Draft of NH DHHS Mental Health Block Grant Application

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1. Access to Care, Integration, and Care Coordination – Required

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The Following resources may be helpful: https://store.samhsa.gov/product/essential-aspects-of-parity-training- tool-for-policymakers/pep21-05-00-001; https://store.samhsa.gov/product/Approaches-in- Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the- States/SMA16-4983.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[37] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different

Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Medical care*, 599-604.Avaiable at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

groups, such as High- Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed support in areas like education, employment, and housing.

1. Describe your State's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:
    a) Adults with serious mental illness
    b) Pregnant women with substance use disorders
    c) Women with substance use disorders who have dependent children
    d) Persons who inject drugs
    e) Persons with substance use disorders who have, or are at risk for, HIV or TB
    f) Persons with substance use disorders in the justice system
    g) Persons using substances who are at risk for overdose or suicide
    h) Other adults with substance use disorders
    i) Children and youth with serious emotional disturbances or substance use disorders
    j) Individuals with co-occurring mental and substance use disorders

The New Hampshire 10-Year Mental Health Plan

New Hampshire's 10-Year Mental Health Plan results from a robust stakeholder engagement process that has included input from hundreds of interested parties statewide through focus groups, workgroups, public sessions, and written comments. It takes a comprehensive and innovative approach to improve access to care for the mental health needs, substance use disorders, and co-occurring disorders of individuals in NH across their life span.

The 10-Year Mental Health Plan was first adopted in 2019 and was most recently updated in 2023. It envisions and lays out a road map to achieve a statewide mental health system that provides:

- Increased access to a full continuum of care, including community education and engagement,
- Prevention and early intervention services,
- Outpatient, inpatient, and crisis support and services,
- Child-focused strategies and recommendations,
- Integration of mental health and primary health care, and
- Intensified efforts to address suicide prevention

for all individuals in New Hampshire.

The Plan includes a vision to expand the crisis continuum to include statewide integrated mobile crisis services; incentives to increase psychiatric bed capacity; increased support for those transitioning to and from higher levels of mental health care; and more peer support as people with a mental illness navigate their way through the system of care. The Plan's 13 recommendations highlight and reflect the stakeholder input received and include action steps on how the Department and stakeholders will implement those recommendations, funding benchmarks, and potential legal and regulatory changes.

Key Accomplishments, to date, for the Plan's 13 Recommendations include the following:

Recommendation 1: Increase Medicaid Rates for Mental Health Services

- Increased Medicaid rates by 3.1% in January 2020 and another 3.1% in January 2021, increasing total funds for providers by $6M
- Annually, $5M of Directed Mental Health Payments have been made since SFY 2019
- Increased the transitional housing/community residence per diem by 88%

Recommendation 2: Action Steps to Address Emergency Department Waits

- Transformed crisis services; integrated Mobile Crisis Teams and Supports; Rapid Response services available statewide
- Access Point/988 Public Outreach and Education
- Mobile Crisis Rural Implementation
- Crisis Stabilization Model Expansion
- Increased Designated Receiving Facility rates and added 34 beds since 2019, with plans to increase inpatient beds by 150 through 2025
- Established 40 new transitional housing beds
- Reallocated capacity at NH Hospital – children's unit transitioned to Hampstead
- State acquired Hampstead Hospital and established the contract to develop the first-ever Psychiatric Residential Treatment Facility in NH.
- Amended NH's substance use disorder Institutions for Mental Disease (IMD) Medicaid waiver to include serious mental illness

Recommendation 3: Renewed & Intensified Efforts to Address Suicide Prevention

- Allocated $450K of new State funds to support suicide prevention

per year since 2020
- Established NH's first suicide prevention specialist position
- NH Suicide Prevention Council revised the statewide suicide prevention plan
- Established school suicide prevention planning and training standards; CALM training provided to 33 individuals statewide
- Developed a standardized suicide screening and risk assessment tool for use in emergency departments
- Collaborative 9-8-8 planning and launch

Recommendation 4: Enhanced Regional Delivery of Mental Health Services
- Expanded services for children's system of care through Senate Bill 14
- Developed a centralized mental health Access Point

Recommendation 5: Community Services and Housing Supports
- Increased Housing Bridge subsidies by over 100 vouchers
- Established Integrated Housing Program, a housing voucher program for individuals with mental illness and criminal records
- Contracted for 60-bed supported housing expansion
- Expanded partnership with NH Housing Finance Authority and secured grant funding from the federal Department of Housing and Urban Development (HUD)
- Launched birth to 5 early childhood enhanced care coordination (EC-ECC)
- Expanded Families and Systems Together (FAST) Forward for children

Recommendation 6: Step-up/Step-down Options
- Launched a Recovery Oriented Step-up/Step-down pilot program (12 beds)
- Expanded the Transitional Residential Enhanced Care Coordination (TR-ECC) program for children
- Launched Critical Time Intervention

Recommendation 7: Integration of Peers and Natural Supports
- Expanded Access to Peer Support Centers
- Expanded training for peer leadership and workforce services
- Expanded youth peer support services
- Increased peers throughout the continuum
- Incorporate peers into ACT/Mobile Crisis Teams, EDs, and SUSD program

Recommendation 8: Establish a Commission to Address Justice-Involved Individuals
- Established Governor's Advisory Commission on Mental Illness and

the Corrections System.
- Commission partnered with the National Council of State Governments Justice Center on a high-utilizer assessment project.

Recommendation 9: Community Education
- Launched *I Care NH* and *Onward NH*, suicide prevention and early intervention campaigns
- Entered into a contract with a vendor to create a public awareness campaign encouraging positive help-seeking behavior and the reduction of stigma

Recommendation 10: Prevention & Early Intervention
- Developed the Early Childhood Prevention and Treatment for Behavioral Health Plan
- Increased availability of First Episode Psychosis intervention services
- Deployed Crisis Teams to children and families
- Developed the Infant Mental Health Plan
- Solicited proposals to study the readiness, capability, and cost-effectiveness of implementing the Certified Community Behavioral Health Clinic (CCBHC) model

Recommendation 11: Workforce Coordination
- Established the Governor's Statewide Oversight Commission on Mental Health Workforce Development
- Invested $5M of ARPA Home and Community Based Services (HCBS) funds to support direct care staff at CMHCs
- Developed the Peer Workforce Advancement Plan
- Conducted cross-department training for criminal justice staff
- Expanded the State Loan Repayment Program (SLRP)
- Enhanced workforce training options

Recommendation 12: Quality Improvement & Monitoring/DHHS Capacity
- The DHHS established a Division of Performance Evaluation & Innovation
- Contracted with an evaluation team that would evaluate and advise on crisis system transformation and implementation
- Created four new staff positions in the Bureau for Children's Behavioral Health

Recommendation 13: Streamlining Administrative Requirements
- Streamlined administrative requirements, annual data enhancement projects, and program reviews
- Informal stakeholder engagement for State rule revisions is underway

Integration of Substance Use and Mental Health Treatment

Challenges experienced regarding gaps in service for individuals with co-occurring mental health and substance use disorders have been identified and targeted for improvement. Ongoing, collaborative work is occurring across NH DHHS mental health and substance use bureaus on care coordination, access, and program development.

NH DHHS 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 and outlining service and access standards has begun. The goal is to streamline standards of care to ensure there is "no wrong door" and leverage innovative, sustainable treatment models.

Critical Time Intervention (CTI)

NH's Critical Time Intervention (CTI) programs provide up to 9 months of intensive support services to individuals discharged from inpatient psychiatric hospitalizations to help prevent readmissions. The 10 NH Community Mental Health Centers have been implementing and operationalizing the NH CTI program in a staggered program launch beginning in 2022.

CTI services enhance the quality of life of adults transitioning from inpatient behavioral health settings while mitigating readmission to psychiatric facilities. CTI is a cost-effective, evidence-based practice offering highly specialized interventions that bridge the gap and ease transitions from institutional to community-based care. When implemented correctly, CTI facilitates successful transitions during critical times of change. The ongoing services facilitate community reintegration and ensure individuals have established ties and support systems for sustained care continuity.

Suicide Prevention Initiatives

Great strides have been made through the ongoing communication and efforts between the Bureau of Mental Health Services (BMHS), the Bureau for Children's Behavioral Health (BCBH), and the Bureau of Drug and Alcohol Services (BDAS) regarding statewide suicide prevention initiatives.

In early 2021, the Division for Behavioral Health (DBH), which houses the BMHS, BCBH, and BDAS, hired its first statewide suicide prevention coordinator, linking the Bureaus' efforts in this area. These Bureaus are actively engaged together in managing the MCO contracts to ensure the 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 ensures system-wide financial and programmatic discussions are occurring and are an ongoing focus for the coming year.

A substance use disorder is a known risk factor for suicide, so even when not in a life-threatening crisis, it is prevalent for individuals with a substance use disorder to have a co-occurring mental health disorder (COD). Addressing COD during treatment for a substance use disorder can improve client outcomes. As a step towards more comprehensive treatment of COD and support for individuals in recovery experiencing COD, NH DHHS is providing Mental Health First Aid and Zero Suicide training to all contracted SUD treatment providers and to recovery community organizations under the umbrella of the Department's contracted facilitating organization. Training may also be made available to other treatment and recovery providers outside of those contracted with the Department upon review of the implementation design.

The BMHS has also contracted with a statewide COD trainer to work with the SUD and MH treatment provider networks to provide COD training, evaluation, and consultation.

Crisis Respite Centers
New Hampshire is transforming its behavioral health crisis system, which includes implementing a statewide integrated (responding to both mental health and substance use crises across the age continuum) mobile crisis response model to work in tandem with the existing infrastructure, such as the Doorways (https://www.thedoorway.nh.gov/), which provides 24/7 support to individuals seeking treatment for a substance use disorder, and community mental health centers.

Crisis Respite and Withdrawal Management Services
New Hampshire's network of Doorways has identified the need for non-clinical, safe housing for individuals waiting to access either residential treatment services or safe housing. Currently, three such programs are funded through State Opioid Response funds; however, a need remains, especially for individuals who use substances other than opioids or stimulants, such as alcohol. These funds would be utilized to stand up respite housing in areas of the State that are currently underserved in this area. A third area of need is Medically Monitored Residential Withdrawal Management (ASAM Level 3.7-WM). These critical services are being explored within New Hampshire. A vital component of this service development would be that the providers must be able to bill Medicaid and private insurance for services beyond the initial startup period for ongoing

service sustainability beyond the grant period.

Development and Coordination of Prevention Services New Hampshire's prevention efforts are primarily driven by the State's Regional Public Health Networks and Community Coalitions. These groups already provide a good network of support, and more work is needed in this space. BDAS is providing funding to apply the Strategic Prevention Framework at both the state and local levels to support and expand existing initiatives, such as Student Assistance Programming and the *I Care NH* Initiative (part of the I Care Mental Health & Wellness Initiative) as well as to develop new initiatives made possible by the rollout of 988. The goal of this work is to help regions, and communities identify the evidenced-based and/or promising practices that will be the most effective in their localities and assist these communities in standing up programs as well as to coordinate better the efforts of these groups in providing population, targeted, and direct prevention services across New Hampshire.

2. Describe your efforts, alone or in partnership with your State's Department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general healthcare fields.

New Hampshire's demand for mental health and substance use services is increasing. Several factors make behavioral health transformation a priority of the State, including enacting 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.

Additional efforts to advance parity include:

- Supported behavioral health (BH) and physical health integration

through the 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 a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention
- 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
- Passage of legislation to authorize the provision of many Medicaid-covered services to be delivered through telehealth, inclusive of pay parity, for behavioral health services with patient consent and as long as it is clinically appropriate for the service to be conducted via telehealth
- Ongoing review and updating of Medicaid rates associated with behavioral health services to support beneficiary access to services and providers (e.g., a 2022 increase to ASAM 3.7 Medically-Monitored Detoxification Treatment, a 2021 increase of residential treatment beds for individuals with a serious mental illness(es)

3. Describe how the State supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

   a) Access to behavioral health care facilitated through primary care providers

   b) Efforts to improve behavioral health care provided by primary care providers

   c) Efforts to integrate primary care into behavioral health settings

Demonstration Project and Integrated Delivery Networks
In 2016, the Centers for Medicare and Medicaid Services (CMS) approved an NH DHHS five-year Medicaid demonstration project to improve access to and quality behavioral health services by establishing regionally-based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical healthcare 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, physical and behavioral care integration, and improving care transitions across settings.

The central 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:

- Integration of primary care and behavioral health
- Supported expanded implementation of Medication Assisted Treatment (MAT) for people with substance use disorders, in conjunction with the Doorways (points of entry for people seeking help for substance use), which have been established in New Hampshire
- Critical Time Intervention (CTI), an evidence-based practice, was used in several regions to improve transitions from emergency departments, inpatient care, residential settings, or incarceration to stable housing and community recovery (individual IDNs targeted different segments of the population)
- Established standardized protocols across multidisciplinary providers for comprehensive assessment, workflows, timely exchange of information, closed-loop referrals, and 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 processes and protocols.
- Integrated Care and Enhanced Care Coordination between hospitals, SUD, FQHCs, and CMHCs
- 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 the expansion of telehealth during the Covid-19 public health state of emergency (funding, training, ongoing technical support)

ProHealth Program in New Hampshire

In 2018, NH received a five-year grant from SAMHSA to provide integrated behavioral and physical health care within the services of Community Mental Health Centers (CMHCs) in New Hampshire to improve health and wellness for its young people with serious emotional disturbance (SED), and serious mental illness (SMI).

This project called the ProHealth NH program, has since delivered integrated medical and behavioral health care, recovery, and wellness services in 3 NH communities (Greater Manchester, Greater Nashua, and Strafford County). 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 the three CMHCs with this project. The other seven CMHCs in the State have also implemented or are now implementing an integrated care program.

The ProHealth program has enrolled over 639 youth and young adults aged 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.

Continuing evaluation, training, and consultation are being provided on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through participating CMHCs and FQHC partnerships. Per SAMHSA guidance, evaluations will measure effectiveness in identifying and addressing serious emotional disturbance, severe mental illness, severe and persistent mental illness, and physical health indicators earlier and improving health outcomes for youth and young adults with mental illness.

NH DHHS continues to conduct the evaluation and reporting of outcomes consistent with federal project requirements to be able to examine the resulting 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.

CCBHC Introductory Efforts

On 3/15/23, SAMHSA awarded NH DHHS a grant of $1 million to fund planning activities for implementing CCBHCs in New Hampshire.

There are three project goals in this CCBHC Planning grant to help the State to build efficiencies and increase the quality of integrated community-based mental health and substance use services through potentially implementing the CCBHC model in NH:

1. Develop and implement a certification system for CCBHCs in NH,

2. Establish Prospective Payment Systems (PPS) for Medicaid reimbursable services, and
3. Prepare an application to participate in a four-year CCBHC Demonstration program

These three goals are vital to the potential establishment of a CCBHC model of service – integrating physical health care with behavioral health care and substance use treatment – across New Hampshire's current Community Mental Health and Substance Use Disorder treatment systems.

Support for integration through MCOs

New Hampshire contracts with three Managed Care Organizations (MCOs) supporting integration with 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 MCO accomplishments include:

- Developed provider resource packets 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 the 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
- Provided training and education to all providers with a focus on a whole-person approach, reducing the 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 24/7 nurse advice line to their entire provider network
- Supported expanded implementation of Medication Assisted Treatment (MAT) for people with substance use disorders in conjunction with the

Doorways established in New Hampshire. Doorways are points of entry for people seeking help for substance use.

4. Describe how the State provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the State vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:
    a) Adults with serious mental illness
    b) Adults with substance use disorders
    c) Children and youth with serious emotional disturbances or substance use disorders

In 2020, NH DHHS contracted with Collective Medical Technologies (now Point-Click-Care, which acquired the original contractor). This company provides the software infrastructure to support event notification, admission/discharge/transfer (ADT), and shared care plan development through an online and integrated platform utilized by over 50% of NH's community hospitals, many nursing homes, FQHCs, CMHCs, other clinics, State IMDs, the Department's three Managed Care Organizations, etc. This platform can be integrated with various electronic medical record/health information technology solutions to quickly capture and transmit ADT data between a patient's applicable providers to support effective and prompt care coordination.

