limited to, family support services, social security, food stamps, housing supports, health support services and other community based resources. If an individual is in need of a higher level of care while staying in a Step Up/Step Down bed, the program shall deploy necessary referrals to engage the individual in accessing this level of care.

National Alliance on Mental Illness – New Hampshire
For over 10 years the SMHA has contracted with NAMI NH (National Alliance on Mental Illness, New Hampshire) to provide family mutual support programming to individuals statewide. In 2021 family mutual support programming contract was competitively procured and awarded, again, to NAMI NH to provide family and peer-run support groups, education classes, trainings, and advocacy opportunities for approximately 11,000 individuals and families affected by mental illness throughout the state. Through this contract, NAMI NH also provides an array of training sessions on best practices for suicide prevention and post intervention for individuals, family members, service providers, and the general public. Additional training sessions on crisis intervention, suicide intervention and peer leadership training. NAMI NH also provides information to the public through web-based media, and distributes electronic and printed materials, with approval from the Department, on topics that include family support and education programs and resources for survivors of a suicide loss. NAMI NH participates on the New Hampshire Suicide Prevention Council as a member organization, and will serve as the fiscal agent for $100,000 of designated state general funds to support implementation of the goals of the suicide prevention council's strategic plan.

Family Peer Support Specialist
• Family Peer Support Specialist (FPSS) bring a commitment and adheres in their practice to the System of Care values and principles and a "lived experience" as a family member who has been or is a parent of a child that meets or has met the criteria for

serious emotional disturbance.
• With the family's consent, the assigned FPSS will be a member of the Wraparound team and will partner with the Care Coordinator; and will participate in the delivery of Family Orientation Meeting with the Care Coordinator or alone depending on scheduling.
• FPSS' will provide coaching, education, information mentoring and/or support and encouragement to the family members to ensure their voice is heard to help primary caregivers participate as "full partners" in Wraparound and/or their service delivery system.
o This would include supporting primary caregivers to identify, prioritize and articulate their goals and needs, identify potential team supports, gain insight into the perspective of other team members, learn how to navigate and advocate within the system, and the importance of self-care; and will provide information and connect families with education and support activities, as well as training, coaching, mentoring and support to take on leadership roles.
• Also, FPSS' will provide interim services to the family if they are placed on the FAST Forward Interim Supports List.

Youth Peer Support Specialists
• Youth Peer Support Specialist (YPSS) in their practice to the system of care values and principles and a "lived experience" as a youth with mental health challenges.
• YPSS' responsibilities might include: supporting youth in identifying, prioritizing and articulating their goals and needs, identifying potential supports, gaining insight into the perspective of other team members, learn how to access the service they need, and modeling importance of self-care.
• Youth Peer Support Specialists will train other youth to strategically share their experience and perspectives in a manner that is safe and does not adversely impact future possibilities.
• Support and coach other youth in wellness and resilience building and consult with Care Coordinators around strategies for engaging with youth in pro-active ways.
• To be eligible for Youth Peer Support, youth will have to have meet the following criteria:
o Between ages 13 -26 and Enrolled in FAST Forward,
o Youth should identify with lived experience and,
o Family and Youth must voluntarily agree to receive Youth Peer Support.

Family and Youth will get support from Care Coordinator and/or Wraparound Team in completing and sending Youth Peer Support Referral Form.

Community Mental Health Centers (CMHCs)
All ten CMHCs operate a supported employment program in which individuals 18 years or older are provided individualized support services to find and maintain employment that meets their skills, interests, and abilities. Through employment, individuals are able to more fully participate in their community and engage in meaningful work; this increases self-confidence, independence, income, and a sense of hope and purpose, all of which support recovery and contribute to more successful health outcomes.

At this time, eight out of the ten CMHCs provide onsite physical health services allowing for a more holistic approach to care and also decreases the burden of care access for those we serve. By engaging in whole health services an individual is more likely to be successful in their recovery.

Starting in 2019, the SMHA contracted with all ten CMHCs to employ a minimum of one housing support specialist. Housing specialists serve individuals who are both engaged, and not engaged, with the CMHCs services and who are in need of targeted housing support services. The housing specialists also administer the state-funded Housing Bridge Subsidy program so facilitate housing vouchers for individuals who are at risk of being homeless to provide a subsidy and housing supports. Housing support specialist engage with local landlords to seek housing options and provide ongoing support services to ensure individuals maintain housing stability.

Starting in July of 2021, the SMHA contracted with all ten CMHCs to stand up six additional supported housing beds in their region. The model of supported housing required was open-ended in order to facilitate an expansion of housing options that meet the need of the local community. All 60 beds will open in SFY 2022.

CMHCs are expected to screen individuals for substance misuse at intake and annually thereafter. The CMHCs utilize the SAMSHA evidence-based models for Co-Occurring Disorders Treatment to develop treatment plans with individuals and to provide an array of evidence-based interventions that enhance recovery for individuals and follow the fidelity standards to such a model. The CMHCs ensure all appropriate referrals are made if the individual requires additional substance use disorder care utilizing the current New Hampshire system of care, and ensuring linkage to and coordination with resources.

CMHC/AA Collaborations
The CMHCs collaborate with the Area Agency that serves their region for individuals with developmental disabilities to address processes that include:
o Enrolling individuals for services who are dually eligible for development and mental health services for both organizations.
o Ensuring transition-aged clients are screened for the presence of mental health and developmental supports and refer, link and support transition plans for youth leaving children's services into adult services identified during screening.

o Facilitating collaborative discharge planning meetings to assess individuals who are leaving New Hampshire Hospital to re-engage them with both the CMHC and Area Agency representatives.
o Ensuring annual training is designed and completed for intake, eligibility, and case management for dually diagnosed individuals and that attendee's include intake clinicians, case-managers, service coordinators and other frontline staff identified by both CMHC's and Area Agencies. The training utilizes the Diagnostic Manual for Intellectual Disability 2 that is specific to intellectual disabilities, in conjunction with the DSM V.
o Planning for each person who receives dual case management by outlining the responsibilities of each organization and expectations for collaboration between the organizations.
o Participating in shared service annual treatment meetings to assess quality and progress towards treatment goals as well as monitoring continued need for dual services when waivers are required for services between agencies.

The Clubhouse Model in NH
Although not funded by the MHBG, Peer Support Clubhouses in NH receive many referrals for members with co-occurring disorders and provide peer support from staff and members (the staff are trained recovery coaches as allies). The Clubhouses meet many recovery requirements:
• Recovery emerges from hope; clubhouses focus on hope and strength of members to engage in the work ordered day.
• Recovery is person-driven; the clubhouse is member-driven.
• Recovery occurs via many pathways; there are several wellness activities along with 1-on-1 recovery coaching.
• Recovery is holistic; addresses both mental health and SUD, and how they're connected.
• Recovery is supported by peers and allies; staff are peers and allies, as are members.
• Recovery is supported through relationship and social networks; recovery coaches help build social networks and supports. The clubhouse is a great environment for healthy relationships.
• Recovery is culturally-based and influenced; there are diverse cultures in clubhouses and the recovery culture is promoted.
• Recovery is supported by addressing trauma; via recovery coaching.
• Recovery involves individuals, families, community strengths, and responsibility; families are often involved in clubhouses.
• Recovery is based on respect. Members and staff are very accepting and respectful.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

NH subscribes to the definition of recovery developed by people in the recovery community and set forth by SAMHSA: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their potential. The 4 major dimensions that support a life in recovery are Health, Home, Community and Purpose. We also promote the 10 Guiding Principles of Recovery.

The NH Board of Licensing for Alcohol and other Drug Professionals has adopted a credential for people who provide Recovery Support Services. Certified Recovery Support Workers (CRSWs) may be peers or non-peers and provide services in multiple settings, including medical, criminal justice, child welfare, behavioral health, SUD treatment and Recovery Community Organizations (RCOs).

Beginning in 2017, NH Bureau of Drug and Alcohol Services (BDAS) has been developing a robust system of Peer Recovery Support Services (PRSS). We contracted with a Facilitating Organization (FO) to identify and support grassroots groups of people in recovery who wanted to develop PRSS in their regions. The FO ensures that RCOs meet national standards for an RCO and that they provide 2 state-required services (Telephone Recovery Support Services and Recovery Coaching) as well as providing other activities determined by their community that support and enhance recovery. The RCOs maintain at least one Recovery Center and coordinate with local organizations to host mutual support groups and other activities. Staff is comprised of people in recovery, many of whom have achieved their CRSW credential while others may be working toward it. Volunteers are also engaged. The FO receives state and federal funds through BDAS and subcontracts with each RCO according to an equitable formula. RCOs are able to bill Medicaid for the 2 required services. Many of them also receive funds directly from a variety of grants, private donations and fund raising.

In 2021, BDAS supports 14 RCOs who manage a total of 20 Recovery Centers situated across the state of NH. They coordinate with local resources, including MH Peer Support Agencies, to offer their members opportunities to achieve and enhance their recovery.

5. Does the state have any activities that it would like to highlight?

Peer Workforce Advancement Plan
As a result of the 10-Year Mental Health Plan, the New Hampshire Peer Workforce Advancement plan was created, which seeks to expand the availability of peers in practice settings and to integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas such as training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies, while other factors are specific to the roles, challenges, and opportunities of people with lived experience in the role of a peer support specialist.

The purpose of the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) is to present actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector.

Preparation of the Advancement Plan included stakeholder input at three (3) public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the SMHA in partnership with the National Alliance on Mental Illness of New Hampshire (NAMI-NH) and Humannovations. Participating stakeholders included individuals representing peer support agencies (PSA), community mental health centers (CMHCs), community and system advocates, and many individuals with lived experience.

NH is working to fully integrate peer supports throughout the mental health continuum, where they can serve as powerful advocates and public educators, provide recovery-oriented outpatient care, and support individuals as they transition into and out of EDs and psychiatric hospitals. Peer support services are also being extended to older children, adolescents, and the elderly through Youth Move NH and other groups. Work is being conducted to outline clear role/job descriptions along with training, education, and coaching for peer and professional staff alike.

NH employs Peer Support Specialists in its contracted Peer Support Agencies, Transitional Housing Programs, Mobile Crisis Response Teams, Assertive Community Treatment Teams, and Supported Employment programs.

Peer Leadership
The SMHA recently hired a full-time Peer Integration Specialist to lead peer expansion efforts on behalf of the Department. One area of focus is peer workforce training and development. The SMHA is working in collaboration with community stakeholders including peer support agencies and community mental health programs to address peer workforce training needs, increase our pool of state trainers in peer support modalities, refine state core training requirements and leadership training, and explore opportunities to collaborate and cross-train peers in various sectors of the mental health system.

Individuals in recovery and family members are utilized in the planning, delivery, and evaluation of behavioral health services in several key ways: participation in the NH Mental Health Planning & Advisory Council (MHPAC), participation in the development of NH's 10-Year Mental Health Plan, and participation in many stakeholder groups that provide feedback and input to the SMHA.

The Impact of Peer Support
Through a learning collaborative, NH has developed shared definitions and language around the importance of peer support. Individuals with lived experience are a crucial component of NH's mental health delivery systems. Peers foster supportive interactions based on shared experiences and assist people to rediscover their potential. Peer support services facilitate resiliency, wellness, and recovery through shared understanding, respect, mutual support and empowerment. Peer support specialists are individuals who self-identify their lived experience in recovery or in the case of family, their experience with a loved one's journey with mental health or co-occurring substance use and mental health. Peers have common life experiences as the individuals they support. Their shared experience affords them the unique capacity to help those they serve reach their identified goals while promoting a sense of hope and belonging with their community.

Recovery from Mental Health Disorders and/or Substance Use Disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Peers share what peer support means to them:
"Staff here will go around and talk with people here offer support, also if people are having issues the staff will discuss these with people, give them information and resources"

"I've been coming since 2007. It's a nice place to talk."

"I like craft group and morning meeting when we check in with one another, talk about what we've been doing or learning and what our goals are for the week"

"I was never someone to keep journal but I felt so supported I started doing that and it's helped"

"[They] reached out to me after respite, feels like someone cares."

"I have schizophrenia and this agency has made all the difference for me"

Training Expectations
In 2019 the NH SMHA received a SAMHSA grant to participate in a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) policy academy The NH BRSS TACS team was driven by the philosophy that the state values wellness and promotes the application of recovery principles and integration of sustainable peer support services throughout our system of care. The team envisioned a system that includes peers in all sectors of healthcare because peers are strong role models who inspire hope and recovery. The team developed a detailed plan that will guide the work to create a sustainable infrastructure for statewide peer run recovery services that will support the needs of individuals in New Hampshire with both mental health and substance use disorder challenges.

All peer support specialists who work in NH are expected to be trained in and operate from the below set of core competencies and fundamental principles that were developed by the BRSS TACS team.

Certified Peer Support Specialists (Mental Health)
According to NH Rule He-M 426.13(d)(4) a. peer support specialists shall:
• Enter into a mutually supportive, non-authoritative relationship that support wellness and recovery as defined by the individual being serviced;
• Participate in trainings as required by the employer and the department;
• Function as a member of the individual's treatment team;
• Function as an advocate for the individuals served;
• Provide services pursuant to the individual service plan;
• Participate in and attend team meetings;
• Be supervised by a supervisor as defined in He-M 426.13(a);
• Meet quarterly with a peer trained in intentional peer support (IPS) for a peer review to evaluate effectiveness of IPS and to review the principles of IPS;
• Be certified in wellness recovery action plans, intentional peer support, whole health action management or equivalents as authorized by the department within 12 months of employment at CMHC; and
• Receive annually:
(i) One evidence based practice training;
(ii) Client rights training; and
(iii) One suicide prevention training.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

16. Recovery

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to

ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:
1. Does the state support recovery through any of the following:
a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
Yes
b) Required peer accreditation or certification?
Yes

c) Block grant funding of recovery support services?
Yes

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
Yes

2. Does the state measure the impact of your consumer and recovery community outreach activity?
Yes

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

NH subscribes to the definition of recovery developed by people in the recovery community and set forth by SAMHSA: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their potential. The 4 major dimensions that support a life in recovery are Health, Home, Community and Purpose. We also promote the 10 Guiding Principles of Recovery.

Peer Support Agencies

Individuals in recovery and family members have access to Peer Support Agencies (PSAs) throughout the state. The SMHA contracts with 8 PSAs (14 locations) statewide, to ensure at least one agency is headquartered in each of the 10 designated community mental health regions. PSAs offer peer support, education, connectedness to the community, activities, training, and employment opportunities among other services. Some of these peer agencies also provide Peer Respite and Recovery Orientated Step Up/Step Down beds. The SMHA and the PSA's continue to work toward expansion of services and integration of services throughout the system. Peer support has been proven successful and has shown to divert individuals from psychiatric hospitalizations, increase the likelihood of employment, reduce suicidality, and lead to better quality of life.

Recovery Oriented Step-up/Step-down programs

In December of 2020, New Hampshire entered into contract with four (4) Peer Support Agencies, each to operate 3-bed Recovery-Oriented Step Up/Step Down programs. These programs offer a new level of crisis care in NH. Step-Up/Step-Down Programs provide short-term recovery based transition services for adults (18 years of older) who are transitioning from inpatient or institutional settings into the community or who require a more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer supports with access to peer staff 24 hours a day 7 days per week. Stays are limited to ninety (90) days per episode of need. Staff focus on recovery oriented peer support services that also work to coordinate and engage with outpatient community based clinical treatment providers. Programs are operated in accordance with the SAMHSA Core Competencies for Peer Support Workers in the behavioral health system and accept referrals from a multitude of community based treatment providers.

Programs support recovery and resiliency oriented interventions through:

- Facilitating connections to natural supports
- Developing and supporting individual discharge plans
- Providing access to at least one SAMHSA recognized peer support model
- Providing opportunities for engagement in structured, daily activities
- Development of individual recovery and wellness plans

Programs also facilitate connections with service providers including, but not limited to, family support services, social security, food stamps, housing supports, health support services and other community based resources. If an individual is in need of a higher level of care while staying in a Step Up/Step Down bed, the program shall deploy necessary referrals to engage the individual in accessing this level of care.

National Alliance on Mental Illness – New Hampshire

For over 10 years the SMHA has contracted with NAMI NH (National Alliance on Mental Illness, New Hampshire) to provide family mutual support programming to individuals statewide. In 2021 family mutual support programming contract was competitively procured and awarded, again, to NAMI NH to provide family and peer-run support groups, education classes, trainings, and advocacy opportunities for approximately 11,000 individuals and families affected by mental illness throughout the state. Through this contract, NAMI NH also provides an array of training sessions on best practices for suicide prevention and post intervention for individuals, family members, service providers, and the general public. Additional training sessions on crisis intervention, suicide intervention and peer leadership training. NAMI NH also provides information to the public through web-based media, and distributes electronic and printed materials, with approval from the Department, on topics that include family support and education programs and resources for survivors of a suicide loss. NAMI NH participates on the New Hampshire Suicide Prevention Council as a member organization, and will serve as the fiscal agent for $100,000 of designated state general funds to support implementation of the goals of the suicide prevention council's strategic plan.

Family Peer Support Specialist

- Family Peer Support Specialist (FPSS) bring a commitment and adheres in their practice to the System of Care values and principles and a "lived experience" as a family member who has been or is a parent of a child that meets or has met the criteria for serious emotional disturbance.
- With the family's consent, the assigned FPSS will be a member of the Wraparound team and will partner with the Care Coordinator; and will participate in the delivery of Family Orientation Meeting with the Care Coordinator or alone depending on scheduling.
- FPSS' will provide coaching, education, information mentoring and/or support and encouragement to the family members to ensure their voice is heard to help primary caregivers participate as "full partners" in Wraparound and/or their service delivery system.
  - This would include supporting primary caregivers to identify, prioritize and articulate their goals and needs, identify potential team supports, gain insight into the perspective of other team members, learn how to navigate and advocate within the system, and the importance of self-care; and will provide information and connect families with education and support activities, as well as training, coaching, mentoring and support to take on leadership roles.
- Also, FPSS' will provide interim services to the family if they are placed on the FAST Forward Interim Supports List.

Youth Peer Support Specialists

- Youth Peer Support Specialist (YPSS) in their practice to the system of care values and principles and a "lived experience" as a youth with mental health challenges.
- YPSS' responsibilities might include: supporting youth in identifying, prioritizing and articulating their goals and needs, identifying potential supports, gaining insight into the perspective of other team members, learn how to access the service they need, and modeling importance of self-care.
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Training Expectations

In 2019 the NH SMHA received a SAMHSA grant to participate in a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) policy academy The NH BRSS TACS team was driven by the philosophy that the state values wellness and promotes the application of recovery principles and integration of sustainable peer support services throughout our system of care. The team envisioned a system that includes peers in all sectors of healthcare because peers are strong role models who inspire hope and recovery. The team developed a detailed plan that will guide the work to create a sustainable infrastructure for statewide peer run recovery services that will support the needs of individuals in New Hampshire with both mental health and substance use disorder challenges.

All peer support specialists who work in NH are expected to be trained in and operate from the below set of core competencies and fundamental principles that were developed by the BRSS TACS team.

GOAL 1.2 – CORE COMPETENCIES

Core competencies, values and guiding principles for each peer model (MH, SUD, families, and youth) with a vision toward standardizing where possible were reviewed

The core competencies in the table below are from team input and SAMHSA.

Core Competencies:	Fundamental Principles:
1. Engages peers in collaborative and caring relationships	1. Recovery-oriented
2. Provides support	2. Person-Centered
3. Effectively shares lived experience of recovery	3. Choice Drive
4. Personalizes peer support	4. Relationship Focused
5. Supports recovery planning	5. Trauma Informed
6. Links to resources, services, and support	
7. Provides information about skills related to health, wellness, resiliency, and recovery	
8. Helps peers to manage crises	
9. Effective communication	
10. Supports collaboration and teamwork	
11. Promotes leadership and advocacy	
12. Promotes growth, development, and wellness	
13. Understanding of co-occurring disorders	

Certified Peer Support Specialists (Mental Health)

According to NH Rule He-M 426.13(d)(4) a. peer support specialists shall:

- Enter into a mutually supportive, non-authoritative relationship that support wellness and recovery as defined by the individual being serviced;
- Participate in trainings as required by the employer and the department;
- Function as a member of the individual's treatment team;
- Function as an advocate for the individuals served;
- Provide services pursuant to the individual service plan;
- Participate in and attend team meetings;
- Be supervised by a supervisor as defined in He-M 426.13(a);
- Meet quarterly with a peer trained in intentional peer support (IPS) for a peer review to evaluate effectiveness of IPS and to review the principles of IPS;
- Be certified in wellness recovery action plans, intentional peer support, whole health action management or equivalents as authorized by the department within 12 months of employment at CMHC; and
- Receive annually:
  - (i) One evidence based practice training;
  - (ii) Client rights training; and
  - (iii) One suicide prevention training.

Please indicate areas of technical assistance needed related to this section.

NA

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	◉ Yes ○ No
Home and community based services.	◉ Yes ○ No
Peer support services.	◉ Yes ○ No
Employment services.	◉ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Community Living and the Implementation of Olmstead

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Yes
3. Peer support services
Yes
4. Employment services
Yes

2. Does the state have a plan to transition individuals from hospital to community settings?
Yes

---

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Amanda D. v. Hassan

The State of New Hampshire's needs assessment "A Strategy for Restoration", crafted in 2008, claims of over-utilization of institutions and prolonged wait times resulted in a class action suit, *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM,* filed in 2013, alleging "New Hampshire's administration of its mental health system violates the rights of individuals with SMI".

The settlement agreement, hereafter referred to as Community Mental Health Agreement (CMHA), finalized in February 2014, mandates the State develop and implement certain services, including an expanded crisis system, expanded Assertive Community Treatment (ACT), Supported Housing (SH) and Supported Employment (SE) programs. Under the Agreement, these services may be provided directly by the State or through contracts with Community Mental Health Programs (CMHPs).

Priority populations specified in the CMHA include adults who have a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) who are patients at New Hampshire Hospital (NHH), residents at Glencliff Home (GH), and who may have been "unnecessarily institutionalized".

Peer Support

The State will ensure there is effective peer support programs throughout the state to help individuals manage and cope with their mental illness. The State will ensure peer support services offered through peer support agencies are open a minimum of eight hours per day, five-and-a-half days per week or the hourly equivalent for individuals to receive support and services.

The State will ensure that peer supports are provided as part of the Assertive Community Treatment (ACT) evidence based practice. The CMHA requires statewide access to ACT services, inclusive of dedicated Certified Peer Support Specialists providing direct support and services as full ACT team staffing members.

Employment Services

The State will deliver evidence based supported employment (EBSE) services in accordance with the Dartmouth evidence-based model. These services will help individuals obtain and maintain paid, competitive employment in integrated community settings. The CMHA requires statewide access to EBSE services, with at least 18.6% of the eligible individuals (adults with SMI or SPMI) participating in EBSE. The State has far exceeded this goal and is currently at over 24%.

Housing Services

The State provides several housing service programs to meet the targeted population needs under the CMHA. The primary program, Housing Bridge Subsidy Program (HBSP), has established permanent or subsidized housing for over 1,000 individuals under the CMHA. The HBSP prioritizes individuals ready for discharge from New Hampshire Hospital, Glencliff Home, and Transitional Housing. Additional prioritized individuals include those being served by Assertive Community Treatment teams in the community who are homeless or at risk of becoming homeless due to their economic circumstances, and individuals served by CMHPs currently in community residences who are ready to transition into the community.

HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, and ongoing supports and access to mental

health services (if desired by the individual). At least 400 individuals receive a State subsidy at any one time that combined with the individual's own contribution toward rent, fulfill monthly rent payments and maintains the individual's access to the apartment. This also allows the individual to remain on a waiting list for traditional HUD funded programs, other municipally administered programs, or until the individual's own income exceeds the HBSP's financial eligibility guidelines.

Additionally, the State supports individuals who need more intensive supports and services to return to the community post psychiatric hospitalization through transitional housing programs (THP). These programs combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living.

Lastly, the State provides members of the target population who do not need ongoing supports to maintain housing with access to HUD supported 811 units. This includes providing assistance with the application process, locating available units, and working with landlords to successfully secure housing. Units accessed under this program are, in effect, long term expansions to NH's affordable housing inventory – created specifically for this population under a grant. The State expanded this service in the previous year to serve 79 more individuals. Twenty new sites, geographically distributed in the state in ten different towns, enabled these individuals to leave institutional settings and return to the community through a more integrated model specific to their needs.