As part of the Department's SUD/SMI/SED IMD waiver demonstration in 2022, the Department also launched plans to implement a closed-loop referral solution after engagement with the solution ended under another demonstration (the Department's 2015-2020 1115 demonstration, known as Building Capacity for Transformation). In that demonstration, a closed-loop referral solution was selected and implemented by the participating IDNs. After the conclusion of the first demonstration, the Department sought and secured legislation for authority to pursue a new statewide closed-loop referral solution. Once fully implemented (target mid-2024), this solution will ensure that medical and non-medical community-based providers and organizations have a platform that can share client/patient-specific information to effectuate referrals between providers of the services needed by the individual. Interfaces and interoperability with the Collective Medical ADT event notification system, key provider groups, and State agencies' case management or electronic business information systems will be incorporated. These emerging technologies are included in the Department's SUD/SMI/SED IMD waiver demonstration and are supported through funding with CMS.

To ensure effective implementation of these solutions and support

community-based provider engagement with them, the Department launched a Care Coordination Initiative in 2022, including Senior Project Management resources and Executive Sponsorship. A Statewide Governance Committee will also be incorporated to ensure that a multi-organization/agency approach to the ongoing success of these solutions is consistently and collaboratively pursued.

5. Describe how the State supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders and mental disorders. Please describe how this system differs for youth and adults.

Within Departmental contracts with providers, including the three Managed Care Organizations, the Department includes provisions to assess individual needs, inclusive of mental health and substance use disorders, and to provide the needed services or refer individuals to applicable providers, as well as to work together on collaborative care approaches, etc. This becomes a more consistent and supported focus for Medicaid beneficiaries who need targeted case management services. For youth Medicaid beneficiaries, in addition to the above approaches, individual service options can be developed if needed, and specially contracted case management entities can be utilized to facilitate access to specialty care.

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

2. Health Disparities - Required

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[38], *Healthy People, 2020*[39], *National Stakeholder Strategy for Achieving Health Equity*[40], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).[41]

Collecting appropriate data are 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.[1] 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.[2] 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, LGBTQI+ 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 evidencebased and promising practices in a manner that meets the needs of the populations they serve.

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

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

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

[41] http://www.ThinkCulturalHealth.hhs.gov

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

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

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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

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 **X**☐Yes ☐ No
   - b) ethnicity X☐Yes ☐ No
   - c) gender X☐ Yes ☐ No
   - d) sexual orientation X☐ Yes ☐ No
   - e) gender identity X☐ Yes ☐ No
   - f) age X☐ 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 subpopulation? ☐ 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?

The State of New Hampshire continues to perform routine quality improvement initiatives for all data submitted to the Mental Health and Substance Use Database (Phoenix) to reduce null, missing, incomplete and inaccurate data identified. This includes elements of both client and service data.

1. The data system used by the Bureau of Mental Health Services (BMHS), Phoenix, can 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 supports the CMHCs 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, specifically focusing on racial, ethnic, language, gender, sexual minorities, and individuals with disabilities. OHE provides coaching and TA to SMHA and external organizations to improve systems and practices for organizations 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 can access spoken and signed language interpreters on-site and available through agencies such as Certified Languages International and the Language Bank. All CMHCs have the 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 2022 Community Mental Health Consumer Survey, administered by JSI Research & Training Institute through the application of MHBG BHSIS funds, 1,694 adult clients were invited to participate in the Adult Survey, and 1,167 Family members of children receiving services were invited to participate in the Family Member Survey to enable assessment of satisfaction scores and behavioral outcomes. 622 or 40% of the selected adult clients and 432 or 39% of the selected family members responded to the survey. The Surveys were provided in English and Spanish when indicated. They 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 provided.

- 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 (77%), general satisfaction (79%), and self-determination (75%). Seventy-one percent of clients were satisfied with their participation in treatment planning. The health and wellness (69%), social connectedness (61%), functioning (56%), and treatment outcomes (50%) domains were lower.
- From 2020 to 2022), there was a statistically significant difference in the health and wellness domain, which increased from 59% in 2021 to 69% in 2022; however, this is likely due to three items and questions being revised in 2022.
- Domain scores were compared across the last three years. Overall, there were no statistically significant differences in satisfaction scores between male and female clients.
- There were statistically significant differences in the three domains by age group. Respondents aged 25-44 had lower satisfaction in the access, general satisfaction, and self-determination domains. Respondents aged 65+ had higher satisfaction in health and wellness, and 70% of clients aged 65+ were satisfied with access, general satisfaction, and self-determination.
- Clients receiving services for one year or more had statistically significantly higher satisfaction with participation in treatment planning (73%) than those who received services for less than a year (57%).
- Currently employed clients had similar satisfaction scores compared to those unemployed in all nine domains. There were no statistically significant differences in the domain.

- Among family members of children receiving services, satisfaction scores were at least 80% or higher in four domains. The highest was in the area of cultural sensitivity of services (94%), followed by participation in treatment planning (85%), social connectedness (80%), access to services (83%), and General Satisfaction (72%).
- Domain scores were compared across the last three years (2020-2022) to determine whether there were any changes in satisfaction over time. There were no statistically significant differences when comparing 2022 domain scores to 2020 or 2021.
- There was no statistically significant difference in satisfaction of family members of children receiving services between male and female children or age groups.
- There were significant differences in the participation in the treatment planning domain by the length of time receiving services. Those who received services for one year or more had significantly higher satisfaction with participation in treatment planning (73%) than those who received services for less than a year (57%).

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

N/A

3. Innovation in Purchasing Decisions - Requested

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 valuebased strategies and structures will be important to the development of M/SUD systems and services. The National Center of Excellence for Integrated Health Solutions[44] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the

[44] https://www.thenationalcouncil.org/program/center-of-excellence/

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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,[3] The New Freedom Commission on Mental Health,[4] the IOM, NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[5]

One activity of the EBPRC[6] was 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."[7] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[8] are best practice guidelines for 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)[9] 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. Each 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

[3] 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, US Public Health Service

[4] 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 use disorder and Mental Health Services Administration.

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

[6] https://www.samhsa.gov/ebp-resource-center/about

[7] http://psychiatryonline.org/

[8] http://store.samhsa.gov

[9] https://store.samhsa.gov/?f%5B0%5D=series%3A5558

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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services. 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) ☐ Leadership support, including investment of human and financial resources.
   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all-payer/global payments, pay for performance (P4P)).
   h) ☐ 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
The State continues contracting with three Managed Care Organizations (MCOs), including a Per Member Per Month (PMPM) rate required for all ten regionally-based CMHCs. These rates are based on the CMHC eligibility status of the Medicaid beneficiary according to acuity levels (e.g., degree of impairment caused by the member's serious mental illness) to ensure a rate consistent with meeting their anticipated CMH service utilization needs. Through this model, CMHCs receive one monthly payment encompassing most Managed Care Program covered services provided to beneficiaries at one rate. The remaining balance of Managed Care Program covered services are required to be reimbursed as a directed payment from the MCOs to the CMHCs, at a minimum fee schedule that is equivalent to the Department's fee-for-service schedule to ensure CMHCs are reimbursed for the total cost of care.

Integration Services

Additionally, the three MCOs have supported the integration of physical health services by promoting the values of whole-person care and fostering 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 receive recommended outpatient screening and treatment for physical and mental health conditions. Such treatment will reduce unnecessary emergency room visits and hospital stays.

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 payment models in the State since 2019. These payment models are specifically designed to improve mental health outcomes and are adjusted each year to ensure an approach that is responsive to trends specific to the NH Medicaid beneficiary population's behavioral health needs.

For the past two years, the directed payment approach includes $5m allocated to:

- Support Assertive Community Treatment (ACT) teams' ability to provide ACT services with fidelity within the 10 CMHCs;
- Ensure prompt and continued access to community-based care through the same day/next day face-to-face service to individuals within 24 hours of discharge from a State IMD or designated receiving facility (DRF), and an additional payment for each subsequent, consecutive weekly (7-day period) with a face-to-face service, up to 90 days. These payments are anticipated to result in decreased readmission rates;
- Timely prescribing for new individuals determined eligible for CMHC services. This payment is attached to the individual's intake and followed by an appointment with the CMHC prescriber within 21 days. It is anticipated to reduce ED visits and readmissions for those individuals not already connected to the State's CMH system.
- Support effective Illness, Management, and Recovery (IMR) program participation. This payment is made if a beneficiary receives at least one hour per week of IMR services for at least 10 out of 13 weeks in 13 weeks. It is anticipated to reduce ED visits and readmissions for program participation.
- Support beneficiaries who are dually diagnosed with a developmental disability and serious mental illness who are being discharged from New Hampshire Hospital with a need to transition to a more community-integrated living situation. This payment supports the specialty residential services they

will need, including receiving coordinated care through a multidisciplinary approach that crosses the MH and DD systems.

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 and 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 service's staff, whether it be a masters-level clinical, bachelors level staff, or 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 improving the quality of EBP's required by the CMHA and in their contracts. Each center can draw down money to achieve a score of "3" in 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. The frequency of service must occur between 2-3 times per week per individual to score a 3. Additional areas will also increase efficacy by addressing both frequency and intensity of services, such as the team approach within the ACT model. The following contract year is anticipated to increase the incentive requirement in these two areas to a score of 4 or 5, thus taking a step-wise approach to quality improvement.

Substance Use Disorder, Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access (SUD SMI SED TRA) 1115 Medicaid Demonstration

The State's 2018 Demonstration originally encompassed SUD IMDs. This demonstration gives the Department authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and

inpatient settings that qualify as an Institution for Mental Diseases (IMD). It also builds on the State's existing efforts to improve models of care focused on supporting individuals in the community and at home, outside of institutions, and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

On June 2, 2022, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to amend the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. The approved amendment increases access to treatment for Medicaid beneficiaries with serious mental illness (SMI). It helps reduce the number of people waiting in hospital emergency departments (EDs) for a mental health bed. The amended waiver allows the New Hampshire Medicaid Program to pay for short-term stays in IMDs provided to Medicaid beneficiaries between ages 21-64 with SMI and approved for full Medicaid benefits.

On June 16, 2023, the Department received approval from CMS to temporarily extend the Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance-Dentures Treatment Recovery and Access Demonstration Waiver. Within the Department's extension request, an additional component was sought to provide Medicaid coverage to incarcerated individuals approaching release from the State's correctional system, who would otherwise be eligible for Medicaid if not for the incarceration and who have a history of mental illness or SUD. This component would provide a limited Medicaid benefit to facilitate timely access to community-based mental health and SUD services upon release, such that Medicaid would be opened for a 45-day pre-release period to ensure all eligibility, assessments, and care plans could be coordinated between existing State correctional providers, the targeted new community-based providers, and the State's Managed Care Organizations. The anticipated outcome of this limited benefit is to reduce ED and hospital stays, as well as correctional system recidivism, by providing continuous access to needed care for this vulnerable population. The Department's request to add this component is under review, and CMS is actively working with the Department to guide development and potential approval.

Other non-fiscal strategies

In addition to financial incentives, the State has implemented the below strategies to ensure evidence-based or promising practices guide purchasing and policy decisions:

- Independent fidelity reviews for IPS-SE and ACT are conducted annually for all 10 CMHCs. If the CMHC scores in the highest fidelity bucket, they are incentivized by being able to "skip a QIP," meaning they do not have to develop a comprehensive quality improvement plan for that fiscal year.

- Quarterly data reports are generated using monthly validated data submissions from the CMHCs regarding service delivery and utilization. Decisions about program expansion and funding are made as a result of data reporting.
- The Department and MCM providers review quarterly data submitted by the State's MCM providers to drive policy and practice decisions.
- Hold contracts with independent experts to provide training, technical assistance, and evaluation of evidence-based programs for providers in areas such as Critical Time Intervention, First Episode Psychosis, Illness Management and Recovery, MATCH, and crisis services.
- The annual client satisfaction survey informs program and practice improvement via a collaborative annual review and quality improvement plan.

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

N/A

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

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 individuals 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.

States 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 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.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with an SMI.

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for SMI/FEP	Number of programs
NAVIGATE (Coordinated Specialty Care)	4

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY 2025

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

All of the CSC ESMI/FEP programs are operated by the State's designated CMHCs. Therefore, for individuals who are Medicaid eligible, the providers are able to bill on a per member/per month basis per terms of their contract with the MCM. Medicaid billing includes reimbursement for individual services provided through the CSC model such as prescription services, medication monitoring, supported employment/education, therapy, functional support services, and case management. Some individual services are billable to private insurance such as prescriber services and therapy. There are currently no specialized rates or billing categories for CSC. Any services, not otherwise billable through Medicaid or private insurance, are supported using MHBG funds.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

HOPE (Helping Overcome Psychosis Early) is a treatment program offered by 4 NH Community Mental Health Centers: Greater Nashua Mental Health, Monadnock Family Services, Seacoast Mental Health Center, and the Center for Life Management. All 4 teams are trained in the NAVIGATE (formerly RAISE) model. NAVIGATE is a model of Coordinated Specialty Care that includes Family Education (FE), Clinician, Psychiatric Medication treatment, Individual Resiliency Training, and Supported Employment and Education provided in a coordinated manner by a team of individuals who work closely together to help individuals with FEP and their families. In New Hampshire, case management and functional support services are also offered to individuals who need them. This form of treatment was shown to be effective for people with first episode psychosis in a randomized controlled trial (Kane et al, 2016).

Each of the 4 Community Mental Health Centers bill for the individual services through client's insurance, as applicable. For those clients who are "un" or "under" insured, there is $60,000 of MHBG dollars allotted to meet their service needs.

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

Additionally, the State has a contract for the provision of a statewide Evidence-Based Center of Excellence that provides training and technical assistance for the Coordinated Specialty Care (CSC) model of treatment for ESMI/FEP. CSC uses a team of health professionals and specialists who work with a person to create a personal treatment plan based on life goals while involving family members as much as possible. The Statewide Center of Excellence helps to bridge gaps between research, policies and practices for an evidence-based CSC model for the treatment of ESMI/FEP through a collaborative and supportive effort with the Community Mental Health Centers (CMHCs) within New Hampshire. The Center of Excellence provides services including training, consultation services, technical assistance, and program fidelity reviews.

BMHS staff meet monthly with the CSC teams to monitor and support service implementation and quality. Programs participate in a learning collaborative of ESMI/FEP-focused programs hosted by our Center of Excellence. Programs receive ongoing training, technical assistance, and consultation to develop and maintain service quality, and fidelity reviews to track telehealth psychiatry services for the participating regions that do not have a current psychiatrist on staff who can meet the needs of their ESMI/FEP clients and improve adherence to the evidence-based practice.

The PEARLS (Psychosis Early Action, Resource and Learning Services) team, which is based at Dartmouth College, have hired staff and begun formal training with the national NAVIGATE team. They have completed almost a year's worth of training to become NH's statewide training and CSC Technical Assistance resource. NH's PEARLS team has partnered with CMHCs that did not already offer FEP services and that have a minimum of 8 individuals enrolled in the CSC program, to offer training and support to meet the regional needs.

Starting in SFY 2019, New Hampshire has engaged in an ESMI/FEP development and planning project with contractors, including the National Alliance on Mental Illness, New Hampshire (NAMI NH) and Dartmouth-Hitchcock, an academic partner with ESMI/FEP expertise.

NAMI NH continues to host monthly stakeholder workgroup meetings open to the public to provide updates about CSC implementation and to receive feedback about implementation and outreach efforts.

FEP Steering Committee meetings also continue with representation from key stakeholder groups, including CMHC administrators and providers, individuals with lived experience, family members, and peer support agencies. The purpose of the Committee is to give input on the implementation of CSC teams around the state, help the team interpret and incorporate stakeholder feedback, and make recommendations for quality improvement of the statewide model of CSC.

Through a contract with the BMHS, NAMI NH developed the "Onward NH" public awareness campaign to help New Hampshire residents recognize ESMI/FEP, connect quickly to resources and support, and understand there is hope – recovery is the expectation. Onward NH launched in May 2020 and is informed by research that spanned public awareness campaigns across the country and features curated content for individuals, family members/friends, providers, and educators. Personal stories from each of these perspectives are featured, alongside resources to help recognize ESMI/FEP, and opportunities for treatment and support throughout New Hampshire.