Community Living and the Implementation of Olmstead

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Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ◉ Yes ○ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Juvenile justice? ◉ Yes ○ No

c) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The System of Care
In the past 5 years NH has made great progress in the implementation of a system of care approach to children's mental health, with the assistance of a CMHI System of Care grant. The following work has been done in the state to further this effort:
• Development of a program to serve high need children and youth with a System of Care and high fidelity Wraparound model.
• Expansion of that program
• Partnership with Department of Education on use of Wraparound in schools, which is being implemented with a CMHI System of Care Grant awarded to the NH Department of Education.
• Partnership with a county to implement System of Care and Wraparound in that specific region, with support from a CMHI System of Care grant.
• Establishment of RSA 135-F System of Care for Children's Behavioral Health, a state statute that mandates the Department of Health and Human Services and Department of Education to partner on the expansion of the System of Care in NH.
• Expansion of a State Youth Treatment services with the assistance of a SYTP grant, to help implement strategies, such as the 7 Challenges for youth and merge the system of care approach with the SUD treatment of Youth.
System of Care Sustainability and Expansion

In 2016, the New Hampshire (NH) Department of Education was awarded a four year, $12 million grant from the federal Substance

Abuse and Mental Health Services Administration (SAMHSA). The project, called NH Families and Systems Together (FAST) Forward for Children and Youth 2020, supports the expansion and sustainability of a state-level system of care (SOC) for children, youth, and their families.

NH FAST Forward 2020 is administered through the Office of Social & Emotional Wellness in partnership with the following school districts: Franklin, Winnisquam Regional, Laconia, Berlin, White Mountains Regional, SAU 7, and Claremont. Efforts are focused on several critical areas including early childhood social and emotional learning and development, prevention, safety, and support for mental, emotional, and Behavioral Health. The goals of FAST Forward 2020 include the following:
1. Create Regional Systems of Care collaborative teams in 3 regions of the state: the North Country, the Lakes Region, and the Claremont area.
2. Provide individualized wraparound planning and an expanded array of services to the highest need for children and youth with mental health challenges.
3. Involve families and youth in all aspects of service delivery and support.
4. Improve the transition from pre-school to kindergarten and 1st grade for young children.
5. Improve the educational and social/emotional outcomes for children and youth.
6. Ensure that systems, supports, and policies are aligned with National CLAS standards.

During year 3 of the expansion of System of Care in NH progress has continued in building cross-agency collaboration among partners and in the building of systems. All work has been conducted through the lens of sustainability.

The NH DOE has received another System of Care Grant and has expanded the Multi-tiered System of Supports approach to more schools throughout New Hampshire.

System of Care grant is also being utilized in areas to address young children's needs particularly for those who are at high risk for ongoing behavioral health conditions later in life.

7. Does the state have any activities related to this section that you would like to highlight?

Establishment of RSA 135-F System Care for Children's Behavioral Health, a state statute that mandates the Department Health and Human Services Education to partner on expansion in NH.

Health and Human Services and Department of Education to collaborate on the expansion of the System of Care in NH.
• Residential treatment services Transformation, transforming the use of this level of care and treatment from a child welfare placement to a behavioral health treatment for episodic treatment when community based treatment is not effective and as an alternative to emergency departments and acute psychiatric hospital stays when appropriate.
• Expansion of Care Management Entity responsibilities to include transitional support through enhanced care coordination for any child in residential treatment and acute psychiatric hospital who may need additional support for family, and community readiness for a successful transition home.
• Three CMHCs have children's Intensive Treatment Teams (aligned with adult Assertive Community Treatment (ACT) teams), managed by the BCBH.
• Implementation of statewide mobile crisis has begun and will be fully implemented by January of 2022 for all individuals experiencing a Behavioral Health Crisis, including ch

Please indicate areas of technical assistance needed related to this section.

NA

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Footnotes:

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- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following items:

Please respond to the following:
1. Does the state utilize a system of care approach to support?
a) The recovery and resilience of children and youth with SED?
Yes

b) The recovery and resilience of children and youth with SUD?
Yes

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD NEEDS?
a) Child welfare?
Yes

b) Juvenile justice?
Yes

c) Education?
Yes

3. Does the state monitor its progress and effectiveness, around?
a) Service utilization?
Yes

b) Costs?
Yes
c) Outcomes for children and youth services?
Yes

4. Does the state provide training in evidence-based:
a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
Yes

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes

5. Does the state have plans for transitioning children and youth receiving services?
a) to the adult M/SUD system?
Yes

b) for youth in foster care?
Yes

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The System of Care

In the past 5 years NH has made great progress in the implementation of a system of care approach to children's mental health, with the assistance of a CMHI System of Care grant. The following work has been done in the state to further this effort:

- Development of a program to serve high need children and youth with a System of Care and high fidelity Wraparound model.
- Expansion of that program
- Partnership with Department of Education on use of Wraparound in schools, which is being implemented with a CMHI System of Care Grant awarded to the NH Department of Education.
- Partnership with a county to implement System of Care and Wraparound in that specific region, with support from a CMHI System of Care grant.
- Establishment of RSA 135-F System of Care for Children's Behavioral Health, a state statute that mandates the Department of Health and Human Services and Department of Education to partner on the expansion of the System of Care in NH.
- Expansion of a State Youth Treatment services with the assistance of a SYTP grant, to help implement strategies, such as the 7 Challenges for youth and merge the system of care approach with the SUD treatment of Youth.

System of Care Sustainability and Expansion

In 2016, the New Hampshire (NH) Department of Education was awarded a four year, $12 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The project, called NH Families and Systems Together (FAST) Forward for Children and Youth 2020, supports the expansion and sustainability of a state-level system of care (SOC) for children, youth, and their families.

NH FAST Forward 2020 is administered through the Office of Social & Emotional Wellness in partnership with the following school districts: Franklin, Winnisquam Regional, Laconia, Berlin, White Mountains Regional, SAU 7, and Claremont. Efforts are focused on several critical areas including early childhood social and emotional learning and development, prevention, safety, and support for mental, emotional, and Behavioral Health. The goals of FAST Forward 2020 include the following:

1. Create Regional Systems of Care collaborative teams in 3 regions of the state: the North Country, the Lakes Region, and the Claremont area.

2. Provide individualized wraparound planning and an expanded array of services to the highest need for children and youth with mental health challenges.

3. Involve families and youth in all aspects of service delivery and support.

4. Improve the transition from pre-school to kindergarten and 1st grade for young children.

5. Improve the educational and social/emotional outcomes for children and youth.

6. Ensure that systems, supports, and policies are aligned with National CLAS standards.

During year 3 of the expansion of System of Care in NH progress has continued in building cross-agency collaboration among partners and in the building of systems. All work has been conducted through the lens of sustainability.

The NH DOE has received another System of Care Grant and has expanded the Multi-tiered System of Supports approach to more schools throughout New Hampshire.

System of Care grant is also being utilized in areas to address young children's needs particularly for those who are at high risk for ongoing behavioral health conditions later in life.

(SOURCE: https://www.dhhs.nh.gov/dcbcs/bbh/documents/soc-year-4-report.pdf)

7. Does the state have any activities related to this section that you would like to highlight?

Establishment of RSA 135-F System Care for Children's Behavioral Health, a state statute that mandates the Department Health and Human Services Education to partner on expansion in NH.

Health and Human Services and Department of Education to collaborate on the expansion of the System of Care in NH.

- Residential treatment services Transformation, transforming the use of this level of care and treatment from a child welfare placement to a behavioral health treatment for episodic treatment when community based treatment is not effective and as an alternative to emergency departments and acute psychiatric hospital stays when appropriate.

- Expansion of Care Management Entity responsibilities to include transitional support through enhanced care coordination for any child in residential treatment and acute psychiatric hospital who may need additional support for family, and community readiness for a successful transition home.

- Three CMHCs have children's Intensive Treatment Teams (aligned with adult Assertive Community Treatment (ACT) teams), managed by the BCBH.

- Implementation of statewide mobile crisis has begun and will be fully implemented by January of 2022 for all individuals experiencing a Behavioral Health Crisis, including children and youth.

Please indicate areas of technical assistance needed related to this section.

NA

Suicide Prevention

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?

Yes

2. Describe activities intended to reduce incidents of suicide in your state.

Because of the impact suicide has on the residents of New Hampshire, NH RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall:

"oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the plan. The council shall also be a proponent for suicide prevention in New Hampshire."

The NH Suicide Prevention Plan was revised in 2020. A product of the State Suicide Prevention Council, the Plan is on a 5-year revision schedule. Recommendations from the National Strategy for Suicide Prevention (2012) are cross walked within the plan. The State of New Hampshire's Injury Prevention Advisory Council (IPAC) has updated the state's Injury Prevention Plan, suicide is one of the components and was submitted by the BMHS.

Please also find efforts detailed in question 5.

3. Have you incorporated any strategies supportive of Zero Suicide?

Yes

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

Yes

5. Have you begun any targeted or statewide initiatives since the FFY 2020 - 2021 plan was submitted?

Yes

Suicide Prevention training for the Peer workforce.

Statewide- Peer Support Agency staff are required to have annual suicide prevention training. Peer support specialists working with individuals experiencing mental health crisis often come in contact with individuals whom are or have experienced thoughts or feelings of suicidality in their life. Allowing peer support specialists to have adequate knowledge regarding suicidality and suicide prevention is important in fostering a supportive and healthy peer relationship, work environment and for maintaining self-care. This population is especially important as many peer support specialists offer a perspective through lived experience that many people do not have. This lived experience can encourage improvement with engagement and utilization of resources, services, opportunities, education and social change.

The **Department of Military Affairs & Veteran Services**, in partnership with DHHS and many other stakeholders, is participating in SAMHSA's Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families. There is a very active team of 30+ individuals that include federal partners, the VA, state agencies, the NH National Guard, veterans, CMHCs, NAMI NH, other non-profits, law enforcement and healthcare providers. An extensive Action Plan was developed that focuses on 3 priority areas: 1) Develop a Coordinated, Statewide SMVF Suicide Prevention Effort; 2) Establish a Centralized, Statewide Resource & Referral Hub for SMVF; and 3) Strengthen Access & Delivery of Services Leading to Suicide Prevention and Recovery Care for SMVF.

The **NH National Guard** has a great deal of resources and programming in place to address suicide prevention. They have several representatives on our Governors Challenge Team. They have a Suicide Prevention Coordinator at the NH National Guard who coordinates a variety of trainings and wellness activities for active service members in the Guard. They participate in and help to coordinate the Suicide Prevention Conference annually. They conduct Military Culture Trainings for mental health providers and other non-profit organizations. They are in the process of working with the National Guard Bureau to bring the Star Behavioral Health Program to New Hampshire, which will provide high quality clinical training to mental health practitioners who work with service members and veterans. They operate Family Assistance Centers with Family Assistance Specialists who are available 24/7 to help service members, veterans or their family members from any branch of the military address any kind of need—financial, housing, mental health, childcare, veterans benefits, etc. They provide short-term "case management" services with closed-loop referrals to get the person the help they need where they need it. This addresses suicide prevention in an upstream way. Most recently, the Family Assistance Specialists and Senior Readiness Resource Coordinators merged and condensed the six Family Assistance Centers down to three. The new titles are Soldier & Family Resource Coordinators (SFR-Cs). They are now Title 5 Civilian Technicians instead of DoD Contractors.

The DHHS Commissioner, in response to the high number of suicides in NH, established a Suicide Prevention Integration Team comprised of all DHHS employees to provide education for staff regarding suicidality. The evidence-based training program, QPR- Question, Persuade, Refer, was selected. There were 18 DHHS staff members trained in November 2020 to become QPR trainers for DHHS staff. Training of staff began in January and as of July 1, 2021, 293 DHHS staff have been trained. The State of New

Hampshire also kicked off an employee focused campaign called **"I Care"**. This initiative supports employees who are feeling suicidal, employees who have loved ones who may be at risk of suicide, and support education around recognition of suicide risks and warning signs in the constituents DHHS serves. The Suicide Prevention Integration Team has also participated in other activities to highlight the resources available regarding suicide, risk factors, and warning signs. "Road Shows" were conducted at 8 of the 10 District Offices highlighting this in addition to videos sent to staff during the month of September 2020, to highlight Suicide Prevention Month.

The Clinical Behavioral Health Learning Collaborative began in February 2019 to address suicide prevention. The Collaborative has representatives from each of the 26 hospitals, the 10 CMHCs, many of the inpatient psychiatric hospital and related partners such as NAMI, the MCOs and DHHS staff.

Additional initiatives include grant work to establish **Crisis and Intensive Treatment Teams** connecting individuals and their families with complicated needs/dual diagnosis to treatment and strengthening resources/supports to ensure the best possible outcomes. Mobile Crisis Response Teams continue to provide crisis intervention in the community and play a large role in educating the community and in some regions work closely with the police department to respond to calls and play a role in educating the police force on mental health. Identifying areas for improvement in education, prevention and treatment is a priority in this state.

HB 652 requires the state Board of Education to adopt rules requiring teachers and administrators in the public schools to receive annual training in suicide awareness and prevention. NAMI New Hampshire's response to crisis and commitment to providing certification for **NAMI Connect Suicide Prevention** ensures there are more trainers throughout the state actively educating professionals, providers, school staff and the community. Signs of Suicide (SOS) is an Evidenced-Based Practice that has also been rolled out in many schools and communities; with some CMHC staff trained as leaders. Connor's Climb, a non-profit organization whose mission is to provide suicide prevention education to New Hampshire youth and the community, sponsors the SMH (Screening for Mental Health) SOS program for all NH schools who commit to its implementation.

HB 1 (the proposed biennial budget) includes $200,000 in each fiscal year to support the state's suicide hotline and $250,000 in each fiscal year to support suicide prevention training. The Suicide Prevention Council (SPC) submitted a written request to the Department to use part of the allocated $250,000 to fund a fulltime staff position to serve as a statewide suicide prevention specialist. In making this request, they noted that the Suicide Prevention Resource Center, which is the national technical assistance provider on suicide prevention for SAMHSA, recently released a white paper on Recommendations for State Suicide Prevention Infrastructure. The top four (4) recommendations are: Designate a lead division or organization, Identify and secure resources, maintain a suicide prevention plan, which is updated every 3-5 years, and maintain a dedicated leadership position. The Department has a newly established position for this purpose. The Department continues to work closely with the SPC, with the directors of the Bureau of Mental Health Services and Children's Behavioral Health serving as its co-facilitators. The SPC updated their strategic plan in 2020 and incorporated best practices and recommendations outlined in the 10 Year Mental Health Plan.

Zero Suicide

Zero Suicide adoption and implementation ensure providers and staff actively work toward consistent and continuing training for both clinical and non-clinical staff as well as quality improvement efforts to close the net to work toward the ideal of no individual slipping through the cracks.

NH Hospital has had a large focus on incorporating the Zero Suicide strategy into their system framework and the SMHA has a representative on their Suicide Prevention Committee.

Many of the CMHCs have adapted their EMRs to incorporate the use of the Columbia Suicide Severity Screen rating scale. This is a recommended tool from the Zero Suicide toolkit.

All three MCOs in NH have implemented a Zero Suicide plan. This plan focuses on integrating attitudes and behaviors of the Zero Suicide program in to the day to day work of all MCO staff members. All staff members are trained in the model and utilize this in all interactions with clients. Each MCOs plan promotes suicide prevention and education across all health care services in NH and many provide training to various health care practices.

Project RED

NH is fortunate to have a community-based suicide prevention and training program that evolved from the Garret Lee Smith work. NH Hospital has a role as part of Project Red (Re-Engineered Discharge), a patient-centered, standardized approach to discharge planning that has been recognized nationally. Project RED improves patient preparedness for self-care and reduces preventable readmissions.

Project Connect!

NAMI-NH contracts with the SMHA to provide suicide prevention and post-vention information and training to families, communities, providers and any other interested stakeholders, through Project Connect!

CALM

Counseling on Access to Lethal Means (CALM) is a protocol delivered in workshop format, developed by NH's Elaine Frank and Mark Ciocca, and accepted into the AFSP/SPRC Best Practice Registry Section III: Adherence to Standards. Per the informational notice,

"Suicide is the second leading cause of death for young people ages 15 to 34 in New Hampshire and a significant cause of death for those of all ages. We know that many attempters are as ambivalent about suicide as they are about life. Preventing these suicides is a very complex puzzle that requires all of us to work collaboratively to complete the picture.

In NH, firearms are the leading method used in suicide deaths accounting for more suicide deaths than all other methods combined."

One piece of that puzzle that has been demonstrated to be effective is to reduce access to lethal means – particularly firearms as well as medications. CALM consists of a three hour workshop designed for mental health and primary care providers that addresses why and how to counsel clients and their families on reducing access to these suicide means

The workshop is not designed to teach suicide risk assessment but rather, once a risk has been identified, it focuses on four specific CALM steps. The workshop has been provided to participants such as the Community Mental Health Centers,

Funding from a Garrett Lee Smith grant allowed for two individuals to be trained as CALM Master Trainers in December 2020. One of the Master Trainers is a BMHS staff member who plans, once COVID restrictions ease, to offer training to the ten CMHCs to train staff to become CALM trainers to help with sustainability of the training.

Required Training for Suicide Prevention

In 2016, demonstrating a commitment to suicide prevention, the NH Legislature amended state law RSA 330-A:10, XIV. This amendment establishes that licensed mental health professionals at least 3 hours of the required continuing education units for biennial renewal shall be from:

"a nationally recognized, evidence-based or best practices training organization in the area of suicide prevention, intervention, or post-vention and how mental illness, substance use disorders, trauma, or interpersonal violence directly impacts risk for suicide."

Partnership with the Office of Chief Medical Examiner

The State Mental Health Authority (SMHA) collaborates with the Office of Chief Medical Examiner (OCME) and is able to access data related to suicides directly. Information about all suicides that occur in the state of New Hampshire is shared with the Community Mental Health Center(s) that are impacted so that immediate response ("post-vention") can occur as well as preparation for any possible contagion. This expedient process informs future projects and targeted community training and support. The Chief Medical Examiner is Public Health-minded and supported the development of a liaison between the OCME and the NH Department of Social Services; this later led to the creation of a similar role between the OCME and the NH National Guard. Reports used to be shared quarterly with all of the CMHCs that showed all of the deaths reported to the BMHS; in 2016 a decision was made by NH DHHS to cease this practice.

Sentinel Event Policy and Unmet Needs

NH's CMHCs and MCOs are required under the Sentinel Event policy to report suicide deaths and "Unanticipated deaths" to DHHS. Deaths that initially appear to be related to an ongoing medical condition are not required to be reported. If the death is ultimately finalized as a "Suicide" death, then the CMHC is informed of this via a streamlined reporting process. Without this reporting process the client records would not reflect an accurate case outcome which is used by the Center to inform efforts that could lead to improved suicide prevention. Strategic Direction Number Four of the National Strategy for Suicide Prevention stresses the need for accurate, timely, data to be shared for suicide prevention efforts.

This unique feedback loop between the SMHA and the CMHCs in NH has been recognized by the Suicide Prevention Resource Center (SPRC) as a "Surveillance Success story". The State of New Hampshire should be working to refine its ability to create an information-sharing process that will allow the CMHCs and the DHHS to effectively promote the reporting of accurate suicides and unanticipated deaths; reduce NH suicides, and demonstrate its commitment to Zero Suicide goals.

Please indicate areas of technical assistance needed related to this section.

NA

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ◉ Yes ○ No

2. Describe activities intended to reduce incidents of suicide in your state.

Because of the impact suicide has on the residents of New Hampshire, NH RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall:
"oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the plan. The council shall also be a proponent for suicide prevention in New Hampshire."

The NH Suicide Prevention Plan was revised in 2020. A product of the State Suicide Prevention Council, the Plan is on a 5-year revision schedule. Recommendations from the National Strategy for Suicide Prevention (2012) are cross walked within the plan. The State of New Hampshire's Injury Prevention Advisory Council (IPAC) has updated the state's Injury Prevention Plan, suicide is one of the components and was submitted by the BMHS.

Please also find efforts detailed in question 5.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

Suicide Prevention training for the Peer workforce.
Statewide- Peer Support Agency staff are required to have annual suicide prevention training. Peer support specialists working with individuals experiencing mental health crisis often come in contact with individuals whom are or have experienced thoughts or feelings of suicidality in their life. Allowing peer support specialists to have adequate knowledge regarding suicidality and suicide prevention is important in fostering a supportive and healthy peer relationship, work environment and for maintaining self-care. This population is especially important as many peer support specialists offer a perspective through lived experience that many people do not have. This lived experience can encourage improvement with engagement and utilization of resources, services, opportunities, education and social change.

The Department of Military Affairs & Veteran Services, in partnership with DHHS and many other stakeholders, is participating in SAMHSA's Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families. There is a very active team of 30+ individuals that include federal partners, the VA, state agencies, the NH National Guard, veterans, CMHCs, NAMI NH, other non-profits, law enforcement and healthcare providers. An extensive Action Plan was developed that focuses on 3 priority areas: 1) Develop a Coordinated, Statewide
SMVF Suicide Prevention Effort; 2) Establish a Centralized, Statewide Resource & Referral Hub for SMVF; and 3) Strengthen Access & Delivery of Services Leading to Suicide Prevention and Recovery Care for SMVF.

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Health Program to New Hampshire, which will provide high quality clinical training to mental health practitioners who work with service members and veterans. They operate Family Assistance Centers with Family Assistance Specialists who are available 24/7 to help service members, veterans or their family members from any branch of the military address any kind of need—financial, housing, mental health, childcare, veterans benefits, etc. They provide short-term "case management" services with closed-loop referrals to get the person the help they need where they need it. This addresses suicide prevention in an upstream way. Most recently, the Family Assistance Specialists and Senior Readiness Resource Coordinators merged and condensed the six Family Assistance Centers down to three. The new titles are Soldier & Family Resource Coordinators (SFR-Cs). They are now Title 5 Civilian Technicians instead of DoD Contractors.

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Zero Suicide adoption and implementation ensure providers and staff actively work toward consistent and continuing training for both clinical and non-clinical staff as well as quality improvement efforts to close the net to work toward the ideal of no individual slipping through the cracks.

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Project RED
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In NH, firearms are the leading method used in suicide deaths accounting for more suicide deaths than all other methods combined."
One piece of that puzzle that has been demonstrated to be effective is to reduce access to lethal means – particularly firearms as well as medications. CALM consists of a three hour workshop designed for mental health and primary care providers that addresses why and how to counsel clients and their families on reducing access to these suicide means

The workshop is not designed to teach suicide risk assessment but rather, once a risk has been identified, it focuses on four specific CALM steps. The workshop has been provided to participants such as the Community Mental Health Centers,

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Required Training for Suicide Prevention
In 2016, demonstrating a commitment to suicide prevention, the NH Legislature amended state law RSA 330-A:10, XIV. This amendment establishes that licensed mental health professionals at least 3 hours of the required continuing education units for biennial renewal shall be from:
"a nationally recognized, evidence-based or best practices training organization in the area of suicide prevention, intervention, or post-vention and how mental illness, substance use disorders, trauma, or interpersonal violence directly impacts risk for suicide."
Partnership with the Office of Chief Medical Examiner

The State Mental Health Authority (SMHA) collaborates with the Office of Chief Medical Examiner (OCME) and is able to access data related to suicides directly. Information about all suicides that occur in the state of New Hampshire is shared with the Community Mental Health Center(s) that are impacted so that immediate response ("post-vention") can occur as well as preparation for any possible contagion. This expedient process informs future projects and targeted community training and support. The Chief Medical Examiner is Public Health-minded and supported the development of a liaison between the OCME and the NH Department of Social Services; this later led to the creation of a similar role between the OCME and the NH National Guard. Reports used to be shared quarterly with all of the CMHCs that showed all of the deaths reported to the BMHS; in 2016 a decision was made by NH DHHS to cease this practice.
Sentinel Event Policy and Unmet Needs

NH's CMHCs and MCOs are required under the Sentinel Event policy to report suicide deaths and "Unanticipated deaths" to DHHS. Deaths that initially appear to be related to an ongoing medical condition are not required to be reported. If the death is ultimately finalized as a "Suicide" death, then the CMHC is informed of this via a streamlined reporting process. Without this reporting process the client records would not reflect an accurate case outcome which is used by the Center to inform efforts that could lead to improved suicide prevention. Strategic Direction Number Four of the National Strategy for Suicide Prevention stresses the need for accurate, timely, data to be shared for suicide prevention efforts.