NAMI NH also led the development of 603 Stories, an anti-stigma campaign to combat discrimination and stigma around mental health conditions. During months of research, stakeholders responded to samples of national anti-stigma campaigns, while also weighing in on practices in their lives that had proven effective at decreasing stigma. The most consistently received feedback noted that stigma was reduced when relationships were built and stories were shared. Making those connections allowed for the individual to be truly seen as an individual, beyond their mental health condition. 603 Stories was born of this research and feedback, with the goals of making connections (via story sharing and virtual events), directing folks to help (via Onward NH), and instilling hope. Target audiences mirror those of Onward NH, including individuals, family members/friends, providers, and educators.

The 603 Stories website and virtual collaborative were launched in fall of 2020. The 603 Stories platform is a curated gathering of stories shared across mediums – including video, essay, visual arts, and more. The site provides a diverse array of stories that will be continuously updated to ensure that they remain engaging and current.

5. Does the state monitor fidelity of the chosen EBP(s)?☐Yes ☐ No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP? ☐ Yes ☐ No
7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Each program actively outreaches various community resources, such as in-patient facilities, peer support agencies, primary care physicians, and other mental health services providers, to coordinate care at the time of discharge and facilitate referrals. In some cases, the individual CMHCs have alternative admission processes to shorten a client's wait to begin ESMI/FEP service treatment. Some of our HOPE programs will provide services to those outside of their catchment area, when no other FEP provider is available in the client's home community.

8. Please describe the planned activities in FY2024 and FY2025 for your state's ESMI/FEP programs.

Planned activities include:

- Completion of training of NH's PEARLS team on a train-the-trainer model, so that NH can support training its own clinicians in the NAVIGATE/CSC model.
- Branding all CMHCs to reflect consistent statewide services for ESMI/FEP clients.
- Continued support of ESMI/FEP un-and under-insured clients with general funds.
- Supporting continual outreach in the community and ongoing enrollment in ESMI/FEP services.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Individuals aged 16 to 35 are served by the ESMI/FEP CSC programs. If an individual outside of this age group is identified, the program may submit a request to serve the 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 (including Schizophreniform and Schizoaffective disorders) to include additional ESMI diagnoses such as Major Depressive Disorder and Mood Disorders, and others that can cause serious impairment.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Less than 2% of the overall population in NH.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

All 4 existing locations of the HOPE (Helping Overcome Psychosis Early) treatment program are nestled within Community Mental Health Centers for easy access to other provided supports. Integration with the CMHCs is the basis of NH's future strategic plan for ESMI/FEP services. Outreach to private and State operated hospitals and clinicians through the NAMI NH network is also part of the outreach strategy.

12. Please indicate area of technical assistance needed related to this section.

Alternative uses for ESMI/FEP funding. In NH, the allocation is larger than the number of teams the State can support – ideas about additional ways to use ESMI/FEP set-aside funds to meet the intention of early intervention and prevention would be welcomed.

5. Person Centered Planning (PCP) –Required for MHBG

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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems https://ncapps.acl.gov/home.html with a systems assessment at https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf.

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.

N/A

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

NH DHHS is dedicated to supporting, promoting, and requiring person-centered planning, to ensure that individuals are fully involved in making decisions about their treatment. In the person-centered system that NH DHHS strives to maintain, individual needs, goals, and values are respected and acknowledged. This approach involves a collaborative partnership between individuals and providers to ensure that each person's values, experiences, and knowledge play a central role in developing a

personalized plan of care and delivering services that focus on their strengths.

Every individual, regardless of age, disability, need, or residential setting, has the right to have an individual support plan developed through a person-centered planning process. The person, along with their family, takes the lead in making healthcare decisions and becomes an equal partner in the planning and delivery of care. This approach acknowledges and honors the unique values, preferences, and circumstances of each individual, leading to increased engagement, ownership of treatment, and adherence, all while upholding the dignity of the person.

Additionally, individual engagement in the development of the individualized service plan is required in State Administrative rule He-M 401.10 (m). The individual service plan is required to include the signature of the consumer/guardian as indication of approval of the plan.

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

New Hampshire strives to maintain 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 Regulation 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 bi-annually with the individual or the individual and their care takers/natural supports/or family with the expectation that the services provided are reviewed to establish an ongoing need from both the provider and the individuals' perspective.

The Bureau of Mental Health Services (BMHS) strongly advocates for and mandates person-centered planning, ensuring individuals' active involvement in their treatment decisions. The state utilizes the CANS/ANSA collaborative tools, which involve the individual and their natural supports in guiding, prioritizing, and supporting treatment choices. Through these tools, a collaborative conversation takes place between the individual, provider, and relevant natural supports to identify strengths and needs, which then translate into goals for the individual service plan. Ratings generated by the New Hampshire version of the CANS or ANSA assessment are utilized to develop individualized, person-centered treatment plans, ensuring that the treatment approach is tailored to each individual's unique needs and preferences.

BMHS 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 BMHS's own 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.

BMHS is dedicated to continuous quality improvement, focusing on enhancing the performance, efficiency, and effectiveness of our

services, with a particular emphasis on person-centered treatment. Our quality improvement initiatives encompass various components, such as the annual Quality Service Reviews (QSR), Managed Care Organizations (MCOs) chart audits, Client Satisfaction Survey, and the Assertive Community Treatment (ACT) and Supported Employment (SE) fidelity reviews. Each of these evaluations includes specific assessments and considerations related to person-centered treatment delivery and planning, ensuring that the individual's needs and preferences remain at the forefront of our care approach.

For example, during the annual Quality Service Reviews of the 10 NH Community Mental Health Centers over the past fiscal year (SFY23), it was found that the scores of 6 out of 10 of the CMHCs were below the state's threshold for providing adequate individual-specific goals, objectives, action steps, and prescribed services that were customized to meet the individuals' identified needs and help achieve their goals. Quality Improvement Plans were then required of each of these CMHCs, and their progress in making improvements to meet those person-centered planning thresholds has been tracked on a quarterly basis to monitor quality improvements.

For individuals in crisis, 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. 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.

Starting in SFY23, NH has implemented Critical Time Intervention (CTI) services at all 10 of its Community Mental Health Centers to support individuals in maintaining recovery after discharge from inpatient hospitalizations. Driven by person centered goals, CTI ensures those individuals have intensive supports available during the initial 9 months of discharge, to improve recovery and quality of life while lowering readmission rates and costs.

Lastly, ensuring that 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.

6. Program Integrity - Required

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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-sharingassistance-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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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. New Hampshire's (NH) Mental Health Block Grant (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
The NH Bureau of Mental Health Services (BMHS) ensures that recipients of mental health services can have full confidence in the confidentiality of their medical information. All Community Mental Health Center (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, PSA 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 a BMHS 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 BHPAC membership is informed of survey progress and are offered opportunities to inform the process. The survey vendor, by contract, is required to present the survey findings and report to the BHPAC, 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 BMHS.

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 2022, 39% of NH MHBG funds were directed to fund the BMHS contracts with 8 independent, non-profit, Peer Support Agencies (PSAs) that provide services at 14 physical locations, thus 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 BMHS 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 annual budgets, monthly financial reports, and quarterly outcomes reports to the BMHS. PSAs undergo annual financial reviews conducted by outside auditors. Audit reports are submitted to the BMHS Financial Management department, and are reviewed and reconciled by the NH DHHS Bureau of Program Integrity.

The BMHS Office of Consumer and Family Affairs conducts annual Mental Health Consumer Satisfaction Surveys of the PSA agencies. The surveys can be completed by paper or via Survey Monkey. In 2019, 339 responses were collected. For the most recent survey, calendar year 2021, 198 responses were collected. BMHS worked on modifying the survey over calendar year 2022 to improve respondent experience and usefulness of experiential data collection. BMHS will be distributing the new survey in August 2023.

In 2018 – 2019, BMHS conducted quality reviews of PSAs for contractual and administrative rule compliance. The review team consisted of several members from BMHS and two staff members from NH DHHS 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 BMHS. Upon completion of all corrective actions, final reports approved and distributed. The process will be repeated on a biannual basis.

As a result of this review, BMHS contracted with the NH Center for Non-Profits, in SFY2020 and 2022, to provide individualized consultation services, training and support, with the focus on improving agency governance, fiduciary oversight and programmatic enhancement. These contracts have been funded by 100% federal funds.

In 2022, BMHS conducted quality reviews of the four (4) Recovery Orientated Step Up Step Down (SUSD) programs. These program contracts are also held by the PSAs. The review team consisted of several members from BMHS and two-four staff members from NH DHHS Bureau of Program Integrity. PSAs were notified of the SUSD review in a detailed letter describing the review process and requesting initial programmatic, policy and financial information. These reviews concluded in SFY 2022 and post-review, program and financial findings are being written in formal reports, to be distributed in the first quarter of SFY2023.

Other Programs Supported and Monitored by BMHS:

NH Behavioral Health Planning & Advisory Council (BHPAC)
The MHBG State Planner oversees the activities of, and provides support to, the NH Behavioral Health Planning & Advisory Council (BHPAC). The role of the MHBG State Planner within the BHPAC involves monitoring for the appropriate and effective use of MHBG dollars in support of the Council's activities. Conversely, the BHPAC reviews and provides feedback on the priorities to which BG funds are directed by BMHS.

MHBG funds allocated for the support of the BHPAC 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 BMHS and DHHS Finance departments before being paid.

BHPAC membership is unpaid; only peers (recipients of mental health services) and family members who are not participating in the council as part of their paid employment are eligible for mileage reimbursement. The BHPAC 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 BHPAC. All funds are disbursed through a cost-effective and compliant process. Other reimbursements or stipends to BHPAC 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 MATCH trainer certification is provided via a contract with Judge Baker Children's Center (affiliated with 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.

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 in children and youth, via the CANS, and for SMI in adults, via the ANSA. The goals is to utilize these instruments as a standard assessment tool statewide throughout the youth and adult systems of care. 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.

Since 2013, the State of New Hampshire has provided technical assistance in the form of CANS and ANSA online training and support for the certification of clinical staff employed by the CMHCs, and by statewide partners throughout the children and youth System of Care, including participants in FAST FORWARD (a Wraparound program), and other community-based partnerships. 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 BMHS Finance Department. Status and balance reports are provided to the MHBG State Planner and BMHS 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.

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

7. Tribes – Requested

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[52] 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.

[52] https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

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 have 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

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

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 2021, there were 107 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: FY21 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 NH.
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 NH.
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 NH, 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 BHPAC have identified the Council as a potential source of BHPAC members. In SFY 2024 a more detailed focus will be applied to council and subcommittee membership as a whole with more of a guiding force from the SMHA.

9. Statutory Criterion for MHBG (Required 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.

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 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 high-quality services are comprehensive and evidence-based.

Community Mental Health Centers

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 (CMHC), and all ten of NH's Regions have Peer Support Agencies providing community-based services.

CMHCs provide comprehensive mental health services to individuals and families across the age span within their catchment area. CMHCs are essential to the State's mental health system, offering a wide range of services to people with various mental health and substance use disorder needs providing accessible and affordable care to individuals of all ages, regardless of their ability to pay. The centers offer psychiatric evaluations, counseling, therapy, crisis intervention, medication management, case management, peer support, housing services, functional support services, and support groups. Additionally, evidence-based programs such as Assertive Community Treatment (ACT), Individual Placement and Support (IPS) Supported Employment, Critical Time Intervention (CTI), Coordinated Specialty Care, and MATCH are delivered through the CMHC provider network.

CMHCs are crucial in supporting individuals with severe mental illnesses (SMI) and severe emotional disturbances (SED) in their recovery journey and in helping them achieve stability and independence. They often collaborate with other healthcare providers, government agencies, and community organizations to create a support network for individuals with mental health needs.

The services provided by Community Mental Health Centers are vital in promoting mental health and wellness within the community, reducing hospitalizations, and improving the overall quality of life for those they serve.

Administrative Rules for CMHCs detail the community-based psycho-rehabilitative services available in NH that are provided with BMHS 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: CHAPTER He-M 400 COMMUNITY MENTAL HEALTH: He-M 401-421 (state.nh.us)
NH contracts with three Medicaid Managed Care Organizations (MCOs). These contracts include provisions that MCOs maintain ongoing relationships with the 10 CMHCs within NH, ensuring services are reimbursable and supported. Each MCO submits a quarterly report identifying individuals admitted to a psychiatric hospital and readmitted within 30 or 180-day days after the initial re-admission. The re-admission report allows the MCO and NH DHHS to conduct continuous quality improvement on services or lack thereof. Ongoing work is being conducted to present these reports to the CMHCs and utilize them for continuous quality improvement.

NH has created a Children's System of Care to organize services into five tiers or levels based on what services our children, youth, and families need: from lower levels of care (Tier 1) to the highest intensity, which is hospital care and psychiatric residential treatment (Tier 5). Assessments are provided at each Tier to ensure that your child or youth is matched to the best service, support, or treatment given their needs. Tier 1 services are for youth and families trying to determine their needs. In tier 2, you will find outpatient behavioral healthcare, treatment, services, and short-term care coordination. Tier 3 includes services and supports for children and youth with complex mental health or substance use concerns but can still be in the community with intensive in-home support. Tier 4 is out-of-home residential treatment, which provides care for children and youth who need short-term treatment for a serious mental or behavioral health concern. A Comprehensive Assessment for Treatment (CAT) is required to enter Tier 4 care. Residential Treatment Providers or NH's Psychiatric Residential Treatment Facility (PRTF) provide this level of care. In contrast, Transitional Enhanced Care Coordinators provide care coordination. Tier 5 services are inpatient psychiatric treatment provided in a hospital setting, including short-term hospitalization and intensive residential treatment.

Peer Support Agencies
Peer Support Agencies (PSA) provide an alternative to traditional clinical treatment delivered by individuals with lived experience of mental illness

and/or substance use disorders. These individuals, often referred to as "peer support specialists" or "peer counselors," have gone through their recovery journey and are trained to provide support and guidance to others facing similar challenges.

The Peer Support Agencies in NH play a crucial role in the mental health system by offering peer-to-peer support, which can be particularly effective in helping individuals experiencing mental health struggles achieve and maintain their recovery goals. Peer support services are based on the principles of hope, empowerment, and shared experience, and they focus on fostering a sense of belonging, self-efficacy, and community integration.

These agencies provide various services, including one-on-one peer counseling, support groups, wellness and recovery planning, advocacy, respite, and assistance in navigating mental health services and resources.

NH PSAs contribute to enhancing mental health care accessibility and promoting recovery-oriented approaches to mental health services. They provide valuable support to individuals seeking to improve their mental health and lead fulfilling lives in their communities.

Recover Orientated Step Up/Step Down
In December 2020, New Hampshire first entered into a contract with four (4) Peer Support Agencies; each to operate a three-3-bed Recovery-Oriented Step Up/Step Down Program. Initial program locations were in Nashua, Manchester, Keene, and Northwood, NH. Additionally, in 2022, Keene expanded to hold two (2) SUSD contracts totaling six (6) beds. These programs offer a new level of crisis care in NH. The Step-Up/Step-Down Programs provide short-term recovery-based transition services for adults (18 years or older) transitioning from inpatient or institutional settings into the community or requiring 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, seven days a week. Staff focuses on recovery-oriented peer support services that also work to coordinate and engage with outpatient community-based clinical treatment providers. Programs are operated per the SAMHSA Core Competencies for Peer Support Workers in the behavioral health system and accept referrals from many community-based treatment providers. Each Program has kept its beds full by over 80% since opening, and most have waiting lists. In 2022, the Department increased stay limits to 120 days per episode of need to allow more time for stabilization and transitional steps back into the community.

Peer Respite
NH has two (2) long-standing contractors within the peer support agency vendors, who provide two (2) peer respite beds per agency, totaling four (4) beds statewide. These programs provide non-clinical peer supports with

access to peer staff twenty-four (24) hours a day, seven (7) days per week. Staff focus on recovery-oriented peer support services and enhancing community connection to support individuals maintaining recovery in their community. Historically these programs have a seven (7) day stay limit; in 2022, the Department increased stay limits to 10 days per episode of need to allow more time for stabilization and transitional steps back into the community.