This unique feedback loop between the SMHA and the CMHCs in NH has been recognized by the Suicide Prevention Resource Center (SPRC) as a "Surveillance Success story". The State of New Hampshire should be working to refine its ability to create an information-sharing process that will allow the CMHCs and the DHHS to effectively promote the reporting of accurate suicides and unanticipated deaths; reduce NH suicides, and demonstrate its commitment to Zero Suicide goals.

Please indicate areas of technical assistance needed related to this section.

NA

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (selected) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (selected) No

If yes, with whom?

Since the last planning period, the System of Care statute has been enacted, ensuring cooperation between state partners around the provision of children and youth behavioral health and special educational services. The passage of SB 534 indicates that there is widespread support for rethinking and improving aspects of the state's systems. Furthermore, largely through smaller-scale, grant-funded projects, efforts have already been underway for a number of years to move New Hampshire towards a system of care model. These efforts focus not only on acute care and intervention, but also on prevention and healthy socio-emotional development for all children. With continued focus on these matters, a more comprehensive, gap-free, and efficient system of child behavioral health services can emerge in New Hampshire.
The NH Governor enacted an executive order 2019-02 that established the Governor's Advisory Commission on Mental Illness and the Corrections System to will look at how to reduce incarceration and improve services for such individuals, and to support individuals with mental illness who are transitioning from jail back to their communities.

In accordance with Chapter 248, Laws of 2019 (SB 292), the New Hampshire Department of Health and Human Services, Division for Behavioral Health developed a comprehensive 10-year mental health plan. By way of background, the 10-year mental health plan, published in January 2019, sets a vision for the State's mental health system and prioritizes 14 recommendations to implement within its first two years. These recommendations are foundational and intended to strengthen the system's infrastructure. Following implementation of these recommendations, New Hampshire will be poised to successfully expand and sustain a robust mental health system.

Hampstead Hospital came online as an approved Designated Receiving Facility that has been the leading agency in taking youth in NH who are in need of a psychiatric hospital level of care.

Beginning in Fiscal Year 2020, the SMHA began a pilot program for individuals with criminal records that would otherwise prevent them from entering into HUD housing. This housing program is called the Integrative Housing Voucher Program, and is a temporary supportive housing program that provides a housing voucher couple with a designated housing specialist who will work with the individual to ensure they remain safely housed. The SMHA established this program and connection between the SMHA and the DOC which did not previously exist before and where there were no housing options before.

The SMHA began a relationship with the Center for Non Profits to provide governance and management training to the Peer Support Agencies throughout NH. The Center for Non Profits is a statewide nonprofit association dedicated to strengthening and giving voice to the state's nonprofit sector. Its programs are designed to advance the capacity of nonprofits by providing board and staff leaders with the information, resources, and tools they need to manage and govern effectively. The Center has a successful record of working collaboratively with the Bureau of Mental Health Services over the past several years. The Center has successfully delivered leadership and governance training for New Hampshire's Peer Support Agencies through a sole source contract with DHHS since 2019. This training series will build upon prior trainings to strengthen governance, management, and fiscal oversight at the Peer Support Agencies.

Starting in June of 2021, the 10 CMHCs shall employ a Work Incentive Counselor that will connect individuals and support them in applying for Vocational Rehabilitation services while also engaging individuals in supported employment (SE) and/or increased employment by providing work incentives counseling and planning. Through partnerships with Vocational Rehabilitation, CMHC providers are working to develop the Partnership Plus Model to identify how Social Security funding will be obtained to support a Work Incentives Counselor position after Vocational Rehabilitation funding ceases. The CMHCs shall also ensure the Work Incentive Counselor staff are certified to provide Work Incentives Planning and Assistance (WIPA) through the no-cost training program offered by Virginia Commonwealth University.

Please indicate areas of technical assistance needed related to this section.

NA

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Support of State Partners

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

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- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

---

1. Has your state added any new partners or partnerships since the last planning period?
Yes

Since the last planning period, the System of Care statute has been enacted, ensuring cooperation between state partners around the provision of children and youth behavioral health and special educational services. The passage of SB 534 indicates that there is widespread support for rethinking and improving aspects of the state’s systems. Furthermore, largely through smaller-scale, grant-funded projects, efforts have already been underway for a number of years to move New Hampshire towards a system of care model. These efforts focus not only on acute care and intervention, but also on prevention and healthy socio-emotional development for all children. With continued focus on these matters, a more comprehensive, gap-free, and efficient system of child behavioral health services can emerge in New Hampshire.

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2. Has your state identified the need to develop new partnerships that you did not have in place?
No

Please indicate areas of technical assistance needed related to this section.

NA

DRAFT

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69]**https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The overdose death rate in New Hampshire, which is one of the highest in the country, has increased the availability of funds and support for SUD treatment programming. The Bureau of Drug and Alcohol Services (BDAS) is tasked with implementing many of these programs. It is arguably true that most individuals with SUD also have mental health needs. The MHPAC has identified treatment of co-existing disorders as crucial. The MHPAC supports the 2016 configuration of the DHHS Division for Behavioral Health (DBH), promoting increased coordination between the SMHA and the SSA, which are included within its purview. The strategic direction is set by the Governor's Commission on Alcohol and other Drugs.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The New Hampshire Mental Health Planning & Advisory Council (MHPAC)
The New Hampshire Mental Health Planning & Advisory Council (MHPAC) maintains the required membership ratios: all required state agencies are represented. Adult consumers, parents of children with serious emotional disturbances and family members of both adults and youth are represented. Efforts to increase the diversity of the Council have been largely successful, though there is still work to be done.

There is robust advocacy representation for both adults and youth. NAMI-NH and several Peer Support Agencies and Recovery Clubhouses are represented. Peers are involved in the MHPAC as active members.

Several representatives and administrators from the Community Mental Health Centers participate collaboratively. Although there are limited block grant dollars supporting CMHC programs, they are encouraged to serve to advocate for the inclusion of their voice in state mental health solutions.

Quarterly MHPAC meetings provide structure for MH block grant updates and monitoring reports; as well as Committee work and reports. The MHPAC is a tremendous resource to the state. Its members are enthusiastic and intellectually curious problem-solvers, who are passionate about monitoring and improving the NH mental health system. The quarterly meetings provide a good

opportunity to highlight successes in programming throughout the system, and to inform community stakeholders of current program initiatives supported by the MHBG.

The Directors (or their designee) of the Bureau of Mental Health Services and Children's Behavioral Health Services are asked to provide updates to the Council at each meeting, and the Council actively engages in dynamic discussions with these Directors about the status of the behavioral health programs; with emphasis on the Community Mental Health Agreement (for adults), progress with the implementation of a System of Care approach to treatment (for youth), and the 10-Year Mental Health Plan. The MHPAC formally supported the 2016 enactment of RSA 135-F: the law Mandating a System of Care for children's mental health. The following subcommittees also meet on a quarterly basis:

The Legislative Advocacy Committee
Selects and presents advocacy issues to the Council with recommended positions on state and federal legislative and regulatory changes affecting mental health, and actively promote positions approved by the Council.

The Membership and Nominations Committee
Responsible for assisting in the receiving and reviewing of applications, maintenance of the membership roster, and nominating members and officers of the Council.

The Planning Committee
Responsible for receiving membership applications, assisting with the application review process, nominating members and officers to the Council, and maintaining a current membership roster.

The Children & Youth Committee
Coordinates and communicates information about children's mental health issues. Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of best practices in Children's Behavioral Health.

Housing
Actively engages with stakeholder organizations to influence policy and ensure access to housing for individuals who are served by the public mental health system. Advocates on legislation and regulatory matters related to funding and programs to serve persons who have mental illness and are experiencing housing instability.

Co-occurring Disorders
Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of co-occurring disorder strategies.

Due to the COVID-19 pandemic many of the sub committees were unable to meet. During early 2021 committee rosters were reviewed by SMHA and updated chairs and co-chairs were assigned. Early in 2021 these committees began re-forming and meeting on a more consistent basis.

Please indicate areas of technical assistance needed related to this section.

NA

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

New Hampshire Mental Health Planning & Advisory Council

BYLAWS

ARTICLE I – NAME AND AUTHORITY

The name of this council shall be the New Hampshire Mental Health Planning & Advisory Council (the Council).

The Council operates under the authority of the State Mental Health Authority (SMHA) for New Hampshire: the Bureau of Mental Health Services (BMHS).

ARTICLE II – MISSION, PURPOSE, AND CHARGE

The Mission of the Council is to bring individuals with lived experience with mental illness 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 mental health services and systems of care in New Hampshire.

The Council's purpose is to represent and advocate for adults of all ages with or at risk of Serious Mental Illness (SMI) and for children and adolescents under age 18 with or at risk of serious emotional disturbances (SED). The Council will, not less than once a year, review state mental health plan(s) and submit any recommendations to the State. The Council will monitor, review, and evaluate, the allocation and adequacy of mental health services within the State.

The Council is charged with focusing its statutory duties in a manner that will strengthen and improve the public mental health system.

ARTICLE III – MEMBERSHIP

Qualifications

Council membership composition shall follow the guidelines set forth in Public Law 102-321 and any subsequent regulations pertaining to Council membership. The number of appointed members may be as many as 35.

The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation.

Youth, ages 14 to 17, may be appointed to the Council with the same status as adult members.

Less than 50 percent of the members of the Council may be State employees or providers of mental health services.

Providers of mental health services are employees who provide publicly funded discrete mental health services at agencies or organizations contracted with BMHS for that purpose.

Council membership will include representatives from these required State Agencies:

Mental Health: Bureau of Mental Health Services (BMHS) and Bureau for Children's Behavioral Health

Education: Department of Education (DOE) with a focus on Vocational Rehabilitation (VR)

Housing: Bureau of Housing Supports or NH Housing Finance Authority) (BHHS or NH HFA)

Criminal Justice: Department of Corrections (DOC)

Requested Additional State Agency representation:

Bureau of Family Assistance (BFA)

Division of Children, Youth & Families (DCYF)

Division of Medicaid Services

Bureau of Drug and Alcohol Services (BDAS)

Appointment

Membership on the Council is by appointment of the Director of the BMHS or designee. Any individual meeting the criteria to serve as a member of the Council may submit a complete application for the Council's consideration, which is then forwarded to the Director.

Applicants for and members of the Council shall be required to disclose any work regularly performed for pay as or for a provider of publicly funded mental health services.

Final determination of appointment, or of removal from an appointment, shall be at the discretion of the BMHS Director or designee.

The members of the Council shall serve without pay, but the Council may recommend the payment of reasonable and necessary expenses incurred in the performance of their duties.

ARTICLE IV – OFFICERS

The elected officers of the Council shall be a Chair and Vice Chair, elected by the Council, and approved by the BMHS Director. Terms for officers will be two years or until such person ceases to be qualified to serve as an officer. Officers may seek re-election for one consecutive term.

The Council Chair shall preside over all meetings of the Council.

The Chair shall see that all motions and resolutions of the Council are acted upon as per the direction of the Council.

The Chair shall perform other duties as the Council may prescribe. The Chair serves as the official point of contact for the Council.

The Chair or designee is the signatory for all official Council correspondence.

The Vice Chair shall, in the absence of the Chair, perform the duties of the Chair and shall perform other duties as the Council may prescribe.

Vacancies

An officer may be removed by the Council whenever, in its judgment, the best interests of the Council would be served. A Recommendation to Remove will be referred to the Director for approval. Such removal shall not affect the individual's Council membership

Any officer may resign at any time by giving written notice, in the form of a Letter of Resignation, to the Council and the State Mental Health Authority (BMHS).

A vacancy in the office of Council Chair shall be filled by the Director of the SMHA (BMHS) or designee until elections are held.

A vacancy in the office of Vice Chair shall be filled in the interim by a Council appointee until elections are held.

Executive Committee

The Executive Committee consists of the Chair and Vice Chair, in consultation with the SMHA (BMHS) Director or designee.

After consultation with the Vice Chair and the SMHA (BMHS) Director or designee, to the extent feasible, the Chair shall set the agenda for meetings of the Council and recommend action to the Council.