Transitional Housing Residential Services
The NH BMHS, through contracted providers, 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 inpatient hospitalizations back into the community, where they can manage their needs with the help of a CMHC. This way, support is titrated from intensive treatment to independence, preventing frequent hospital re-admissions. 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, including:

- 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 include Illness Management and Recovery and Supported Employment.

Comprehensive Crisis Response
NH is actively expanding and transforming its crisis services to create a comprehensive and integrated crisis response system for individuals of all ages experiencing mental health and/or substance use crises. This initiative is aligned with the national Crisis Now model and has been gradually implemented over the past two years. It now encompasses a full continuum of care, including location-based crisis intervention. Crisis services include:

- The New Hampshire Rapid Response Access Point (NHRRAP) is the centralized crisis contact (call, text, chat) center designed to act as the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services. NHRRAP also can deploy the closest available mobile crisis team promptly. Individuals in NH have

immediate, around-the-clock access to mental health and substance use crisis support through NHRRAP via various communication channels, including telephone, text, chat, and telehealth services.

- Statewide NHRR Mobile Crisis Response Teams (NHRR): These teams operate 24/7, providing mobile crisis intervention services. Comprising two specially trained crisis responders, MCRTs can respond to requests for crisis assessments and interventions within one hour of receiving calls. Once engaged with a case, MCRTs can offer services and supports for up to 30 days after the crisis, ensuring individuals remain stable and receive the necessary assistance within their community.
- Crisis Apartment Beds: Available in the Nashua, Manchester, and Concord regions, Crisis Apartments serve individuals aged eighteen (18) years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to 7 days per episode and sometimes longer when necessary.
- Currently in the process of implementing two location-based crisis centers. These crisis centers will offer short-term (23-hour) observation and crisis stabilization services, accommodating all referrals in a homelike, non-hospital environment and 7-day crisis apartments for individuals and families.

Through these initiatives, NH aims to ensure that individuals in crisis receive timely and effective assistance, promoting their well-being and recovery while fostering a sense of stability and connection within their communities.

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-occurring 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 for Children's Behavioral Health (BCBH) and 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 reinforces coordinating 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 specialized SUD treatment services directly. Still, all refer to close partners in SUD treatment based on identified needs. 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 NH DHHS DBH. Detailed financial and programmatic strategies require ongoing development to address the continuum of care. Cross walking of both DBH 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 bureaus within DBH work together to oversee the behavioral health components of the MCO contracts to ensure contract terms, performance metrics, and quality improvement efforts meet the expectations and needs of all individuals with behavioral health needs.

The five tiers of NH's Children's System of Care each have a level-appropriate screening tool to identify the best match of individual services for our clients. Tier 2 has our CMHCs utilizing the Child and Adolescent Needs and Strengths (CANS) tool as eligibility for services. Tier 3 utilizes the CANS, as well, in companionship with additional high-fidelity wraparound tools to identify the underlying needs of the clients to best reach effective change for themselves. Tier 4 utilizes that CAT, of which a CANS assessment is one component, followed by a psychosocial interview and client record review to best identify the appropriate level of care for the client. Tier 4 & 5 offer additional oversight of treatment and support to our families through our Traditional Residential (& Psychiatric) Enhanced Care Coordination (TR-ECC), which is a model designed to guide families through the process of helping a youth or child come back into the community or a lower level of care if they are in a residential treatment program, or to find and receive an episode of residential treatment when needed.

3. Describe your State's case management services

Community Mental Health Case Management

The philosophy of case management stems from the concept of wellness. 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 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. 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 needs 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 can select the agency to manage their case.

Supported housing programs in NH for individuals with SMI/SPMI who qualify and provide case management as an essential support. The Program shall provide case management services if the individual still needs a case manager

.

Supporting individuals diagnosed with SED and SMI to help them integrate into their community of choice is a crucial 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 bi-annually) 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

4. Describe activities intended to reduce hospitalizations and hospital stays.

The NH community mental health system, is designed to offer high-quality services across various intensity levels, including outpatient services and hospitalization for individuals who require that level of care. Timely and effective outpatient services have proven instrumental in preventing illness exacerbations for many people with Serious Mental Illness (SMI) and Severe Emotional Disturbance (SED), reducing the need for hospitalization.

Among the most effective community-based services supported by the BMHS (through contractual arrangements) are Critical Time Intervention (CTI), Functional Support Services, Assertive Community Treatment, Supported Employment, Supported Housing, Mobile Crisis Response Teams, First Episode Psychosis early intervention (FEP), Case Management, Peer Support Center services, including day programs, Step-up, step-down beds, and Crisis Respite. These services play a critical role in promoting the overall well-being of individuals and supporting their mental health needs.

Functional Support Services (FSS)
Functional Support Services (FSS) are core rehabilitative services. FSS workers assist in supporting clients with community integration as needed. Frequent, routine FSS contact can prevent clients from falling through the many social and functional "cracks" that can trigger relapses and hospitalization.

Assertive Community Treatment (ACT)
Assertive Community Treatment (ACT) is a community-based approach that provides mental health services for individuals with severe mental illnesses. Its primary goal is to support individuals in their recovery and enable them to lead successful lives in the community. ACT has proven highly effective in reducing hospitalizations, enhancing overall functioning, and promoting recovery. It is considered a best practice for serving individuals with severe and persistent mental illnesses. The ACT team includes Functional Support Specialists among its members.

Individual Placement and Support - Supported Employment (IPS-SE)
Individual Placement and Support - Supported Employment (IPS-SE) is an evidence-based practice designed to help individuals with severe mental illness find and maintain competitive employment in the community. IPS-SE focuses on assisting individuals in securing jobs that align with their

preferences, interests, skills, and abilities while considering their unique needs and circumstances.

The core principles of IPS-SE include rapid job search, job integration, and ongoing support. The approach aims to place individuals directly into jobs without requiring extensive pre-employment training or workshops. Employment specialists work closely with the individual to understand their vocational goals, provide ongoing job coaching and support, and collaborate with employers to ensure successful job placements and retention.

IPS-SE has been proven to be highly effective in helping individuals with mental illness achieve successful employment outcomes, leading to increased independence, financial stability, and overall well-being. Supported Employment specialists are included on every ACT team and in freestanding Supported Employment programs in all ten CMHCs.

NH Rapid Response Teams (NHRR)
Mobile crisis response teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals in their homes and other community-based settings outside a traditional clinical office. Crisis intervention teams work to intervene with an individual/family in crisis and safely direct them to treatment appropriate for their condition, thus reducing the arrest rate, incarceration, or unnecessary emergency room visits.

Over 1,400 individuals were served by NHRR and Crisis 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 BMHS. As of January 2022, mobile crisis response services have been made available statewide as part of the State's mental health system transformation efforts.

The BMHS implemented the NHRRAP system on January 1, 2022. Before that date, there were up to 20 different numbers that an individual might call for access to crisis services. The goal of NHRRAP was to have one number, regardless of the time of day and/or caller's location, to call for behavioral health crisis support in NH. The State contracted with Carelon (formerly Beacon Health Options) to provide the NHRRAP service. The AP answers calls 24 hours a day, seven days a week. Most calls (80%) are resolved at the "call" level. The RRAP number is 1-833-710-6477.

988 became the National Suicide Prevention Lifeline (NSPL) number on July 16, 2022 (with the former 1-800-273-TALK still in place). The main goal of 988 is to have an easy number to remember, akin to 911. Headrest has been the NSPL call center provider in NH for many years. Headrest continues to answer the calls that come in via 988.

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 strain 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 BMHS to assist individuals experiencing homelessness due to disabling symptoms of mental illness.

The BMHS is working with the 10 CMHCs to accommodate 60 new supported housing beds across NH. These beds include independent units with supportive services, fully staffed residences, and in-home provider housing, a new model for individuals in NH. The BMHS also has a few smaller specialty residential programs, including a 3-bed dual diagnosis, fully staffed residence called Northam House; staff-supported units in the Northern area of the State called the Gilpin Residence; and A Place to Live, which is a temporary voucher program for individuals who need short term rental assistance.

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 Housing Specialists assigned to each individual in the program. The Housing Specialist will assist the individual in finding an appropriate unit, sign and understand their lease, and ensure 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 to vouchers and remain available to the individual should they require further housing assistance.

The SMHA 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 can access the full support services the CMHCs provide. 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 2023.
Total Supported Housing subsidies by the end of the quarter: 1010
Housing Bridge Subsidy: 392
Section 8 Voucher

(NHHFA): Transitioned from Housing Bridge* 310
811 Units: PRA* 164
Mainstream* 75
Other Permanent Housing Vouchers (HUD, Public Housing, VA)* 32

Peer Support Agencies (PSA)
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. PSAs offers support groups, resources, warm line services, community connection, on-site activities, educational events, Recovery Orientated Step-up Step-down (SUSD), and Peer Respite. Peer Respite and SUSD provide an alternative to psychiatric ED or inpatient hospitalization. 143 out of 195 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: NH Peer Support Outcomes Survey 2021).
In SFY2023, PSAs have served 2331 total members and see an average of 161 daily visits.

Peer Respite and SUSD services are operated by people who have experience living with a mental illness (i.e., peers) and are designed as calming, homelike environments with support for individuals in crisis twenty-four (24) hours a day. Peer Respite is offered in two of NH's Peer Support Agencies. Peer Respite stays are ten days or less but may be extended through approval by the BMHS if needed. SUSD is offered in four NH Peer Support Agencies. SUSD stays are ninety to one hundred- twenty days or less but may be extended through approval by the BMHS if needed. Peer Respite and SUSD services are generally shorter term than crisis residential services.

Each year, the 15-bed Recovery Oriented Step-up/Step-Down program serves approximately 72 people, 17 stepping down from inpatient care and 40 seeking an alternative to inpatient care.

PSAs also 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."

First Episode Psychosis
In the last two years, NH has operated the HOPE (Helping Overcome Psychosis Early) Program/FEP treatment teams at four CMHCs. These centers have been and continue to utilize the NAVIGATE Coordinated Specialty Care (CSC) model. One of the CMHCs, 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 teams are 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. Block Grant funds will continue to support the HOPE program with implementation costs and reimbursement for uncompensated HOPE program services.

NH has expanded efforts to increase awareness and reduce stigma related to mental illness in young people generally and first-episode psychosis specifically. The state has 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 2021-23, the State carried out a stakeholder engagement process to identify, propose, and begin an implementation strategy for a statewide ESMI or FEP treatment model using funds provided by the block grant 10% set-aside. The initiative included two components: proposing a treatment model that we can scale to provide ESMI/FEP services statewide and a public awareness campaign focusing on the importance and availability of early interventions. NH continues to work on the expansion of FEP services statewide.

Critical Time Intervention (CTI)
In July of 2022, the BMHS launched Critical Time Intervention (CTI), an intensive care transition program to support individuals preparing for discharge from psychiatric inpatient settings. CTI aims to connect these individuals with services and support in their home communities. CTI is vital in ensuring patients leaving hospital settings can access the necessary support and services to improve their quality of life and prevent unnecessary re-admissions. The Program is a partnership among Designated Receiving Facilities, New Hampshire Hospital, and ten CMHCs. It supports individuals in transitioning between inpatient and outpatient services effectively.

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

N/A

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.

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)

2. 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. 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, waitlists, and staffing; and Supported Employment program utilization, waitlist, staffing, and aggregate count reports of clients by employment status.

NH also utilizes data from the state psychiatric hospital (from New Hampshire Hospital's Avatar electronic health record system) to produce reports on admissions, daily census, re-admissions, and discharge.

These reports are utilized for program planning, budgeting, and 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

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

N/A

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs. Does your State integrate the following services into a comprehensive system of [10]

a) Social Services ☐ Yes ☐ No
b) Educational services, including services provided under IDEA ☐ Yes ☐ No
c) Juvenile justice services ☐ Yes ☐ No
d) Substance misuse prevention and SUD treatment services ☐ Yes ☐ No
e) Health and mental health services ☐ Yes ☐ No
f) Establishes defined geographic area for the provision of the services of such systems ☐ Yes ☐ No

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

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.

a. Describe your State's targeted services to the rural population. See SAMHSA's Rural Behavioral Health page for program resources (https://www.samhsa.gov/rural-behavioral-health).

All ten CMHCs must care for 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 via telehealth platforms, within the community or clients' living location, and provide support in transportation

[10] A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

where needed. The local Peer Support Agencies often provide transportation services for individuals to attend appointments and receive support. 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 NH DHHS, 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 are to support communities and stakeholders that provide innovative and effective access to quality healthcare 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 healthcare services, especially for uninsured residents. The PCO is the location of the NH Health Professions Data Center. It 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 healthcare providers and organizations. It 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 the above program areas to increase or retain the supply of health professionals serving NH. 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 NH 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 designated as having a shortage of healthcare providers by the Secretary of Health and Human Services. It 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 healthcare 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 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.

b. Describe your State's targeted services to people experiencing homelessness. See SAMHSA's Homeless Programs and Resources for program resources[11]

Four of the ten CMHCs provide Street Outreach and Supportive Services Only through SAMHSA's Projects for Assistance in Transition from Homelessness (PATH). These PATH programs comply with the Federal Public Health Services Act, Section 522(b) (10), Part C to individuals experiencing homelessness or at imminent risk of becoming homeless and believed to have 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 continue to focus and work with the individual to enhance treatment and housing readiness.

NH also has one SAMHSA-funded Grant for the Benefit of Homeless Individuals (GHBI) Program, targeting increased access to and retention of safe and affordable housing for participants exiting a residential substance use disorder treatment facility experiencing homelessness. The Program provides holistic recovery-focused care coordination services, benefits and housing navigation, and access to emergency financial assistance. The target population for the care coordination services is SAMHSA priority population service members, veterans, and their families (SMVF) throughout NH, of all ages and military eras, who experience homelessness and substance use disorder (SUD) or co-occurring disorders (COD).

All PATH and GBHI providers coordinate and actively participate in the 3 NH Continuums of Care for local community organizations and housing resource connections.

Homelessness

[11] https://www.samhsa.gov/homelessness-programs-resources

The US Department of Housing and Urban Development (HUD) defines someone who is experiencing homelessness as "an individual or family who lacks a fixed, regular, and adequate nighttime residence," meaning the individual:

1. Has a primary nighttime residence that is a public or private place not meant for human habitation;
2. 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
3. Is exiting an institution where the individual 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.
4.

During the 2022 HUD Point in Time Count in New Hampshire, 1,605 persons were identified as experiencing homelessness on a single night in January. Of those:

- 331 individuals were experiencing unsheltered homelessness
- 478 individuals had mental health diagnoses that were expected to be of long, continued, and indefinite duration and that substantially impaired the person's ability to live independently
- 337 individuals had chronic substance use disorders, defined by HUD as alcohol misuse, illicit drug misuse, or both, that are expected to be of long-continued and indefinite duration, and that substantially impair the person's ability to live independently
-
- According to *The State of Homelessness in NH,* by the New Hampshire Coalition to End Homelessness, while overall yearly data showed a nominal decrease in the total homeless population, the variance in the subpopulation data year to year was considerable. Individuals experiencing unsheltered homelessness more than doubled from 2020 to 2021- with 411 individuals in 2020 to 1,082 individuals in 2021.
-
- The unsheltered increase represents the extreme impact that COVID-19 had on individuals experiencing homelessness. With emergency shelters pivoting to adjust for pandemic safety measures and an extremely low housing vacancy rate, many people experiencing homelessness in 2021 stayed in places not meant for human habitation as their only solution to survival. Regions across the State responded with increased homeless outreach services to bridge this population to available services. However, many emergency shelters remained at capacity, and housing options were limited.
-
- In 2021, there was also an increase in chronic homelessness, which describes those experiencing homelessness while struggling with a

serious mental illness, substance use disorder, or physical disability. Eight hundred and eighty-nine individuals identified as chronically homeless in NH. These individuals comprise 19% of NH's sheltered and unsheltered homeless population.

-
- Black and Hispanic individuals are overrepresented in the homeless population. They are more likely to experience homelessness than White people in NH are. Six percent of people experiencing homelessness identified as Black in 2021 despite making up only 1.46% of the population in the State. Similarly, people who identified as Hispanic were 9% of the homeless population but only 4% of the population in New Hampshire. Black and Hispanic populations in New Hampshire have less income on average, making these groups susceptible to increased housing instability.
-
- Reports from the New Hampshire Housing Finance Authority also show that the housing market across the State remains exceedingly tight, with a high demand for rental units, a low vacancy rate, and ongoing pressure on the affordability of rental units. To afford the statewide median cost of a typical two-bedroom apartment with utilities, a NH renter must earn 137% of the estimated statewide median renter income, or over $70,600 a year.
-
- The 2023 New Hampshire Housing Finance Authority Residential Rental Cost Survey Report found that:
- Statewide monthly median gross rent (including utilities) of $1,764 for two-bedroom units has increased by 11.4% since 2022.
- Rents statewide continued their steady 10-year climb.
- Increasing rents are both a cause and a result of inflation in the broader economy. They generally occur when leases are renewed or when rental properties are sold.
- Average monthly utility costs increased substantially over the last year due to a spike in energy prices, contributing to the survey's reported 11.4% increase in monthly median gross rent for two-bedroom units.
- With a vacancy rate of 0.8% for all rentals, finding an affordable apartment is very difficult. (A vacancy rate of 5% is considered a balanced market).
- Based on the State's estimated population growth, a total of 23,670 additional housing units is needed today to meet NH'a current housing shortage
-
- A lack of affordable Housing is the primary precipitating factor leading to homelessness in New Hampshire. However, an often-overlooked factor leading to homelessness for single individuals is having a disability. Disabilities can include physical, behavioral, and/or

intellectual disorders. Acknowledging disabilities as a precipitating factor in homelessness is critical as it recognizes the need to design responsive programming for this specialized population.

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- While many factors influence health, stable housing is a crucial "social determinant of health" that directly impacts health outcomes. Just as untreated behavioral health diagnoses can precipitate homelessness, homelessness is a significant risk for poor mental health. While some need only short-term assistance to regain health- including behavioral health- and reconnect to employment and housing independently, others may be seriously ill and/or disabled and need longer-term support services to maintain housing. Other health outcomes improve by increasing access to safe, affordable housing and improving housing stability.
-
- The Bureau of Housing Supports (BHS) provides various statewide services, which act as a safety net for some of NH's most vulnerable citizens. Projects include priorities for identified vulnerable populations, such as new Supplemental COC funding supporting Supportive Services for unsheltered individuals and COC Permanent Supportive Housing for chronically homeless individuals. Services are provided through five Community Action Agencies and other non-profit service providers across the State. These agencies provide service and financial interventions targeted at ending the homelessness experience and improving ongoing housing stability. Various program types make up a Continuum of Care- from Street Outreach through Permanent Supportive Housing- all based on preventing the homelessness experience, or for those already homeless, quickly connecting to permanent housing solutions. Examples of services provided include:

- Assisting people experiencing housing instability or homelessness with urgent needs to access Housing, shelter, and/ or other services to achieve or maintain housing stability and independence.
- Providing short and medium-term rental assistance through Rapid Rehousing and Permanent Supportive Housing to individuals, youth, and/ or families, along with supportive services to maintain housing stability.
- Providing outreach services to those considered "hard to reach," such as chronically homeless residing on the streets or other places not meant for human habitation in rural regions to increase their transitions to housing stability.
- Provide intensive case management services to connect individuals and families to appropriate services, including medical and behavioral health care, TANF/SNAP benefits, SSI/SSDI, and other necessary services.
-

- Services provided through the Bureau of Housing Supports follow the Housing First approach. Housing First is a homeless assistance approach guided by 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 people should start with stable, permanent housing. They may then choose to address other life issues contributing 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. Still, participation is optional as services have been found to be more effective when a person chooses to engage.
-
- A Housing First approach's flexible and responsive nature allows it to be tailored to help anyone based on their choice. Individuals using a Housing First model have been shown to access Housing faster. They are more likely to remain stably housed.
-
- Additionally, all programs must participate in the statewide Coordinated Entry process to ensure people with the longest histories of homelessness and with the most severe service needs are given priority and expedient access to available permanent supportive housing. Case management services also include connecting individuals with housing based on their needs, including housing opportunities outside of COC resources such as Housing Choice Vouchers, low-income Housing, affordable housing, or other solutions. Through this, individuals and families experiencing homelessness are assessed and linked to housing navigators who can help the individual/ family navigate housing services and supportive services such as mental healthcare, employment/benefit supports, and mainstream services that help keep households 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, including through:
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1. State Funded Emergency and Transitional Shelters

2. HUD Continuum of Care funding
3. HUD Emergency Solutions Grant Funding
4. SAMHSA's Projects for Assistance in Transition from Homelessness
5.

c. Describe your State's targeted services to the older adult population. See SAMHSA's Resources for Older Adults webpage for resources[12]

New Hampshire is Aging
As of 2019, NH's population over 65 increased by 2.7%. A need exists for services and programs targeted to our aging population, which is 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, the 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 NH Senior Housing, 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 ensures that 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 safely and with dignity. Services range from home care, meals on wheels, care management, transportation assistance, and assisted living to nursing home care.

The ServiceLink Resource Centers and the NH DHHS District Offices can access various social and long-term services and supports. Services and supports are intended to assist people to live as independently as possible, safely, 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

[12] https://www.samhsa.gov/resources-serving-older-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 provides the level of medical care the person requires.

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

N/A

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provide 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.

a. Describe your State's management systems.

MHBG-Funded Staff and Training Management Systems

I. Adults: PEER SUPPORT AGENCIES – STAFFING, TRAINING, and OVERSIGHT
In NH, the most extensive recovery support services are through our network of Peer Support Agencies that the MHBG and State general funds subsidize. To maintain professionalism, expand implementation, support individuals with mental illness, and in compliance with contract provisions of services, the PSA system in NH remains heavily reliant on ongoing training and leadership development.

NH has fourteen Peer Support Agencies that employ individuals who 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 must be trained in Intentional Peer Support (IPS), Whole Health Action Management, and Recovery Action Planning (materials developed by Mary Ellen Copeland, Ph.D., and SAMHSA). Currently, NH has one certified IPS trainer and is evaluating the peer training infrastructure/modalities and increasing the number of state trainers to support the peer workforce statewide.

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 non-profit best practices, including the customized board of directors training for each agency in "Deepening Community Awareness and Fundraising," "Board Recruitment and Retention," and "Non-profit Financials," among others.

The Supplemental award also allowed NH to receive consultation from the national trainer and peer leader, Eduardo Vega, to develop the Peer Workforce Advancement Plan. The NH Peer Workforce Advancement Plan (Advancement Plan) aims to present actionable recommendations for developing and enhancing the workforce of people with lived experience across NH's mental health services sector. This plan results from the 10-Year Mental Health Plan's Recommendation #7, which seeks to expand the availability of peers in practice settings and integrate people with lived experience into various parts of the mental health system. Doing so requires concerted efforts in several areas: training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies. At the same time, other factors are specific to the roles, challenges, and opportunities of people with lived experience as peer support specialists.

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 BMHS, National Alliance on Mental Illness of New Hampshire (NAMI-NH), and Eduardo Vega, Humannovations. Participating stakeholders included individuals representing PSAs, CMHCs, community and system advocates, and many individuals with lived experience.

On-Site monitoring visits occurred in SFY 20-21 at all PSAs. Interviews and file reviews 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 NH'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), training sessions for personnel working with individuals with mental

illness who are involved with the justice system occurred. Attendees included more than 275 staff from the NH DOC, the 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. The 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 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 provide the CMHCs and the BMHS with management reports that 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 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 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

The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projects 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:
The MHBG will be the 100% sole source of funds for the MATCH training –

Judge Baker contract. All deliverables and projects have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract.

First Episode Psychosis
PROGRAM SUPPORT AND STAFF TRAINING COSTS
Each year since the inception of the requirement for 10% of the block grant required to set aside for First Episode Psychosis (FEP) programming, these MHBG funds have been 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 $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 $60,000 each to four CMHCs to support non-billable programming costs and staff time.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

b. Describe your State's current telehealth capabilities, how your State uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

NH is committed to improving mental health care accessibility by promoting the convenience and effectiveness of service delivery in line with federal rules and regulations. Through the implementation of telehealth initiatives, such as virtual consultations, telepsychiatry, and teletherapy services, individuals can connect with mental health professionals remotely. These services enable assessments, counseling, crisis intervention, and medication management through secure video conferencing. The primary goal is to overcome geographical barriers, enhance appointment flexibility, and provide timely support to those in need. By embracing telehealth, the State aims to optimize mental health outcomes and ensure that individuals receive the care they require conveniently and efficiently.

The NEW HAMPSHIRE TELEMEDICINE ACT Section 415-J: 3 outlines the intent and requirements for telemedicine coverage in NH. It mandates that insurers offering health plans must provide coverage and reimbursement for health care services delivered through telemedicine on the same basis as in-person services. It specifies eligible providers who can perform telehealth services. It ensures that coverage cannot be restricted based on the telehealth mode (video, audio, etc.). Insurers are prohibited from imposing additional limitations on telemedicine coverage that are not applied to similar in-person services. The section does not allow insurers to reimburse more for telehealth services than they would for in-person services. It aims to facilitate and promote telehealth services to ensure access to medically necessary care for covered individuals.

Guidance was issued in response to the COVID-19 State of Emergency Declaration (Emergency Order #8) that temporarily expanded telehealth services in NH, allowing audio-only telehealth reimbursement during the emergency period. Eligible providers include various mental health professionals, including Community Mental Health Programs designated by the Department of Health and Human Services. There were no restrictions on originating sites, which may include private residences. Medicaid reimburses telehealth services at the same rate as face-to-face appointments. HIPAA rules are relaxed during the emergency, allowing the use of popular video chat applications for telehealth sessions, but public-facing platforms should be avoided. Telephone-only audio is also permitted. The expansion and guidance were effective only during the State of Emergency.

During the COVID-19 pandemic, NH faced challenges; however, CMHCs remained operational as essential businesses, with some employees working remotely. Following CDC and NH Division of Public Health Services (DPHS) guidelines, CMHCs had adjusted service delivery to prioritize participant health and safety. Telehealth services were offered for those who prefer remote options. In contrast, in-person services are available for individuals who prefer that method.

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

N/A

11. Quality Improvement Plan- Requested

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.

1. Has your state modified its CQI plan from FFY 2022-FFY 2023?

a) ☐ Yes ☐ No

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

The NH DHHS BMHS Quality Improvement efforts are managed centrally by the DHHS Bureau of Program Quality (BPQ), which conducts and monitors annual Quality Service Reviews (QSRs) for each CMHC. The QSRs result in quality improvement plans jointly monitored by BPQ and BMHS.

In addition, the Bureau's annual Fidelity Reviews assess evidence-based practices in each CMHC for Assertive Community Treatment (ACT) and Individual Placement and Support Supported Employment (IPS-SE) for fidelity to the EBP model. Dartmouth-Hitchcock (DH) consultants conduct these independent reviews and provide Fidelity Reports with improvement recommendations. Training and technical assistance from BMHS experts help CMHCs maintain high-quality practices.

Other evidence-based practices such as ESMI/FEP and Critical Time Intervention also undergo CQI. The BMHS has contracts with experts to provide training, consultation, and evaluation of these evidence-based programs.

The BMHS continues to be responsible for program reviews of the Peer Support Agencies. Review tools were further refined over the last two years 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 was completed on SFY18; in SFY20, follow-up was done on those findings. PSA quality reviews include site visits, a member interview, a staff interview, an Executive Director interview, an interview with the Board of Directors, and a 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.

Each CMHC undergoes a re-approval review every five years to maintain its community mental health provider status. The review covers the previous five years of operation. It involves assessing various tools, including Quality Service Reviews (QSRs), Fidelity Reports, Managed Care Organization (MCO) audits, and satisfaction surveys. The process ensures compliance with administrative rule He-M 403, governing the Approval and Operations of a Community Mental Health Program. After the review, reports are written, shared with agencies, and made public on the NH DHHS website. If necessary, corrective action plans are submitted to BMHS for approval. BMHS closely monitors the implementation of these plans to address any identified gaps or needs, ensuring that CMHCs continue to provide quality mental health services.

The BMHS collaborates with the three MCOs in NH for monthly chart audits in the CMHCs. This audit tool reviews specific items outlined in contracts or NH rules that other reviews may not cover. Each month, one MCO is assigned to audit all ten CMHCs, following a rotational schedule that repeats four times yearly for comprehensive coverage. The audit reports are shared with the respective CMHCs and discussed with their quality departments in a supportive manner to identify any additional technical assistance needed. The reports are also consolidated quarterly and reviewed with the CMHC Quality Improvement (QI) directors collectively. This collaborative approach helps ensure continuous improvement and adherence to quality standards across the CMHCs.

The BMHS partners with JSI Research & Training Institute, Inc. (JSI) of Boston, MA, to conduct the annual CMHC Client Satisfaction Survey. The survey aimed to gather input from adults and parents of children who use or have used public mental health services provided by the ten CMHCs in the state.

The survey serves several valuable purposes that contribute to improving mental health services and meeting the needs of clients and their families:

1. Gathering Client Feedback: The survey allows mental health centers to receive direct feedback from clients and their families regarding their experiences with the services provided. This input is crucial in understanding the strengths and weaknesses of the mental health system, identifying areas for improvement, and tailoring services to meet clients' needs better.
2. Identifying Service Gaps: Through the survey, mental health centers can identify potential gaps in services or areas where clients may not receive adequate support. This information enables the centers to address those gaps and enhance the overall quality of care provided.
3. Informing Service Enhancements: The survey data helps mental health centers make informed decisions about service enhancements and improvements. By knowing what clients and families value most and what aspects of care may need refinement, mental health centers can focus on areas that will significantly impact client satisfaction and well-being.

4. Meeting SAMHSA Grant Requirements: The survey data fulfills the reporting requirements of the SAMHSA Community Mental Health Services Block Grant. This ensures compliance with grant regulations and facilitates the continued funding and support of mental health services.
5. Facilitating Accountability: CMHCs are committed to accountability and transparency by regularly conducting client satisfaction surveys. The survey results hold centers accountable for the quality of care provided to clients and help them track progress over time.

Overall, the survey is an essential tool for continuous quality improvement in the mental health system, enabling mental health centers to understand better and respond to the needs of their clients, enhance services, and work towards achieving positive outcomes for individuals and families seeking mental health support.

The BMHS 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.

The BMHS monitors the Housing Bridge Subsidy Program (HBSP) closely, including bi-annual and financial audits as needed. Bi-annually, the BMHS visits each vendor to review case files of randomly selected HBSP individuals. The BMHS ensures that each file contains the history of the individual, all ongoing supports and services requested and needed, a complete check of the individual's financial status, and information regarding barriers and strengths regarding their housing situation. The vendors are responsible for completing annual reviews for each individual in the HBSP, which include but are not limited to inspection of the unit to ensure safety, review of the individual's income to ensure their portion of the rent is correct, and updated criminal record checks to ensure the individual remains compliant with HUD regulations.

12. Trauma -Requested

Trauma[58] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist retraumatizing 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[59] paper.

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[58] 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.* [59] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers? ☐ Yes ☐ No
4. 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
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No
6. Does the state use an evidence-based intervention to treat trauma? ☐ Yes ☐ No 5) Does the state have any activities related to this section that it would like to highlight.

The Bureau of Mental Health Services (BMHS) has implemented administrative rules that mandate Community Mental Health Centers (CMHCs) to conduct trauma history screenings and documentation during the initial assessment and intake process. The assessments, including the Child & Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA), include specific trauma-related prompts and are conducted at intake and annually after that.

CMHCs adhere to trauma-informed models of care, as defined by SAMHSA, ensuring that their clinical standards and operating procedures focus on wellness, recovery, and resiliency.

To cater to individuals across the life span who have experienced trauma, CMHCs offer a range of Trauma-Informed evidence-based practices (EBPs) and services, such as the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), Prohealth NH, Trauma-Focused Cognitive Behavioral Therapy, Art Therapy, and Illness Management and Recovery.