Upon delegation by a majority of a quorum of the Council, the Executive Committee may make any other decision concerning the Council in the interim between properly called meetings of the Council.

In guiding the Council the Executive Committee shall derive its direction from the suggestions, requests, and expressions of the full Council membership.

ARTICLE V - STANDING COMMITTEES

Participation on a committee is a requirement of each Council member.

Except for the Nominating Committee, the Chair, in consultation with the Council, shall appoint all chairs and members of all sub-committees of the Council.

Committee Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.

1. Nominating/Membership – Responsible for assisting in the receiving and reviewing of applications, maintenance of the membership roster, and nominating members and officers of the Council.
2. Planning – Responsible for receiving membership applications, assisting with the application review process, nominating members and officers to the Council, and maintaining a current membership roster.
3. Children and Youth – Coordinates and communicates information about children's mental health issues. Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of best practices in Children's Behavioral Health.
4. Legislative Advocacy – Selects and presents advocacy issues to the Council with recommended positions on state and federal legislative and regulatory changes affecting mental health, and actively promote positions approved by the Council.
5. Housing - Actively engages with stakeholder organizations to influence policy and ensure access to housing for individuals who are served by the public mental health system. Advocates on legislation and regulatory matters related to funding and programs to serve persons who have mental illness and are experiencing housing instability.
6. Co-occurring Disorders – Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of co-occurring disorder strategies.

Other Committees may be appointed by the Chair as the Council shall from time to time deem necessary or expedient to carry on the business of the Council. The members are encouraged to suggest and to serve on committees in order to further the activities of the Council.

The standing committee chairs and ad hoc committee chairs shall only have the authority to make decisions as may be specifically assigned by a majority of a quorum of the Council at a properly called meeting of the Council.

ARTICLE VI – MEETINGS

All regular meetings of the Council shall be open to the public, with a reasonable time set aside for members of the public to address the Council.

Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Rules of Order

In all procedural matters not governed by these Bylaws, the chair determines questions of order, subject to being overruled by the membership.

Quorum

The Council can take official action only when a quorum is present, which shall consist of 50% or more of the members as of the day prior to the meeting.

Alternates; Abstention

There shall be no proxies for meetings of the Council. However, state employees and members of advocacy organizations who are designated as members by virtue of their office or advocacy organization representation may appoint a designated alternate to attend meetings in their stead, and such alternate may cast a vote.

No Council member may abstain in any matter not involving a conflict of interest for that member, and all non-voting members who do not declare a conflict shall be counted as affirmative votes.

Members who may have a conflict of interest with any item being voted on in Council session or Executive Committee shall abstain from the vote.

Any member may call into question the potential for a conflict of interest, to be discussed and resolved before the vote is taken.

Elections for officers shall be conducted as needed during the Council meeting held in the 4th quarter of the State fiscal year.

ARTICLE XI – ANTI-DISCRIMINATION

The Council shall not discriminate against any individual or group with regard to any individual or group beliefs, physical or mental characteristics, race, ethnicity, sexual orientation, language barriers, or any other attributes, actual or perceived.

ARTICLE XII – AMENDMENT AND REVISION OF BYLAWS

These Bylaws may be amended at any time, provided that any such potential amendment is approved by a recorded majority of a quorum of the Council.

Sub-Committee Position	Name	Affiliation	Email
Chair	Jamie Kelly	BMHS	Jamie.Kelly@dhhs.nh.gov
member	Denise Green	HEARTS PSA	denrog94@aol.com
member	Bureau of Housing Rep: TBD		
member	Lynn Lippitt	NHHFA	llippitt@nhhfa.org

Phone
271.6991
913-9177

Sub-Committee Position	Name	Affiliation
member	Denise Green	HEARTS PSA
member	Scott Garnett	Seacoast Pathways/Granite Pathw

Email	Phone
denrog94@aol.com	913-9177
SGarnett@granitepathways.org	717-8677

Sub-Committee Position	Name	Affiliation
Chair	Dellie Champagne	New Futures
Member	Terri Clyde	
Member	Renee DePalo	Grafton County Alternative Sentencing
Member	Hannah Maynard Yung	BCBH
Member	Amy Parece-Grogan	Office of Health Equity
Member	Brian Huckins	NAMI NH
Member	Michelle Myler	DOE
Member	Michele Merritt	New Futures
Member	JoAnne Malloy	UNH - IOD

Email	Phone
dchampagne@new-futures.org	
tlclyde@comcast.net	(603) 566-2142
rdepalo@co.grafton.nh.us	787-2042
Hannah.v.maynardyung@dhhs.nh.gov	892-8732
Amy.Parece-Grogan@dhhs.nh.gov	
bhuckins@naminh.org	603-731-8518
michelle.myler@doe.nh.gov	

Sub-Comm	Name	Affiliation	Email
Chair	Greg Burdwood	Connections	greg@connectionspeersupport.org
Member	Thomas Grinley	BMHS	thomas.grinley@dhhs.nh.gov
Member	Melissa Silvey	Infinity peer Support	melissa@infinitypeersupport.org
Member	Patt Fancy	LRCAB	lrcab1@metrocast.net
Member	Ken Lewis	HEARTS	kenl-hearts@comcast.net
Member	Paula Rockwell		poetrygirl2012@gmail.com
Member	Robin Brenner	MHCGM	brennerr@mhcgm.org
Member	Sean Jameson		Sdjameson05@gmail.com

Phone

948-1043
528-7742
603-809-7884.

Sub-Committee Position	Name	Affiliation
Chair	Renee DePalo	Grafton County Alternative Sentencing
Member	Nicole Fortune	
~~Member~~	~~Scott Garnett~~	~~Granite Pathways~~

Email	Phone
rdepalo@co.grafton.nh.us	787-2042
fortunenicole@rocketmail.com	
~~SGarnett@granitepathways.org~~	

Sub-Committee Position	Name	Affiliation
Chair	Sharon Reynolds	Tri-City Co-op
Member	Renee DePalo	Grafton County Alternative Sentencing
Member	Lisa Beck	DOE - Vocational Rehabilitation
member	Bret Smith	MHCGM
Member	Doug Robertson	
Member	Victor Topo	CLM

Email	Phone
sharonlynnereynolds@yahoo.c	742-9660
rdepalo@co.grafton.nh.us	787-2042
Lisa.M.Beck@doe.nh.gov	334-4481
smithbre@mhcgm.org	
thereddouglass1988@aol.com	undeliverable address
vtopo@clmnh.org	

State of New Hampshire
Department of Health and Human Services
DBH/BMHS
Mental Health Planning & Advisory Council
Quarterly Meeting

DATE: Tuesday, July 13, 2021
TIME: 9:30a-12:00p

ATTENDEES: Janelle Lavin, Sharon Reynolds, Martha Hewitt, Christine Allen, Dellie Champagne, Lisa Beck, Susan Seidler, Vic Topo, Terri Clyde, Hannah Maynard-Yung, Lynn Lippitt, Scott Garnett, Greg Burdwood, Renee DePalo, David Blacksmith, Barbara Holstein, Mark Guptill, Ayla Kendall, Jen Doris, Megan Sheehan, Julianne Carbin, Amy Parece-Grogan, Brian Huckins, Sean Jameson, Patt Fancy, Ann Strachan, Megan Sheehan, Julia Blackburn, Lauren Mekinova, Julianne Carbin

Agenda

Ground Rules: (i.e. Please be present and actively engaged; please hibernate technology.)

Time	*Topic*	*Category*	*Leader(s)*	*Key Takeaways & Action Items*
9:35 am	• Welcome! ○ Introductions ○ Agenda Overview	Discussion	Martha-Jo Hewitt, NH MHPAC Chair	• Welcome & New MHPAC Members and Subcommittee Members • Agenda Over view
9:50 am	• PSA Overview ○ Slideshow Presentation	Information	Ayla Kendall, PSA State Planner	• Alternative Life Center • H.E.A.R.T.S. • Infinity Peer Support • Stepping Stone Drop-in Center • On the Road to Wellness • Lakes Region Consumer Advisory Board • Connections Peer Support Center • Monadnock Peer Support

11:00 am	• DBH Updates
	  ○ Progress Updates
		Information	Julianne Carbin, Director, DBH	• 9-8-8 New Hampshire
				  o Live July 2022
				• ESMI/FEP Extension/ Expansion
				• Supported Housing expansion
				• Suicide Prevention Efforts - Public Health Network (PHN) has been funding. Jennifer Sabin, Suicide Prevention Coordinator-Invite to October meeting a
				• Time Intervention (CTI) Coordinator to attend in October)
				• Children's Residential Treatment Expansion
				• Children's Comprehensive Standardized Assessments Expansion
				• DOE Mental Health Partnership Grant
				• NH Center for Non-Profits Organizational Development training for PSAs
				• Vocational Rehab Partnership for expansion of benefits specialists.
				• FY2022 Training and Cooperative Service … in three locations: MFS, SMH and CLM…

11:00 am	• MHBG Updates ○ Introduction/Bio ○ ARP Application ○ MHBG Application ○ SAMHSA Monitoring ○ Funding Guidance ○ Satisfaction Surveys from Julia McNamara, BMHS	Information	Janelle Lavin, MHBG State Planner	• Statewide Satisfaction Survey was released about 5 weeks ago. There has been a 25% response rate to date. Followup phone calls will be starting soon. Work group has been meeting with Children Services and NAMINH. • American Rescue Plan (ARP) through SAMSHA, has offered the state the opportunity to apply for a $5 million grant. Application deadline was July 2nd. We met the deadline. The grant will be used to expand the current initiatives in the 10 Year MentalHealth Plan. • Janelle has been working on a Fund Request Form. Nothing has been finalized. • No information on the FY2023 Mental Health Block Grant as of this date.

11:30 am	• Sub-Committee Breakouts ○ Legislative Advocacy ○ Children’s ○ Housing ○ Nomination/Membership ○ Planning ○ Co-Occurring ○ Vacancies/Needs to Fill	Discussion	Committee Chairs	• Due to time restraints, Sub-Committee Breakouts were not conducted at this meeting. • Renee DePalo has offered to be the chairperson to State Planning Committee. • There are chairperson vacancies. Please contact Martha if you are interested. • Sub Committees were encouraged to meet before the next meeting.
11:50 am	• Meeting Closeout ○ Approval of Minutes ○ Committee Report Out ○ Votes & Reports ○ Recruitment ○ Next Steps ○ Adjourn	Information	Martha-Jo Hewitt, NH MHPAC Chair	• April Meeting minutes will be approved at the October 2021 meeting. • No Sub Committee Report outs. • Always looking for new members. Let Martha know if you know someone who would be an asset to the Council. • Thanked everyone for the time, energy an effort to the NHMHPAC.

Next Meeting Date: October 13, 2021, 9:30 am by Zoom

***A copy of this Agenda with Notes will be sent to all Council Members after the meeting.**

NH Mental Health Planning and Advisory Council
VIRTUAL Spring Meeting
4/13/2021

9:30 – 11:30

1. 9:30 – 9:35 WELCOME: Agenda overview, Welcome Participants - Martha Jo Hewitt, Chair of the NH-MHPAC
2. 9:35 – 10:15 JSI Research 2020 Consumer Survey Report Out
    a. Presentation occurred. Discussed use of data moving forward within small group of CMHCs.
    b. https://www.dhhs.nh.gov/dcbcs/bbh/documents/2020-nh-cmhc-consumer-survey-report.pdf
3. 10:15-10:30 Step Up Step Down Presentation from PSAs
    a. Presentation occurred: included with minutes
4. 10:30- 11:00 MHPAC Sub Committee report outs
    a. Report outs:
        i. Advocacy/legislation: working on how to operationalize this group. Is in need of more members for this group. Looking to coordinate efforts with other advocacy groups to make a bigger impact.
        ii. Children's: System of care meetings have been occurring. Focusing of ED waiting times, increased referrals to WRAP services, ensuring supports are in place for children to return to school and what that will look like. Dellie will be the new chair!
        iii. Housing: Lead for this group was not on the call
        iv. Nominating/Membership: Lead for this group was not on the call
        v. Planning: Lead for this group was not on the call
        vi. Co-occurring: Lead for this group was not on the call
    b. Lauren will send out the current list of sub-committees for everyone to update
    c. Need to fill Housing, Nominating and Membership, Planning, and Co-Occurring
5. 11:00 – 11:20 DBH Report Out
    a. BMHS Director Julianne Carbin Updates
        i. DBH System Wide Updates: BMHS Specific updates Housing, Crisis Services, Peer Work Force Etc.
            1. Presentation included in meeting minutes
6. 11:20-11:45 MHBG update: Lauren Quann, BMHS Administrator of Operations
    a. BG Application Planning:
        i. Review of MHBG Goals: See attached document for details

ii. Reminder of feedback on application due May 1st

1. This includes all subcommittee meetings minutes submitted as well

iii. MHBG Funding Presentation: See attached presentation for details

1. Technical Assistance and Training for Children's Behavioral Health Evidence Based Practices RFP link: https://www.dhhs.nh.gov/business/rfp/rfp-2021-dbh-05-techn.htm

2. DOC Suicide Prevention MOU Link: https://sos.nh.gov/media/deqdxbde/19-gc-agenda-021721.pdf

7. 11:45-11:50: Minutes Approval; Committee Breakouts, Votes & Reports – Committee Chairs: *Please send notes to Martha and State Planner*

   a. Minutes approved

8. 11:50-12:00 Recruitment, Next Steps and Adjourn – MHPAC Chair.