In 2022, the State of New Hampshire enhanced crisis services by implementing New Hampshire Rapid Response Access Point (NHRRAP) and expanding the Mobile Crisis Response Team. NHRRAP provides immediate, 24/7 access to mental health and/or substance use crisis support through telephone, text, and chat services. CMHCs, through their mobile rapid response teams, provide crisis intervention and stabilization services to

individuals experiencing psychiatric and/or substance use-related crises using short-term, trauma-informed approaches.

Furthermore, to support non-clinical recovery, various trauma-informed best practices through block grant-funded Peer Support Agencies, including Intentional Peer Support (IPS), Whole Health Action Management (WHAM), and the EBP Wellness Recovery Action Plan (WRAP). These practices create a supportive environment for individuals on their journey to recovery.

New Hampshire's CMHCs have effectively employed Peer Support Specialists to provide outreach, support, community connection, and empathy to individuals with serious mental illness (SMI). In addition to their roles as Peer Support Specialists, these staff members are also integral components of various programs offered by the CMHCs, such as ACT, FEP, Mobile Crisis, and Fast Forward. Their contributions significantly enhance the support and assistance provided to individuals experiencing trauma and other mental health challenges.

By incorporating Peer Support Specialists into these programs, CMHCs have created a supportive and empathetic environment that promotes the well-being and recovery of individuals with SPMI. These dedicated staff members play a crucial role in establishing strong connections and fostering a sense of belonging within the community, which is invaluable in healing and recovery.

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

N/A

13. Criminal and Juvenile Justice - Requested

More than a third of people in prisons and nearly half in jail have a history of mental health problems.[13] Almost two-thirds of people in prison and jail meet the criteria for a substance use disorder.[14] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[15] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system

Addressing the mental health and substance use disorder treatment and service needs of people in the criminal justice system requires various approaches. These include:

- Better coordination across mental health, substance use, criminal justice, and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing an MH or SUD-related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, in jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;

[13] Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. *Bureau of Justice Statistics*, 1-16.

[14] Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. *Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention*.

[15] Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." *Journal of the American Academy of Child and Adolescent Psychiatry* 47(3):282–90.

- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a more robust array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve the coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice_system-involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.
Please respond to the following items:

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

☐ Coordination across mental health, substance use disorder, criminal justice and other systems

☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups

☐ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder

☐ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g., Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)

☐ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;

☐ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community

☐ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)

☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)

☐ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system

☐ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met

☐ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges

☐ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels

☐ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system

☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD

☐ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ☐ Yes ☐ No

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

The Governor's Advisory Commission on Mental Illness and the Corrections System was established through Executive Order in 2019. The Commission's mission is to examine and make recommendations on issues facing individuals with mental illnesses in the corrections system, including but not limited to the following: a) steps that can be taken to reduce incarceration and improve mental health services for incarcerated individuals who suffer from mental illnesses;

b) the use of restraints during transports to and from either mental health or corrections facilities;
c) methods for improving transitions between county and state institutions; d) reforms to support individuals with a mental illness who are transitioning from incarceration back into the community; and
e) any other issues which the Commission deems relevant to its charge
In 2022, state leaders in New Hampshire launched a Justice Reinvestment Initiative effort to address the high and persistent utilization of public health and county jail resources by people with mental illnesses and substance use disorders (behavioral health conditions). For the project, CSG Justice Center staff conducted extensive analysis of case level data from county jails as well as Medicaid claims data from the Department of Health and Human Services (DHHS). Examining these data revealed information about local trends in jail populations, including identification of behavioral health (BH) needs, participation in treatment and services within jails, and services accessed by people before and after incarceration. The project resulted in a comprehensive report of key challenges and findings as well as five overarching policy recommendations.
The Commission has submitted annual reports in 2019, 2021 and 2022 report.

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

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each State to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *.....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> o *Crisis call centers* o *24/7 mobile crisis services* o *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed Crisis Services: Meeting Needs, Saving Lives, which includes "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" as well as an Advisory: Peer Support Services in Crisis Care and other related National Association of State Mental

Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "National Guidelines for Child and Youth Behavioral Health Crisis Care" which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Regional Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Regional Crisis Call Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A regional crisis call center provides an alternative. Regional crisis call centers should be made available statewide, provide real-time access to a live mental health professional on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 because either they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911based system with dispatchers who forward calls to either the police department's co-responder team (police officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with police officers who have received Mental Health First Aid and Crisis Intervention Training, including de-escalation methods and behavioral health symptoms; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers then refer to local mobile response teams (MRTs), also called mobile crisis teams

(MCTs); and (3) State or local Crisis Call Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be de-escalated by phone. In the current system, police are often dispatched to the location of the individual in crisis. But in an effective crisis system, two-person teams, including a clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be transported to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a no-reject policy. Particularly when police or EMS are dropping off an individual, the hand-off should be "warm" (welcoming) and efficient, and these facilities provide assessment and address mental health and substance use crisis issues. A warm hand-off establishes an initial face-to-face contact between the client and the crisis facility worker. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of professionals and volunteers who are trained to utilize best practices in handling distress calls. Local call centers automatically perform a safety check for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (PL 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and State 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 but the , 1-800-273-TALK is still operational. The 988 transition has supported and expanded to the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited crisis services, but a few have an organized system of services that coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved

dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly narrate your State's crisis system. For all regions/areas of your State, include a description of access to crisis call centers, availability of mobile crisis and behavioral health first responder services, and utilization of crisis receiving and stabilization centers.

The NH 10-year Mental Health Plan, called for the transformation of NH's crisis system. Therefore, in 2019, NH began planning to expand and integrate crisis services across mental health and substance use disorder and ensure all levels of crisis care were available to children, youth, adults, and families statewide.

The transformation of crisis services is aligned with the national Crisis Now model and has been gradually implemented over the past two years. The NH Rapid Response (NHRR) crisis system launched on January 1, 2022. This system includes the NH Rapid Response Access Point (NHRRAP), a 24/7 crisis contact center, statewide integrated mobile crisis response teams (NHRR), and soon-to-be-established crisis centers.

The NHRRAP is the centralized crisis contact (call, text, chat) center designed as the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services 24 hours a day, 7 days a week. NHRRAP also can deploy the closest available mobile crisis team promptly. Prior to the transformation, at least 20 different numbers existed for someone in crisis. The goal of the NHRRAP was to have one number, regardless of the time of day and/or location of the caller, to call for behavioral health crisis support in NH. The State contracted with Carelon (formerly, Beacon Health Options) to provide the crisis contact center. Most calls (80%) are resolved at the "call" level. The NHRRAP number is 1-833-710-6477.

988 became the National Suicide Prevention Lifeline (NSPL) number on July 16, 2022 (with the former 1-800-273-TALK still in place). The main goal of 988 is to have an easy number to remember, akin to 911. Headrest has been the NSPL call center provider in NH for many years. Headrest continues as the primary call center for 988. Additionally, a Memorandum of Understanding between Headrest and Carelon was established to do a warm hand-off if necessary and provide backup. Headrest answers the calls that come into 988, and Carelon responds to texts and chats. There has been extensive work with the NH Department of Safety wherein protocols have been developed to identify and facilitate call transfers to the 988 system based on mutually developed level of care measures.

The NHRRAP can also schedule "Same day/Next day" appointments for callers whose crisis does not meet a level of deployment and/or requests to be seen later (as long as a credible safety plan is in place). These appointments take place at the Community Mental Health Centers (CMHCs).

Mobile response teams are available statewide when the NHRRAP cannot resolve the crisis on the phone (or the caller requests an in-person response). The NHRR teams are located at each of the State's 10 CMHCs. These teams operate 24/7, providing mobile crisis intervention services. Comprising two specially trained crisis responders, NHRR teams can respond to requests for crisis assessments and interventions within one hour of receiving calls. Once engaged with a case, NHRR teams can offer services and supports for up to 30 days after the crisis, ensuring individuals remain stable and receive the necessary assistance within their community.

NHRR teams are deployed, via the NHRRAP, using a virtual platform. Deployments are to the closest available team, expecting teams to arrive in person within one hour. If the closest team is busy with another deployment (or isn't fully staffed with two responders), the next closest team is deployed. If the caller requests telehealth, the closest team with telehealth capability is given the dispatch.

A dispatch level is part of the deployment that indicates to the NHRR team if there are issues to consider before deploying. Levels 3 and 4 are recommended to include law enforcement as the primary responder or in conjunction with law enforcement.

Four (4) crisis apartment beds are available in the Nashua, Manchester, and Concord regions. Crisis Apartments serve individuals aged eighteen (18) years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to 7 days per episode and sometimes longer when necessary.

The BMHS is working with contracted vendors to establish two Crisis Stabilization Centers in state fiscal year 2024. One Center will be located in Plymouth, NH. The other will be located in the southern part of the State. The Crisis Centers are for lengths of stay of no more than 23 hours and are designed for the stabilization of symptoms, safety planning, initial linkage to services, and follow-up telehealth appointments.

2. Per the guidelines below, identify the stages where the existing/proposed system will fit in.
   a) The ***Exploration*** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
   b) The ***Installation*** stage: occurs once the State comes up with a plan and the State begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.
   c) ***Initial Implementation*** stage: occurs when the State has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.

d) ***Full Implementation*** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) ***Program Sustainability*** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

2. Someone to talk to: Crisis call Capacity
   a. number of locally based crisis call Centers in State
      i. In the 988 Suicide and Crisis Lifeline network
      ii. Not in the suicide lifeline network
   b. Number of Crisis Call Centers with follow up Protocols in place
   c. Percent of 911 calls that are coded out as BH related
3. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)
   a. Independent of first responder structures (police, paramedic, fire)
   b. Integrated with first responder structures (police, paramedic, fire)
   c. Number that employs peers 3. Safe place to go or to be:
      a. Number of Emergency Departments
      b. Number of Emergency Departments that operate a specialized behavioral health component.
      c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating State's stage of implementation

	Exploration Planning	Installation	Early implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to						X
Someone to respond					X	
Safe place to go or to be		X				

b. Briefly explain your stages of implementation selections here.

Someone to talk to: the NHRRAP has 24/7 coverage for caller/text/chat. There is an incident log for questions/concerns for ongoing quality assurance. Additionally, the NH has contracted with Dartmouth Hitchcock to evaluate the entire Crisis Response system and issue recommendations to NH DHHS for improvement in the NHRRAP and NHRR mobile teams.

Someone to respond: While each CMHC has an NHRR mobile team, not all are fully staffed 24/7. The CMHC in the northern part of the State uses a unique model of having 2 Peers respond and having a Master's level clinician be part of the team via

telehealth. This model was proposed to address the rural nature of the area, the longer commutes, and the smaller population of staff who can work in these teams.

A safe place to go or to be: New Hampshire is in the early stages of implementing Crisis Stabilization Centers with 2 of the 10 CMHCs.

4. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the State will develop the crisis system.

NH is currently working to address the workforce issue by developing a "Crisis Responder" training to be centrally delivered for all NHRR mobile crisis responders. This model is used in other states (Alaska and Maine). Graduates of the Crisis Responder training will be hired as NHRR mobile team responders, lessening the need for Master's level staff. The Master's level clinicians can then be utilized in other areas of need.

5. Briefly describe the proposed/planned activities utilizing the 5% set aside.

The NHRRAP and the proposed 2 Crisis Stabilization Centers are using, in part, the 5% set aside.

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

The State of New Hampshire has applied for technical assistance from SAMHSA to guide the implementation of the Crisis Stabilization Centers.

16. Recovery – Required

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to; and coverage for, health care drives 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

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, 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 National

Technical Assistance and Training Centers. SAMHSA strongly encourages states to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs.

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 organizations and direct resources for enhancing consumer, family, and youth networks such as RCOs and RCCs 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.

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) Use block grant funding of recovery support services? ☐ Yes ☐ No
    d) Involvement of people with lived experience /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.

Peer Support Agencies (PSAs) provide services statewide through 8 contracts and 14 physical locations across the state. These peer-run agencies offer peer support, education, connectedness to the community, activities, training, and supported employment opportunities among other services. Some of these peer agencies also provide peer respite and Recovery Orientated Step-up Step-down beds. Many regions have made great strides in delivering peer services over the past few years despite the pandemic and the challenges it brought forth. All of the PSAs quickly stood up virtual support groups and services in response to COVID-19, and increased their phone outreach to members while on-site activities were halted. This technology enhancement provided an opportunity for the agencies to continue offering virtual and hybrid support beyond the pandemic. This ability has continued to increase access for those seeking peer support who may have various challenges preventing on-site attendance.

Over the past year each agency has been working with a consultant contracted through NH Center for Nonprofits to enhance their leadership, board governance and fiduciary infrastructure. In FY2022 each agency developed priorities through a work plan, and in FY2023 agencies will work on implementation of these work plans.

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. 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.

BMHS and the PSA's continue to work toward expansion of services and integration of services throughout the system. In December of 2020, New Hampshire first entered into contract with 4 Peer Support Agencies; each to operate a 3-bed Recovery-Oriented Step Up/Step Down program. Initial program locations were in Nashua, Manchester, Keene and Northwood, NH. Additionally in 2022, Keene expanded to hold 2 SUSD contracts totaling 6 beds. These programs offer a new level of crisis care in NH.

The Recovery-Oriented 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. 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. Each program has kept their beds full over 80% since opening and most have waiting lists. In 2022 the department increased stay limits to 120 days per episode of need to allow more time for stabilization and transitional steps back into the community. The department completed Quality Assurance reviews of each SUSD program within the last few months; results are being reviewed and reports will be issued identifying strengths and areas for improvement.

For over 10 years the BMHS has contracted with NAMI NH (National Alliance on Mental Illness, New Hampshire) to provide family mutual support programming to individuals statewide. In 2021, the 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. Over the past 2 years NAMI NH has also started supporting the work of the Olmstead Settlement Agreement by providing the Glencilff Liaison position to help support individual transition to the community from Glencliff Home, the State's specialized psychiatric nursing home. More recently NAMI NH entered into contract to support the advisory work and stakeholder feedback for the CCBHC model assessment project.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

In New Hampshire Mental Health Peer Support Agencies have begun participating in co-occurring training and shared learning opportunities to better serve those in need.

Recovery Community Organizations (RCOs) are peer-led and peer-run agencies that provide services to support people in their recovery from substance misuse. All recovery centers throughout the state of New Hampshire are low barrier and no cost for services; the only requirement is a desire to focus on your recovery. RCOs support all pathways to recovery and offer peer recovery coaching, telephone support, mutual aid groups, and family support programs. Most centers include services in harm reduction, system navigation, and advocacy. There are currently 16 RCO locations as described here.

5. Does the state have any activities that it would like to highlight?

Peers on Mobile Crisis Teams
New Hampshire Community Mental Health Centers (CMHC's) have expanded their staff and service array to offer Rapid Response mobile crisis services. These teams are comprised of multi-disciplinary staff including clinical staff and at least 1 peer specialist responding to individuals in the community. This shift in our system has grown NH's peer workforce tremendously. These teams are able to screen, assess and connect with individuals to provide support and refer to additional services as needed. Peers play a significant role in engaging individuals in crisis and following up to support individuals in connecting with their community. In the North Country, peers lead the mobile response and reach out to a clinician only when necessary. Statewide over 70% of dispatches are resolved with individuals remaining in the community. This model should be studied more.

Peer Workforce Advancement Plan

In 2021, a New Hampshire Peer Workforce Advancement Plan was developed. It identifies 13 actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector. The Advancement Plan is the result of the NH 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. In 2023 a procurement was posted for the implementation of the Advancement Plan and the department is in the process of finalizing that procurement.

Department Peer Leadership

In the past two years the department has hired 2 Peer Programming staff to assist the administrator of Peer and Family Support with peer program expansion. Areas of focus include peer workforce training and development, refining state core training requirements, leadership training, and exploring opportunities to blend funding and cross-train peers in various elements of the mental health system, as well as data collection and contract monitoring.

Peer Training

The department has been working to enhance training availability and access for individuals statewide. Through the pandemic, this training was able to be offered virtually. Within the past two years, the department has fully funded all Certified Peer Support Specialist (CPSS) training requirement components. We are also collaborating on a project to refine the NH CPSS certification curriculum to be more comprehensive and expand access to the curriculum available through the NH Community College network or an established training hub.

In 2022, the Department worked with Dartmouth-Hitchcock delivering a Peer Supervision ECHO series over 6 months. The statewide ECHO series provided monthly educational opportunities as well as open discussion with panel experts and attendees regarding various topics related to peer supervision such as boundaries, ethics, helping vs co-learning and self-disclosure. Attendees were from various agencies and background however the majority of attendees were peer specialist and peer supervisors.

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

17. Community Living and the Implementation of Olmstead- Requested

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:

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

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?

In 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 (18+) 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".

The core areas of the agreement include:

Crisis Services
The CMHA requires that the State develop a 24/7 crisis system that provides timely access and services to individuals experiencing a mental health crisis, via the development of mobile crisis teams and crisis apartments in 3 regions of the state.

- NH has far exceeded these requirements by not only establishing mobile crisis teams and apartments in the three designated regions but found the service to be so beneficial that mobile crisis services are now available statewide and serve both children and adults.

Assertive Community Treatment (ACT)
The CMHA requires that the State develop and implement Assertive Community Treatment (ACT) teams in alignment with evidence based practice. The CMHA also requires statewide access to ACT services and the capacity to serve at least 1,500 individuals at any given time.

- NH has established multi-disciplinary ACT teams in all 10 CMHC designated regions. All ACT programs undergo annual fidelity reviews by an external reviewer. Expert consultants provide training, consultation, and technical assistance to the ACT teams.

Housing Services
The CMHA requires that the State expand supported housing options by creating 600 additional supported housing units that meet CMHA standards,

and have the capacity to serve in the community 16 individuals with mental illness and complex health care needs sho are residing at Glencliff Home.

- NH has far exceeded these requirements through a variety of efforts to meet the targeted population needs under the CMHA. The total additional supported housing units exceeds 1,000 through the following programs:
  - The primary program, Housing Bridge Subsidy Program (HBSP), has established permanent or subsidized housing for up to 500 individuals at any one time 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, 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. Currently more than 300 people who transitioned off HBSP to another Section 8 subsidy are being supported under the terms of the CMHA.
  - The State has created a new housing voucher program, Integrative, for individuals who do not meet the criteria for the HBSP due to criminal history. This pilot program is funded to serve up to 50 people and provides housing support services in addition to a housing rental voucher.
  - 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 (totaling 76 beds statewide) combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living.
  - The State also 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 75 through the 811 Mainstream program and 164 through the PRA 811 program. 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.

- The state has recently entered a contract to establish four 5-bed specialty residential programs (20 beds total) for individuals transitioning out of Glencliff Home or for those at NH Hospital on the waitlist for Glencliff Home.

Employment Services

The State agreed to deliver evidence based supported employment (EBSE) services in accordance with the Dartmouth evidence-based model. These services help individuals obtain and maintain paid, competitive employment in integrated community settings. The CMHA requires statewide penetration rate of individuals with SMI receiving EBSE to be 18.6% of the eligible individuals (adults with SMI or SPMI).

- NH has far exceeded the penetration requirements with over 24% penetration rate in EBSE.
- NH has established multi-disciplinary EBSE teams in all 10 CMHC designated regions. All EBSE programs undergo annual fidelity reviews by an external reviewer. Expert consultants provide training, consultation, and technical assistance to the EBSE teams

Family & Peer Support

The CMHA requires that the State will ensure there is effective family and peer support programs throughout NH to help individuals manage and cope with their mental illness. Peer support services offered through peer support agencies were required to be 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.

- NH has maintained a contract for the provision of family mutual support services with NAMI NH.
- NH has established a network of peer support programs statewide through 8 vendor contracts that offer 14 physical locations statewide. Programs are open to a minimum of 44 hours/week.

Transition Process

The CMHA requires that the State will provide each individual in NHH and Glencliff with effective transition planning and a written transition plan. To address this provision, the State has:

- Developed standard transition planning processes and protocols which include "visioning" with individuals to help them explore the idea and imagine life in an alternative community setting.
- Established a multi-disciplinary Central Team to assist in addressing and overcoming any of the barriers to discharge identified during transition planning and/or set forth in the transition plans.
- Designed and implemented a system for in-reach activities including coordination with the community mental health centers and hire of an In-Reach Liaison employed through NAMI NH to work with individuals, guardians, staff, and community providers to support transition planning and successful transitions.

Quality Assurance and Performance Improvement

The CMHA requires that the State will develop and implement a quality assurance and performance improvement system, emphasizing the use of client-level outcome tools and measures, to ensure that existing community-based services described in the Agreement are offered in accordance with the CMHA.

- NH established an excellent Quality Service Review (QSR) tool and process to conduct in-depth annual reviews of the CMHC network to ensure services are delivered in line with the terms of the CMHA. The review, which takes place at each CMHC over a 6 day period by a team of 8-12 State staff, includes interviews with clients, staff, and leadership, along with chart and data reviews.

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

N/A

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[16] 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.[17] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[18]

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 substances before the age of 18, one in four will develop an addiction compared to one in 25 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 use, 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 relate to available mental health and/or substance use 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

[16] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).

[17] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-ofonset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602.

[18] 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 use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

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

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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 2017 Report to Congress68on systems of care, services: reach many children and youth typically underserved by the mental health system.

1 improve emotional and behavioral outcomes for children and youth.
2 enhance family outcomes, such as decreased caregiver stress.
3 decrease suicidal ideation and gestures.
4 expand the availability of effective supports and services; and
5 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. 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., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

Please respond to the following:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ☐ Yes ☐ No

b) The resilience of children and youth with SED? ☐ Yes ☐ No

c) The recovery of children and youth with SUD? ☐ Yes ☐ No

d) The resilience of children and youth with SUD? ☐ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youthserving agencies in the state to address M/SUD needs:

a) Child welfare? ☐ Yes ☐ No

b) Health care? ☐ 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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ☐ Yes ☐ No

d) Does the state have an established FEP program? A CHRP program? ☐ Yes ☐ No

e) Is the state providing trauma informed care? ☐ Yes ☐ No

6. Describe how the state provides 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 NH 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 NH 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.
- Creation of a State Youth Treatment Plan with the assistance of a SABG & GOEFFR dollars, to help identify strategies 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 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 the System of Care NH DOE 2020-2024 grant, 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.

During FY22, a $4.2 million contract was approved for the development of a new Children's Behavioral Health Resource Center (CBHRC). Working in collaboration with other institutions, family groups, providers and youth and families, the CBHRC is strengthening the network of behavioral health supports for children across the state. The CBHRC is designed to help address the current shortage of resources by improving the capacity of providers, educators and agencies to deliver high-quality, research-based practices across the state. The CBHRC will focus on providing evidence-based training, technical assistance, easy-to-access information about strengths-based and youth-centered practices and approaches to best address the behavioral health needs of children up to the age of 21 years.

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

State statute RSA 135-F System Care for Children's Behavioral Health mandates that NH DHHS and the Department of Education partner and collaborate on the expansion of the System of Care in NH to provide:

- Residential services (such as therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).
- Residential Treatment services for SUD Youth.

The Bureau of Children's Behavioral Health (BCBH) provides a focus on children, youth, and families experiencing behavioral health issues, by developing programming with an appreciation the system care approach. Recent expansion of the program include:

- Three CMHCs have developed children's Assertive Community Treatment (ACT) teams, managed by the BCBH.

- One CMHC has engaged with BCBH to pilot and provide a collaborative model of High Fidelity Wraparound for children youth.
- BCBH is developing other pilot programs to provide a collaborative model of Assertive Community Treatment (ACT) and High Fidelity Wraparound for children and youth.

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

N/A

19. Suicide Prevention – Required for MHBG

Suicide is a major public health concern, it is a leading cause of death nationally, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, and social isolation. Mental illness and substance use 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? x Yes ☐ No
2. Describe activities intended to reduce incidents of suicide in your state.

The NH Suicide Prevention Plan has two overarching goals:

1. Promote awareness that suicide in NH is a public health problem that is generally preventable.
2. Reduce stigma associated with obtaining mental health, substance misuse, and suicide prevention services.

The activities associated with these goals include, but are not limited to:

- Support data collection, analysis, and visualization on suicide rates and prevention efforts.
- Fund, organize, and/or promote suicide prevention trainings.
- Engage with our legislators, policy makers, educators and providers to inform public policy and education.
- Identify, recruit, and retain diverse stakeholders for the NH Suicide Prevention Council who represent various regions, racial/ethnic diversity, and high-risk populations.
- Develop and/or promote campaigns to raise awareness of best practice suicide prevention strategies.
- Conduct an Asset and Gaps analysis to inform where there are greatest needs in the state.

Further, the State of New Hampshire has a liaison to the Office of Chief Medical Examiner (OCME). The liaison serves to connect notifications and confirmations of suicide deaths in the State of New Hampshire and inform the local Community Mental Health Center. The purpose is to have timely information about the deaths in order to proactively address postvention activities. School districts are contacted when there is a student death and

offered the SAMHSA toolkits. Workplaces that experience a suicide death on site are likewise contacted and offered The Manager's Guide to Postvention Supports. Survivor of Suicide Loss packets are mailed to the Next of Kin of the deceased by the liaison. The packets provide information about a variety of SOSL supports. Statistically, knowing someone who dies by suicide increases the risk of suicide in that individual. The packets are one way to attempt to lessen this negative outcome.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? X Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? X Yes ☐ No
If yes, please describe how barriers are eliminated.

Critical Time Intervention (CTI) is an evidence-based, intensive care transition program that connects people to services and supports in their home communities upon discharge from one of the State's designated receiving facilities, to include patients with suicidality. CTI coaches work with participants to develop goals as they prepare to return home, and continue to support them throughout the first nine months following discharge.

Participants in the CTI program receive intensive support at the beginning of the program, which gradually decreases as they grow more comfortable working with the connections created within their communities. CIT coaches are employed at NH's community mental health centers.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? X Yes ☐ No
If so, please describe the population of focus?

The NH DHHS invested in a targeted pilot program, subcontracting with the EDC Zero Suicide Institute to provide training, implementation support, a 9-month community of practice, and two levels of consultation on the Zero Suicide framework. These services are being delivered to three substance use disorder recover/treatment facilities, recruited for participation.

The launch of the pilot Zero Suicide Pilot Project included a successful introductory webinar, with over 100 participants. Each of the participating organizations attended a 1-Day in-person workshop, which was facilitated by Zero Suicide Institute staff and offered initial assessment and implementation support.

Currently, the participating organizations are engaged in the community of practice which offers the participants an opportunity to refine their zero

suicide strategies and receive real-time feedback on adherence/fidelity to the framework. Each participating organization will be receiving one-on-one consultation with Zero Suicide Institute to offer customized facilitation on priority areas identified thus far in the process.

This initiative is focused on bolstering NH suicide prevention efforts in facilities focused on the treatment and recovery of substance use disorders. These organizations will add to the growing body of institutions in New Hampshire who are in various phases of implementation of the zero suicide framework. There is statewide interest in developing a community of practice attached to the NH Suicide Prevention Council to help foster connections across organizations who are at all phases of implementation.

Further, funding for suicide prevention education and training was put into contract with NHADACA to support the interdisciplinary training needs around suicide prevention, intervention, and recovery. This body of work serves as layers to the evidence-based Connect Programming and will focus on special populations and specific clinical interventions to build the knowledge and confidence of our workforce around suicidality in clinical settings. For example, one of the first of these initiatives is a Zero Suicide Pilot with Substance Use Disorder Recovery and/or Treatment Facilities.

6. Have you conducted any work using the suicide protocol language with your crisis services set-aside? ☐ Yes ☐ No If so, please describe the work?

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

N/A

20. Support of State Partners - Required for MHBG

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.

- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be essential in Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?

   ☐ Yes ☐ No

As part of the Bipartisan Safer Communities Act, SAMHSA awarded the SMHA over $260,000 in funding to prepare communities to respond to adverse events involving youth, such as a school shooting. The plan is to use the funds to sponsor a variety of trainings with a variety of stakeholders.

One training program to be delivered is Mental Health First Aid for Youth, which focuses on identifying, understanding, and responding to signs of mental illness and/or substance use disorders in youth. This training provides the skills needed to reach out and support children and adolescents developing mental health or substance use problems. The goal is to help to connect them to appropriate care. This 9-hour course will be offered primarily to New Hampshire's Disaster Behavioral Health Response Team (DBHRT) members. DBHRT has over 700 volunteers who support communities following "disasters" of any kind, such as unanticipated deaths, suicide deaths, crimes, and natural disasters. There are 5 DBHRT regions covering the state, and current explorations are underway to host training in each DBHRT region. Training sites, trainers, and dates are currently being researched; BMHS aims for late fall 2023 for at least one training.

Other training opportunities being explored now are to offer 3-day training in Critical Incident Stress Management (CISM). This will be offered in groups of up to 75 attendees, including representatives from the 10 CMHCs, members of DBHRT, and members of law enforcement. The BMHS is exploring a three-tiered model for CISM training: the initial 3-day course, a virtual 3-hour follow-up course where the opportunity to "practice" CISM is provided, and additional training for some attendees to be able to teach the initial 3-day training. While still in the initial planning stages, the goal is to have at least one of the CISM courses offered in the late fall of 2023.

2. Has your state identified the need to develop new partnerships that you did not have in place?

☐ Yes ☐ No

If yes, with whom?

Since the last planning period, the System of Care statute has been enacted, ensuring cooperation between state partners around providing 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, through smaller-scale, grant-funded projects, efforts have been underway for over ten years to move NH towards a system of care model. These efforts focus on acute care and intervention, prevention, and healthy socio-emotional development for all children. With continued focus on these matters, a more comprehensive, integrated, and efficient child behavioral health services system can emerge in New Hampshire.

In 2019, the NH Governor enacted an Executive Order 2019-02, which established the Governor's Advisory Commission on Mental Illness and the Corrections System to 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.

The BMHS has an ongoing partnership with New Hampshire Housing Finance Authority (NHHFA) to provide a link between the BMHS's temporary housing programs, such as the Housing Bridge Subsidy Program and the Integrative Housing Voucher Program, and permanent housing through HUD's Housing Choice Voucher Program (HCV). The BMHS and NHHFA work together to ensure that individuals in the BMHS programs are provided with a preference for HCV, significantly decreasing wait time. The BMHS also partners with NHHFA to apply for and manage grants for permanent housing, such as the PRA811 program and the Mainstream 811 program.

The BMHS partnered with the New Hampshire Center for Nonprofits to provide governance and management training to Peer Support Agencies throughout NH. The Center for Nonprofits is a statewide nonprofit association dedicated to strengthening and giving a 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 BMHS, through contracts, over the past several years. The Center has delivered leadership and governance training for New Hampshire's Peer Support Agencies through a sole source contract with DHHS since 2019. This contract with NH Center for Nonprofits is 100% federal funds. This training series will build upon prior training to strengthen governance, management, and fiscal oversight at the Peer Support Agencies; customized agency consultation services were made available through the SFY2022 contract with NH Center for Nonprofits.

Since June 2021, CMHCs have employed a Work Incentive Counselor. These positions were made available through a partnership with the Department of Vocations Rehabilitation. The counselor's responsibilities include:

1. Assisting individuals in connecting, applying, and transitioning to Vocational Rehabilitation services.
2. Engaging individuals in Supported Employment services or increased employment through work incentives, counseling, and planning.
3. Developing comprehensive plans for individuals, considering the impact of different income levels on existing benefits, and identifying specific work incentive options to increase financial independence and accept pay raises.
4. Documenting all existing disability benefits programs, such as SSA disability programs, SSI income programs, Medicaid, Medicare, Housing Programs, and food stamps and food subsidy programs.
5. Collecting data to create quarterly reports on employment outcomes and work incentives counseling benefits.

6. Collaborating with Vocational Rehabilitation providers to develop a partnership and promote cooperation between Employment Specialists and Vocational Rehab.

To ensure the Work Incentive Counselor's competence, the CMHCs ensure that their staff is certified to provide Work Incentives Planning and Assistance (WIPA) through the training program offered by Virginia Commonwealth University.

These CMHCs are partnering with Vocational Rehabilitation to develop the Partnership Plus Model, which aims to secure Social Security funding for the Work Incentives Counselor position after Vocational Rehabilitation funding ends.

Dartmouth Hitchcock and the BMHS have joined forces with CMHCs to focus on supporting COD treatment within NH Assertive Community Treatment (ACT) teams. A Co-Occurring Disorders (COD) Consultant & Trainer from Dartmouth Hitchcock is working with the CMHCs to enhance provider knowledge and skills in working with individuals with CODs. The initiative includes collaborating with implementation teams to improve clinical and administrative processes, delivering targeted COD training, and offering additional consultation and training as each CMHC needs. Furthermore, peer-to-peer consultation will be available to help ACT Teams maintain their strengths. The initiative aims to enhance the support and treatment for individuals with Co-Occurring Disorders (CODs) within NH Assertive Community Treatment (ACT) teams.

PLACEHOLDER – add language regarding partnerships/intersect with NH Medicaid e.g. CCBHC work, ID/DD & MH projects - training and shared contract language, DLTSS work around MFP, DOC/DHHS partnership around SCG project and Medicaid waiver application, BDS/DLTSS/SMHA partnership to expand specialty residential options individuals w/ complex medical needs, partnerships w/ DOS and LE around 988 and CIT, new epidemiologist position at PH focused on BH, work with school systems/DOE

3. Describe how your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

New Hampshire RSA 135-F requires the New Hampshire Education Department and the DHHS to share responsibilities for creating a children's behavioral health system of care. DHHS is partnering with the University of New Hampshire, Institute on Disability to provide resources to families and resources and technical assistance to providers statewide to ensure the availability of community-based evidence-based practices are universally accessible.

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

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

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 SUPTRS BG, 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.[19]

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? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)

This is still under development....The advisory council now BHPAC was given a preview of the application with the mission and goals of the SAMHSA Block Grant in June 2023. There is an upcoming meeting in August for final review after the public comment section.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

[19] https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ☐ Yes ☐ No

4. 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

5. 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.

Michelle Wagner chair to contribute to this section/

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

Additionally, please complete the Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[20]

Advisory Council Members

Name	Type of Membership*	Agency or Organization Represented*	Address Phone & Fax	Email Address (If Available)
		**State Mental Health Agency		
		**State Education Agency		
		**State Vocational Rehabilitation Agency		
		**State Criminal Justice		

[20] 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.

		Agency		
		**State Housing Agency		
		**State Social Services Agency		
Diana Lacey		**State Medicaid Agency	129 Pleasant St, Concord, NH 03301	Diana.M.Lacey@dhhs.nh.gov
		***State Marketplace Agency		
		***State Child Welfare Agency		
		***State Health Agency		
		***State Agency on Aging		

*Council members should be listed *only once* by type of membership and Agency/organization represented.
** Required by Statute.
***Requested not required

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery (to include family members of adults with SMI)		
Parents of children with SED		
Vacancies (individual & family members)		
Others (Advocates who are not State employees or providers)		

Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		
Individuals/Family Members from Diverse Racial and Ethnic Populations		
Individuals/Family Members from LGBTQI+ Populations		
Persons in recovery from or providing treatment for or advocating for SUD services		
Representatives from Federally Recognized Tribes		
Youth/adolescent representative (or member from an organization serving young people).		
Total Membership (Should count all members of the council)		

22. Public Comment on the State Plan- required

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 diverse audiences (including federal, tribal, or other public agencies, racial, ethnic, sexual and gender minority populations) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ☐ Yes ☐ No

b) Posting of the plan on the web for public comment? ☐ Yes ☐ No If yes, provide URL:

Currently posted on DHHS web site: https://www.dhhs.nh.gov/news-and-media/community-mental-health-services-block-grant-fy-2024-2025-application

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Currently soliciting comments from the public, via email to the Bureau of Mental Health Services at: BMHS@dhhs.nh.gov, and also at the following Survey Monkey link: www.SurveyMonkey.com/r/CH7QBM7

c) Other (e.g., public service announcements, print media) ☐ Yes ☐ No

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

A. Finance

Plan Table 2: State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (7/1/23-6/30/25). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

*Please note that MHBG and SUPTRS BG now have two separate Table 2 submissions.

MHBG – Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding

MHBG Table 2a									
Planning Period:		**From:**			**To:**				
State Identifier									
State Agency Planned Expenditures									
Activity	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	G. COVID-19 Relief Funds (MHBG) [a]	H. ARP Funds (MHBG) [b]	I. Bipartisan Safer Communities Funds [c]
1. Mental Health Prevention [d]	$	$	$	$	$	$	$	$	$
2. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) [e]	$	$	$	$	$	$	$	$	$
3. State Hospital		$	$	$	$	$	$	$	$
4. Other Psychiatric Inpatient Care		$	$	$	$	$	$	$	$
5. Other 24-Hour Care (Residential Care)	$	$	$	$	$	$	$	$	$
6. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$	$	$	$
7. Crisis Services (5 percent Set-Aside) [f]	$	$	$	$	$	$	$	$	$

Table 2a (Cont.) **Activity**	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other	G. COVID-19 Relief Funds (MHBG) [a]	H. ARP Funds (MHBG) [b]	I. Bipartisan Safer Communities Funds [c]
8. Administration (Excluding Program and Provider Level) [g]	$	$	$	$	$	$	$	$	$
9. Total	$	$	$	$	$	$	$	$	$

[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" MHBG. Columns G should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[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 the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from October 17, 2022 thru October 16, 2024 and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Columns I should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

[e] Column 2A should include Early Serious Mental Illness programs funded through MHBG set aside.

[f] Row 7 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation. [f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

Plan Table 2b. State Agency Planned Expenditures

SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG

ACTIVITY (See instructions for using Row 1.)	A. SUPTRS BG	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 (SUPTRS BG) [a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention and Treatment	$		$	$	$	$	$		$	$
a. Pregnant Women and Women with Dependent Children*										
b. Recovery Support Services										
c. All Other										
2. Primary Prevention	$		$	$	$	$	$		$	$
a. Substance Use Primary Prevention										
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[f]										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										

6. State Hospital										
ACTIVITY (See instructions for using Row 1.)	A. SUPTRS BG	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.COV ID-19 Relief Funds (SUPTRS BG) [a]	J. ARP Funds (SUPTRS BG)[b]
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program / provider level) MHBG and SUPTRS BG must be reported separately g										
10. Crisis Services (5 percent set-aside)[h]										
12. Total	$	$	$	$	$	$	$	$	$	$

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost

Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the

COVID-19 Relief Supplemental Funds. Per the instructions, the standard MHBG/SUPTRS BG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2023 – June 30, 2025, for most states. Please enter SUPTRS BG COVID-19 planned expenditures for the period of 7/1/23 through 6/30/25.

[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 the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of 7/1/23 through 6/30/25.

[c]Prevention other than primary prevention [d]The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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

[f]Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside. Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

[g]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.

Plan Table 3: SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

Plan Table 3 SUPTRS BG Persons in need/receipt of SUD treatment		
State Identifier:		
	Aggregate number estimated in need	**Aggregate number in treatment**
1. Pregnant Women		
2. Women with Dependent Children		
3. Individuals with a co-occurring M/SUD		
4. Persons who inject drugs		
5. Persons experiencing homelessness		

Please provide an explanation for any data cells for which the state does not have a data source.

Plan Table 4: SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Plan Table 4	SUPTRS BG Planned Expenditures
State Identifier:	

Expenditure Category	FFY 2024 SUPTRS BG Award	COVID-19 Award [1]	ARP Award [21]	FFY 2025 SUPTRS BG Award	COVID-19 Award [1]	ARP Award [2]
1. Substance Use Disorder Prevention[3] and Treatment	$	$	$	$	$	$
2. Substance Use Primary Prevention	$	$	$	$	$	$
3. Early Intervention Services for HIV[4]	$	$	$	$	$	$
4. Tuberculosis Services	$	$	$	$	$	$
5. Recovery Support Services[5]						
6. Administration (SSA level only)	$	$	$	$	$	$
7. Total	$	$	$	$	$	$

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. If your state
or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the planning period for the standard SUPTRS BG expenditures for the FFY 2024 SUPTRS BG Award is October 1, 2023 - September 30, 2024. For purposes of this table, all COVID19 Relief Supplemental planned expenditures between 10/1/23 and 9/30/24 should be entered in this first COVID-19 column, and all COVID 19 Relief Supplemental planned expenditures between 10/1/24 and 9/30/25 should be entered in the second COVID-19 column.

entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column [2]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of

Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS

[21] 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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be

BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP).. The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5] This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

Table 5a: Primary Prevention Planned Expenditures

States must spend no less than 20 percent of their SUPTRS BG award on substance use primary prevention strategies. The state must spend the majority of the funds implementing a comprehensive primary prevention approach that includes at least one of the six substance use primary prevention strategies, as applicable. These strategies are directed at individuals not meeting the diagnostic criteria for a SUD or identified to not be in need of treatment. To report on their primary prevention planned expenditures, states must complete Table 5a.

States need to make the most efficient use of funds for substance use primary prevention and be prepared to report on the outcomes of these efforts. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data-driven substance use primary prevention system. Specifically, SAMHSA recommends that states align the 20 percent set-aside for primary prevention of the SUPTRS BG with other federal, state, and local funding that will aid the state in developing and maintaining a comprehensive substance use primary prevention system, as well as collaborate with and assure that behavioral health is part of the state's larger public health prevention activities.

Table 5a SUPTRS BG Primary Prevention Planned Expenditures by Strategy and IOM Category

The state's primary prevention program must include at least one of the six primary prevention strategies defined below. On Table 5a, states should list their FFY 2024 and FFY 2025 SUPTRS BG planned expenditures within the six primary prevention strategies, depending on capacity and other factors. Expenditures within the six strategies should be directly associated with the cost of completing the activity or task; for example, information dissemination should include the cost of developing pamphlets, the time of participating staff or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

In most cases, the total SUPTRS BG amount should equal the amount reported on Plan Table 4, Row 2, Substance Use Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non-Direct Services/System Development activities. The total on Table 6 prevention column combined with the total on Table 5a should equal to expenditure Table 4, Row 2 in most instances.

Primary Prevention Planned Expenditures by IOM Category

Information Dissemination– This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, misuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education - This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

Alternatives - This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and drugs through these activities.

Problem Identification and Referral - This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based Process - This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

Environmental - This strategy establishes, or changes written and unwritten community standards, codes, and attitudes; thereby, influencing alcohol and other drug use by the general population.

Other - States that plan their primary prevention expenditures using the IOM model of universal, selective, and indicated should use Table 5a to list their FFY 2024 and FFY 2025 SUPTRS BG planned expenditures in each of these categories.

Institute of Medicine Classification: Universal, Selective, and Indicated

Prevention strategies may be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by the population prioritized. Definitions for these categories appear below:

Universal: Activities prioritized to the public or a whole population group that have not been identified based on individual risk.

Universal Direct. Row 1: Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after-school

program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).

Universal Indirect. Row 2: Interventions support population-based programs and environmental strategies (e.g., establishing policies regarding alcohol, tobacco, and other drugs (ATOD), modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.

Selective: Activities prioritized to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities prioritized to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not meeting diagnostic levels (Adapted from The Institute of Medicine).

States that are able to report on both the strategy type and the population served (universal, selective, or indicated) should do so. If planned expenditure information is only available by strategy type, then the state should report planned expenditures in the row titled Unspecified (for example, Information Dissemination Unspecified).

Section 1926 - Tobacco: Costs Associated with the Synar Program. Per January 19, 1996, 45

CFR Part 96 Tobacco Regulation for Substance Use Prevention and Treatment Block Grants; Final Rule (45 CFR § 96.130), states may not use the Block Grant to fund the enforcement of their statute, except that they **may expend funds** from their primary prevention set aside of their Block Grant allotment under 45 CFR § 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.

Public Law 116-94, signed on December 20, 2019, supersedes this legislation and increased the minimum age for tobacco sales from 18 to 21. SAMHSA revised its guidance to clarify that the prevention set-aside may be used to fund revisions to States' Synar program to comply with PL 116-94. These funds should be reported in the appropriate columns.

Plan Table 5a: SUPTRS BG Primary Prevention Planned Expenditures							
State Identifier:							
Report Period- From: To:							
	A	B			C		
Strategy	IOM Target	FFY 2024			FFY 2025		
		SUPTRS BG	COVID-19 [1]	ARP [2]	SUPTRS BG	COVID-19 [1]	ARP [2]
1. Information Dissemination	Universal	$			$		
	Selective	$			$		

	Indicated	$			$		
	Unspecified	$			$		
	Total						
2. Education	Universal	$			$		
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
3. Alternatives	Universal	$			$		
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
4. Problem Identification and Referral	Universal	$			$		
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
5. Community-Based Processes	Universal	$			$		

Plan Table 5a (cont.)							
	A	B			C		
Strategy	IOM Target	FFY 2024			FFY2025		
		SUPTRS BG	COVID-19 [1]	ARP [22]	SUPTRS BG	COVID-19 [1]	ARP [2]
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
6. Environmental	Universal	$			$		

[22] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is

September 1, 2021 – September 1, 2025, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
7. Section 1926 (Synar)-Tobacco	Universal	$			$		
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
8. Other	Universal Direct	$			$		
	Universal Indirect	$			$		
	Selective	$			$		
	Indicated	$			$		
	Unspecified	$			$		
	Total						
9. Total Prevention Expenditures		$			$		
Total Award [23]		$			$		
Planned Primary Prevention Percentage		%			%		

[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" SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025, for most states.

[23] Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures Plan Table 5b: SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards. Planning Period Start Date: 10/12023
Planning Period End Date: 9/30/2025

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Marijuana	☐	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Priority Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indian/Alaska Native	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Pacific Islander	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Other Underserved Racial and Ethnic Minorities	☐	☐	☐

Footnotes:

[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" SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

Plan Table 6

Categories for Expenditures for System Development/Non-Direct-Service Activities

Please note there are separate tables for MHBG and SUPTRS BG. Only complete this table if the state plans to fund expenditures for non-direct services/system development with MHBG, SUPTRS BG, COVID-19, BSCA, and/or ARP dollars.

Expenditures for these activities may be direct expenditures (involving the time of state or substate personnel, or other state or sub-state resources) or be through funding mechanisms with independent organizations. Expenditures may come from the administrative funds and/or program funds (but may not include the SUPTRS BG HIV set-aside funds). These include state, regional, and local personnel salaries prorated for time spent and operating costs such as travel, printing, advertising, and conducting meetings related to the categories below.

Non-direct services/system development activities *exclude* expenditures through funding mechanisms for providing treatment or mental health or substance use disorder "direct service" and primary prevention efforts themselves. Instead, these expenditures provide support to those activities.

Please utilize the following categories to describe the types of expenditures your state supports with BG funds, and if the preponderance of the activity fits within a category. Although the states may use a different classification system, please use these categories to describe the types of expenditures your state supports with BG funds, when the preponderance of the activity fits within a category.

Information systems – This includes collecting and analyzing treatment data as well as prevention data under the SUPTRS BG in order to monitor performance and outcomes. Costs for EHRs and other health information technology also fall under this category.

Infrastructure Support – This includes activities that provide the infrastructure to support services but for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, and respite services.

Partnerships, community outreach, and needs assessment – This includes state, regional, and local personnel salaries prorated for time and materials to support planning meetings, information collection, analysis, and travel. It also includes the support for partnerships across state and local agencies, and tribal governments. Community/network development activities, such as marketing, communication, and public education, and including the planning and coordination of services, fall into this category, as do needs-assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Planning Council Activities – This includes those supports for the performance of a Mental Health Planning Council under the MHBG, a combined Behavioral Health Planning Council, or (OPTIONAL) Advisory Council for the SUPTRS BG.

Quality assurance and improvement - This includes activities to improve the overall quality of services, including those activities to assure conformity to acceptable professional standards, adaptation and review of implementation of evidence-based practices, identification of areas of technical assistance related to quality outcomes, including feedback. Administrative agency contracts to monitor service-provider quality fall into this category, as do independent peer review activities.

Research and evaluation - This includes performance measurement, evaluation, and research, such as services research and demonstration projects to test feasibility and effectiveness of a new approach as well as the dissemination of such information.

Training and education - This includes skill development and continuing education for personnel employed in local programs as well as partnering agencies, as long as the training relates to either substance use disorder service delivery (prevention, treatment and recovery) for SUPTRS BG and services to adults with SMI or children with SED for MHBG. Typical costs include course fees, tuition, and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.