Next meeting 7/13/2021

So that we can take mandatory attendance, PLEASE MAKE SURE TO TYPE YOUR NAME WHEN ENTERING THE MEETING, or add it in the Chat.
THANK YOU!

NH Mental Health Planning and Advisory Council
VIRTUAL Fall Meeting Minutes
10/13/2020

9:30 – 12:00

MHPAC Business

1. WELCOME: Agenda overview, Welcome Participants - Martha Jo Hewitt, Chair of the NHMHPAC
2. Peer Specialists in the Workforce – Dr. Karen Fortuna, Dartmouth Peer Research; Robert Walker, Massachusetts DMH (Department of Mental Health (See attached slide deck); BMHS Peer Integration Specialist Ayla Kendall

- Dr. Karen Fortuna
  - Reviewed peer academic partnership for research
  - Peer tech application
  - Digital peer support certification process
  - Peer Specialist issues in New Hampshire
- Rob Walker
  - Mental Health services in Massachusetts
  - Contractual requirements for peer specialists
  - Certified Peer Specialist training
- Ayla Kendall
  - Reviewed work being done with Eduardo Vega and the NH Lived Experience Workforce Advancement Blueprint.

3. BMHS Report: "MH System Response to COVID" – Julianne Carbin, BMHS Director
   - Updates on new programs and services
   - Covid 19 response and services provided
   - 10-Year Plan Report has been loaded onto the DHHS website
4. MHBG update – Beth Anne Nichols
   - Have Training and Assistance funds again. Question as to what extent they can be used for services
5. 11:20 – 11:25 Report on Results of Member vote: Bylaws Language for Legislative and Advocacy Committee Charge; Co-Occurring Disorders & Housing Committees – ONLINE BALLOTING- Martha Hewitt
   a. Majority approved two new committees: Housing & Co-occurring Disorders. A system will be devised to allow all members to select committee membership and to be able to easily access updated Committee information.
   b. Greg Burdwood talked about a brief meeting of the Legislative and Advocacy Committee and will address the approval of the Committee Charge with the group.
   c. Discussion about getting more Legislators onto the Council

6. Committee Chairs: *Please send notes to Martha and Beth Anne*

7. Recruitment, Next Steps and Adjourn 12:00 – MHPAC Chair.

Respectfully Submitted,

Tom Grinley

Beth Anne Nichols

Next meeting 1/12/2021

Mental Health Planning and Advisory Council

Minutes

January 12, 2021

- Martha announced that Beth Anne has retired and Lauren Quann, Administrator of Operations will be serving as the MHPG state planner. Her email is Lauren.A.Quann@dhhs.nh.gov and her phone is 271-8376
- Martha announced she was leaving Tricity Peer Support Agency but would remain active with the MHPAC
- Martha introduced new members since our last meeting
- Jamie Kelly gave a presentation on housing programs: See includes slides.
    - Bridge program bridges people to the Section 8 program. Average wait for Section 8 is 3 years. Program to have a capacity of 500.
    - All Community Mental Health Centers now have at least one housing specialist
    - Integrative Housing has a capacity of 25 and is for people not eligible for other programs due to having a criminal record
    - In general, NH is experiencing a lack of housing units
    - Property owners and some small towns are giving up doing vouchers any more
    - Section 811 targets the same population but the voucher is tied to the unit and not the person
- Julianne Carbin gave a Bureau update
    - Working on crisis redesign. Applied for a planning grant for the new 988 number to be in place by 2022. MH Block Grant will also have 5% set aside funds for crisis response. See includes document for details.
    - Step Up/Step Down programs should be starting in next couple of months. Intended to divert people from inpatient admissions (Step Up) or provide for a reintroduction to the community from an inpatient admission (Step Down)
    - The bureau also has Federal COVID-19 Relief funds and additional SAMHSA appropriations
- Greg Burdwood provided more details about Step Up/Step Down programs
    - Sites will be in Exeter, Keene, Nashua and Manchester
    - Very unique to New Hampshire not much similar in the US but something similar in Australia
- Lauren Quann
    - Will be covering for Beth Anne until position is filled
    - This is an application year for the Mental Health Block Grant. Lauren shared the timeline for development and feedback. Planning committee will coordinate goal setting. Draft goals are due March 1. See attached documents.
- Dr. Mary Brunette and Alicia L'Esperance gave a presentation on the Pro-Health program
    - Called reverse integration because instead of integrating mental health with primary care, this program integrates primary care into mental health settings
    - Focus is on young people (16-35) with SMI/SED

- Presented data on untreated health issues in this population and talked about early mortality
- Pro-Health New Hampshire:
  - Universal screening
  - Co-location of services
  - Cultural competence
  - Education and decision support
  - Collaborative care
  - 89% satisfaction

- Committees should meet before the annual meeting in April. Martha will send out committee lists.

NH Mental Health Planning and Advisory Council
Tom Fox Chapel
Main Building
State Office Park
105 Pleasant Street
Concord, NH

1/14/2020

MINUTES

10:05 WELCOME: Housekeeping, Agenda overview, Fall Quarterly Meeting Minutes Review, Welcome New Members, New Vice-Chair Sharon Reynolds, and Visitors. Announcing Scott Garnett's resignation, due to career responsibilities.
Martha Jo Hewitt, Chair of the NHMHPAC

Fall MHPAC Minutes approved.

10:05 -10:15 INTRODUCE VISITORS: Representation from the Massachusetts DMH State Mental Health Planning Council–*Martha.*
David Tringari (State Planner), Bobbi Spofford
Here to learn from NH compared with MA. Youth representative, peer specialists in various capacities run the Council where we do the admin piece. Strategic planning exercise a couple of years ago, with assistance of SAMHSA TA. Subcommittee structure issues they are hoping to receive assistance with. They also hold Council meetings quarterly. Meeting locations can change to cover geographic area. Building issues create problems with WiFi and WebEx access. Council website has stimulated interest. Problems obtaining membership from state agencies. MA mandated to have peers in all licensed hospitals and residential programs. MA General hires their own peers; hospitals that contract with DMH are paid for by DMH but there are funding limitations. Hoping to maximize WebEx.
Sharon suggested MA getting involved with the Alternatives Conference.
Public Health manages the Substance Abuse Block Grant, and are represented in their MH Council.

10:15 – 10:45 MENTAL HEALTH PROGRESS REPORT: MH Housing programs
Jamie Kelly, Housing Coordinator
Overview and update on Bridges and the two (2) 811 programs, which we work with NHHFA on. presented data. Participants do not need to be determined eligible and participate in CMHC services. Fair market value properties are difficult to find. Admin rule with qualifications is He-M 406. Permanent housing vouchers are the ultimate goal of the Bridge program. Average wait time is 2-3 years.

- Bridge Program: Questions about application process. Need to come from CMHC housing specialists, who need to do outreach. There currently is no DHHS website with information about the program. Ayla will send the PSA EDs the list of CMHC Housing Specialists.Request to have the CMHC Housing Specialists come and do presentations at the PSAs. Jamie will reach out to PSAs and offer a Housing Specialist visit.
- 811 Project Rental Assistance – HUD-funded; jointly managed by BMHS and NHHFA. Discussion of challenges and successes. Largely new properties. Permanent housing vouchers.

- Mainstream 811 – working with BDS. Permanent vouchers. Expedited placements. Complex application – involvement of housing specialists not required, but assistance is helpful.

10:45 – 11:30CMHC CONSUMER SURVEY REPORT:
Wendy Chow - JSI Research
Powerpoint presentation attached. Final report forthcoming.
MA selects a separate adult program every year to oversample in addition to the general sample.
Council feedback:

- Brian asked what the State does with these results – funding effect? Are Medicaid rates affected?
- Sharon suggested that a Best Practices effort to share positive results and potential causes.
- Staffing and regional obstacles such as transportation can present obstacles to access.
- Interest expressed in background causes for high youth school expulsions/suspensions. Council should share with DOE as these are alarming statistics.
- Brian – youth-led crisis response and mobile crisis services – is there access to them? Potential added questions for next year.
- Wendy will send a fact sheet for dissemination, as the report is too long
- Resolution (Greg) – what do the CMHCs do with this information? Consumers will want to know what are the results of gathering this information?:
  See attached resolution. Motion was made by Ken Lewis, seconded by Sharon Rynolds, and approved by voice vote.

11:30 – 11:45 PSA REPORT – PSA Conference The PSA Conference was held on Monday, December 2nd at the Grappone Center in Concord. Due to the winter weather the conference ended at 1:00 PM. All sessions were held except the afternoon. In the future the conference will not be held in December. NH Peer Voice looking at having a regional PSA Conference and inviting surrounding states (MA, Maine, VT, etc) and collaborating with the Alternatives Conference. There will be continued discussion.

11:45 – 12:00 BLOCK GRANT REPORT – Annual Report feedback: All & Beth Anne
A brief outline of current projects, including the FEP/ESMI project. Funding for PSAs will continue at the current level. Supplemental Technical Assistance funds will be used for PSA training and support, among other things. This is an "off" year for the MHBG application. MHBG 2018-2019 goals were met 100%.

12:00 – 12:30 LUNCH AND PREPARE for Committee reports:

a. Member vote: Combining Legislative and Advocacy Committees
   A workgroup, to be led by Greg, and consisting of Ken, Greg, and Martha, was established to report back to the Council at the Annual Meeting in April.
b. Updates and notes for the record; proposed Committee action plans for 2018
   Tabled for Annual Meeting

c. Discuss Annual Meeting topics - Tabled

12:30 – 1:15 COMMITTEE REPORTS:
Committee Chairs (see attached)

1:30 – 2:00 April Meeting Planning, Closing, Announcements
Martha Hewitt

NH Mental Health Planning and Advisory Council
VIRTUAL SUMMER MEETING
7/14/2020

DRAFT Minutes

MHPAC Business

1. WELCOME: Agenda overview, Welcome Participants - Martha Jo Hewitt, Chair of the NHMHPAC. 38 participants – see below - Lynn Lippett on phone.
2. FEP-ESMI Brief Update & Q&A – Kelly Aschbrenner, Dartmouth Mary Hitchcock; Kim Murdoch, NAMI-NH.
3. Kelly: (see attached slides). Current status: planning process involving stakeholder engagement to inform model selection. Presented draft model, took questions. Greg B: role of peer support? Peer support for youth? Referrals from CMHCs? Would like involvement in planning for local involvement/community partners. Kelly: a peer might be employed at the hub. Uncertainty about this. Greg: significant differences between peer support model and clinical settings. Historic misunderstanding between the two cultures. Lisa Beck: is this the model you're proposing? Kelly: we've been gathering information from stakeholders and experts and craft a model to present to the state for an RFP process…Lisa: upper levels can be on board but attrition at the provider level can cause the program to deteriorate. Kelly (Concord High): we would address this with implementation support. Ongoing training and support. Kathryn: not only young adults but also much younger. Involve other local providers like private psychologists. Kelly: segue to NAMI re: referrals and outreach. Sharon: do you already have a hub in mind? Kelly: not now. Just developing the concepts now, to flesh out the components of the hub. Kelly (Concord) involve first responders. Email me or Beth Anne with comments about the model.
4. Kim: Introduced Michelle Wagner as colleague working on this Public Awareness initiative. (see attached slides and webinar flyer) add stakeholder information here. Kathryn would like to get involved.
5. TA and BG funds – Beth Anne. NAMI-NH was awarded funds as part of their contract amendment: for support of the ESMI-FEP outreach program. *(Did not think to add: Additional funds were included, to engage the services of Eduardo Vega to promote and expand the engagement of individuals with lived experience across all levels of the MH system.)* There is no guarantee of supplementation BG technical Assistance (TA funds for FFY 21). Youth peer support was advocated for by several members, and Brian Huckins gave a brief summary of Youth Peer Support initiatives.
6. PSA Annual Report – PSA Executive Directors and Ayla Kendall (see attached slides)
7. Report on Results of Member vote: Combining Legislative and Advocacy Committees and next steps – ONLINE BALLOTING - Martha Hewitt. Overwhelming majority voted in favor of combining the committees.

8. Report on Results of Member Elections: Chair, Committee Chairs (except State Plan Committee) ONLINE BALLOTING. – Sharon Reynolds. Results:

Chair: Martha Hewitt

Advocacy Committee Chair: Greg Burdwood

Membership and Nominations Committee Chair – Donna Mailhot-Dornhofer (interim)

Children's Committee Chair – Brian Huckins

9. Next Steps – Members should take the time to offer feedback on the mini-application questions that will be sent them by Melinda Bellanti, Planning Committee Chair.

10. a12:10 - Adjourn – Martha.

Next meeting October 13, 2020.

Modality TBD

Participants:

Participants (35)

Find a participant

BETH NICHOLS (Host, me)
Greg Burdwood, Connections Peer Support Ctr. (Guest)
Martha Jo Hewitt (Guest)
16033770932 (Guest)
bellantm (Guest)
Corbin Simas (Guest)
Dick Wiggins (Guest)
Robin Brenner (Guest)
Alicia L'Esperance (Guest)
Amy Parece-Grogan
Ann Strachan (Guest)
Barbara Holstein (Guest)
Bret Smith (Guest)
David Blacksmith (Guest)
Doug Robertson (Guest)
Emily Dobson (Guest)
Gabrielle Huapaya (Guest)
Hannah Maynard Yung/Bureau of Children's Behavioral Health (Guest)
Julianne.Carbin (Guest)
Kathryn Langille (Guest)
Kelly Aschbrenner (Guest)
Ken Lewis (Guest)
Kim Murdoch (Guest)
Laura Mekinova (Guest)
Lisa Beck (Guest)
Matt O (Guest)
Michelle Wagner (Guest)

Participants (36)

Patt Fancy (Guest)
Peter Starkey (Guest)
Sharon Reynolds (Guest)
Shawn Blakey
Susan Seidler (Guest)
Susan Stearns - she/her/hers (Guest)
Thomas Grinley
Donna Mailhot-Dornhofer (Guest)

Late or by Phone:
Brian Huckins, Reilly Nichols

NH Mental Health Planning and Advisory Council
ANNUAL MEETING
4/14/2020

MEETING CANCELLED **DUE TO THE CURRENT PUBLIC HEALTH CRISIS**

SOME BUSINESS WILL BE CONDUCTED VIA ONLINE POLLING:

MHPAC Business

1. Member vote: Combining Legislative and Advocacy Committees – ONLINE BALLOTING
2. Member Elections: Chair, Committee Chairs (except State Plan Committee) ONLINE NOMINATIONS *please note: if you have already voted, there is no need to vote again.*
3. Updates and notes for the record; proposed Committee action plans for 2020-2021 – **tabled until July meeting.**
4. The council should consider scheduling and advertising meetings in rural areas throughout the state to develop and encourage diversity. (SAMHSA recommendation) – **tabled until July meeting.**
5. TA funds expenditures – Beth Anne to report to group with election results post-April 14.
6. MHPAC influence on BG discretionary funds – **tabled until July meeting**

FEP/ESMI Project Progress, Goals, Timeline, Q&A – Dr. Will Torrey, Kelly Aschbrenner, Michelle Wagner - tabled until July meeting.

CANCELLED

State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application-

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

---

1. How was the Council involved in the development and review of the state plan and report?

MPHAC Input on the MH Block Grant Application

The Council participates in the development of the state plan for the Community Mental Health Block Grant by providing input to the State Mental Health Authority and contributes to the writing of the MHBG application. This occurs in several ways: all MHPAC committees worked individually to identify areas of need and prioritize them; each committee provides monthly reports of areas of concern; members solicit data regarding grant expenditures and budgets and provide comment; and members delegate and volunteer to author or at least provide research on various elements of the plan application.

Every two years, the Council assists in the design of the time lines for the MHBG application. MHPAC involvement in preparation for the application serves the purpose of reinforcing their statutory responsibilities and their understanding of grant priorities, strategies, and requirements.

The MHPAC reviews and comments on plan goals as well as the individual sections, both required and requested, of the plan application. Several members actively contribute to plan content in a structured system largely managed by the MHPAC State Planning Committee. Goals are crafted based on both SMHA and MHPAC priorities, collected and ranked by the MHPAC Advocacy Committee. The required state agencies take an active role in the informational and communications process between these agencies and consumers on the Council.

The MHPAC was oriented to this year's Block Grant application at their January meeting. The Council reviewed the drafted planning priorities and reviewed progress on the 2019-2021 goals, and the program

budgets. The Planning Committee was also provided all the previous submitted application sections for review and input.

Due to the organizational skills and drive of the MHPAC members, the SMHA was well on its way with the MHBG application early in the year, in accordance with the timeline created by the Planning Committee and the MHPAC Chair.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

The overdose death rate in New Hampshire, which is one of the highest in the country, has increased the availability of funds and support for SUD treatment programming. The Bureau of Drug and Alcohol Services (BDAS) is tasked with implementing many of these programs. It is arguably true that most individuals with SUD also have mental health needs. The MHPAC has identified treatment of co-existing disorders as crucial. The MHPAC supports the 2016 configuration of the DHHS Division for Behavioral Health (DBH), promoting increased coordination between the SMHA and the SSA, which are included within its purview. The strategic direction is set by the Governor's Commission on Alcohol and other Drugs.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
Yes

2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
Yes

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The New Hampshire Mental Health Planning & Advisory Council (MHPAC)
The New Hampshire Mental Health Planning & Advisory Council (MHPAC) maintains the required membership ratios: all required state agencies are represented. Adult consumers, parents of children with serious emotional disturbances and family members of both adults and youth are represented. Efforts to increase the diversity of the Council have been largely successful, though there is still work to be done.

There is robust advocacy representation for both adults and youth. NAMI-NH and several Peer Support Agencies and Recovery Clubhouses are represented. Peers are involved in the MHPAC as active members.

Several representatives and administrators from the Community Mental Health Centers participate collaboratively. Although there are limited block grant dollars supporting CMHC programs, they are encouraged to serve to advocate for the inclusion of their voice in state mental health solutions.

Quarterly MHPAC meetings provide structure for MH block grant updates and monitoring reports; as well as Committee work and reports. The MHPAC is a tremendous resource to the state. Its members are

enthusiastic and intellectually curious problem-solvers, who are passionate about monitoring and improving the NH mental health system. The quarterly meetings provide a good opportunity to highlight successes in programming throughout the system, and to inform community stakeholders of current program initiatives supported by the MHBG.

The Directors (or their designee) of the Bureau of Mental Health Services and Children's Behavioral Health Services are asked to provide updates to the Council at each meeting, and the Council actively engages in dynamic discussions with these Directors about the status of the behavioral health programs; with emphasis on the Community Mental Health Agreement (for adults), progress with the implementation of a System of Care approach to treatment (for youth), and the 10-Year Mental Health Plan. The MHPAC formally supported the 2016 enactment of RSA 135-F: the law Mandating a System of Care for children's mental health.

The following subcommittees also meet on a quarterly basis:

The Legislative Advocacy Committee
Selects and presents advocacy issues to the Council with recommended positions on state and federal legislative and regulatory changes affecting mental health, and actively promote positions approved by the Council.

The Membership and Nominations Committee
Responsible for assisting in the receiving and reviewing of applications, maintenance of the membership roster, and nominating members and officers of the Council.

The Planning Committee
Responsible for receiving membership applications, assisting with the application review process, nominating members and officers to the Council, and maintaining a current membership roster.

The Children & Youth Committee
Coordinates and communicates information about children's mental health issues. Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of best practices in Children's Behavioral Health.

Housing
Actively engages with stakeholder organizations to influence policy and ensure access to housing for individuals who are served by the public mental health system. Advocates on legislation and regulatory matters related to funding and programs to serve persons who have mental illness and are experiencing housing instability.

Co-occurring Disorders
Provides input into planning and development activities and initiatives to support consistency, accountability and sustainability of co-occurring disorder strategies.

Due to the COVID-19 pandemic many of the sub committees were unable to meet. During early 2021 committee rosters were reviewed by SMHA and updated chairs and co-chairs were assigned. Early in 2021 these committees began re-forming and meeting on a more consistent basis.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2024

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Lisa Beck	State Employees			
Melinda Bellanti	Others (Advocates who are not State employees or providers)			
Robin Brenner	Others (Advocates who are not State employees or providers)			
Greg Burdwood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathleen Chambers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Sandra Davidson	State Employees	NH DHHS Office of Medicaid Services		
Patt Fancy	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Scott Garnett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Molly Gray	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Denise Green	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Thomas Grinley	State Employees	NH DHHS BMHS Office of Client & Family Services		
Laura Harwood	Others (Advocates who are not State employees or providers)			
Martha Hewitt	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Brian Huckins	Others (Advocates who are not State employees or providers)	NAMI-NH		

Sean Jameson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Ken Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	H.E.A.R.T.S. Peer Support Agency		
Lynn Lippett	Others (Advocates who are not State employees or providers)	NH Housing and Finance Authority		
Donna Mailhot-Dornhofer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lisa McCann	Others (Advocates who are not State employees or providers)			
Michelle Myler	State Employees	NH Dept. of Education	NH,	
Amy Parece-Grogan	State Employees	NH DHHS Office of Health Equity		
Sharon Reynolds	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Doug Robertson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Paula Rockwell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Bret Smith	Persons in recovery from or providing treatment for or advocating for SUD services			
Ann Strachan	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Vic Topo	Providers			
Richard Wiggins	Persons in recovery from or providing treatment for or advocating for SUD services			

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2024

Type of Membership	Number	Percentage
Total Membership	**28**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	11	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	6	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**22**	**78.57%**
State Employees	5	
Providers	1	
Vacancies	0	
Total State Employees & Providers	**6**	**21.43%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

MPHAC Input on the MH Block Grant Application

The Council participates in the development of the state plan for the Community Mental Health Block Grant by providing input to the State Mental Health Authority and contributes to the writing of the MHBG application. This occurs in several ways: all MHPAC committees worked individually to identify areas of need and prioritize them; each committee provides monthly reports of areas of concern; members solicit data regarding grant expenditures and budgets and provide comment; and members delegate and volunteer to author or at least provide research on various elements of the plan application. Every two years, the Council assists in the design of the time lines for the MHBG application. MHPAC involvement in preparation for the application serves

the purpose of reinforcing their statutory responsibilities and their understanding of grant priorities, strategies, and requirements.

The MHPAC reviews and comments on plan goals as well as the individual sections, both required and requested, of the plan application. Several members actively contribute to plan content in a structured system largely managed by the MHPAC State Planning Committee. Goals are crafted based on both SMHA and MHPAC priorities, collected and ranked by the MHPAC Advocacy Committee. The required state agencies take an active role in the informational and communications process between these agencies and consumers on the Council.

The MHPAC was oriented to this year's Block Grant application at their January meeting. The Council reviewed the drafted planning priorities and reviewed progress on the 2019-2021 goals, and the program budgets. The Planning Committee was also provided all the previous submitted application sections for review and input.
Due to the organizational skills and drive of the MHPAC members, the SMHA was well on its way with the MHBG application early in the year, in accordance with the timeline created by the Planning Committee and the MHPAC Chair.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

		Yes	No
a)	Public meetings or hearings?	○	●
b)	Posting of the plan on the web for public comment?	●	○
	If yes, provide URL: https://www.dhhs.nh.gov/dcbcs/bbh/grant.htm		
c)	Other (e.g. public service announcements, print media)	○	●

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: