Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-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 and children with an emotional disturbance. BMHS works to ensure the provision of efficient and effective services to those citizens who are most severely and persistently disabled by mental, emotional, and behavioral dysfunction as defined by NH laws and rules. To this end, BMHS has divided the entire state into community mental health regions. Each of the ten regions has a BMHS-contracted Community Mental Health Center and many regions have Peer Support Agencies.

Administrative Rules in the He-M 400 range detail the community-based psychorehabilitative 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 He-Ms governing mental health treatment may be found here: http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html

2. Does your state provide the following services under comprehensive community-based mental health service systems?

   a) Physical Health
   b) Mental Health
   c) Rehabilitation services
   d) Employment services
   e) Housing services
   f) Educational Services
   g) Substance misuse prevention and SUD treatment services
   h) Medical and dental services
   i) Support services
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   k) Services for persons with co-occurring M/SUDs

   Please describe as needed (for example, best practices, service needs, concerns, etc)

   All psychorehabilitative services and services for persons with co-occurring M/SUDs are provided by all ten CMHCs. Several CMHCs additionally offer SUD treatment services, or refer to close partners in SUD treatment. Most CMHCs have Memorandums of Understanding or less formal relationships with local School Administrative Units (SADs) or the schools themselves.

   NH has greatly expanded Housing supports and services; these efforts are successful and demonstrate the necessity and effectiveness of stable housing for positive recovery outcomes.
The NH Legislature has become an advocate for improvements to the Mental Health needs of NH citizens. Budget constraints increase with every budget cycle, however. Continued advocacy for people impacted by mental illness or co-occurring disorders is an ongoing need.

3. Describe your state’s case management services

The community mental health system in the State of New Hampshire is built upon a foundation of robust case management. The Administrative Rules guiding the structure of NH community mental health programs invokes case management and case managers throughout its service delivery and client-centered services system requirements. For example, case management is offered, at intake, to all SPMI and SED clients. The client-driven treatment planning process is facilitated by the case manager; they are the primary contact for the client.

In accordance with Targeted Case Management (TCM) principles, Community Mental Health programs may serve as the sole case management entity for SPMI or SED individuals, or the Centers may serve as the linkage point for mental health services for clients whose cases are coordinated by another entity, including schools, developmental services agencies, or nursing homes. The TCM requirement limiting case management billing to one entity per client encourages communication across the service spectrum and a client-centered experience. Individuals involved across the system have the option to select the agency to manage their case.

An annual case management assessment and care plan pursuant to He-M 426, includes documentation of the following, when applicable:

- Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual; Assessing the individual’s strengths; and determining the individual’s preferences; and
- Identification of the consumer’s case management needs.

If the consumer agrees to accept case management, the referral and monitoring activities to be provided are documented in the individual’s care plan which, after having been developed, is revised periodically.

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.

The consumer’s needs and strengths may or may not be assessed through use of the CANS (for SED clients) or ANSA (for SPMI clients). Each Community Mental Health Center may choose to use the CANS and ANSA, or a case management needs assessment of their own design.

An individual may decline to receive services that are suggested in the care plan.

Further description of the Case Management service may be found in Administrative Rule He-M 426.15 at http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html

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

Transitional Housing Services (THS)

New Hampshire DHHS, through a contracted provider, offers THS to serve the clinical, medical, vocational and residential needs of adult men and women with mental health issues. The goal is to help individuals successfully transition from New Hampshire Hospital into the community as well as maintain their independence in the least restrictive environment possible. Transitional Housing Services offers the following:

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

The Housing Bridge Subsidy program, administered by the BMHS, is proving to be highly successful, moving eligible persons out of the state hospital or transitional group housing into safe, affordable residences in the community. This program uses NH general fund dollars to provide rental subsidies to adults with SMI who are homeless or at risk of becoming homeless. Priority candidates for the Housing Bridge program are those recently discharged from the psychiatric hospital or those at risk of hospitalization or re-hospitalization.

All of these services are designed in an effort to reduce unnecessary institutionalization:

- 24/7 Crisis Service System
- Mobile Crisis Teams
- Community Crisis Apartments
- Assertive Community Treatment ("ACT")
New resources approved by the Legislature in June 2017
In an effort to alleviate the wait times that individuals with severe mental illness (SMI) experience for a bed at New Hampshire Hospital as well as to successfully transition individuals from NH Hospital to the community, the NH DHHS has taken the first step in the implementation of the significant investments that NH Legislature have made in the expansion of mental health services in the State. Initiatives include:

(1) Establishing up to 20 additional designated receiving facility beds for up to two years to serve individuals with severe mental illness who meet the criteria for involuntary emergency admission;
(2) Adding transitional and community residential beds with wrap-around services and supports;
(3) Adding a mobile crisis team and apartments in a geographic location that has high rates of admissions to and discharges from New Hampshire Hospital; and
(4) Conducting an independent evaluation of the capacity of the current health system in NH to respond to inpatient, acute psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions.

Children
DHHS has worked cross-departmentally to blend funding and leverage resources to meet the needs of children and youth who have intense behavioral health needs. This beginning work of de-siloing services and funding streams within DHHS will provide a foundation for continued efforts. Shared or blended resources and funding can help keep children and youth from moving into more costly and ineffective service systems such as psychiatric hospitalizations, out-of-home placements, and court involvement.

Three CMHCs have children’s Assertive Community Treatment (ACT) teams, managed by the BBH. One CMHC has engaged with BCBH to pilot and provide a collaborative model of Assertive Community Treatment (ACT) and High Fidelity Wraparound for children and youth.
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 behavioral health system.

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>14%</td>
<td>21%</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>6%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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 URS tables for planning and reporting purposes.
Does your state integrate the following services into a comprehensive system of care?

a) Social Services

b) Educational services, including services provided under IDEA

c) Juvenile justice services

d) Substance misuse prevention and SUD treatment services

e) Health and mental health services

f) Establishes defined geographic area for the provision of services of such system

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Narrative Question

Criterion 3: Children’s Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

**Criterion 3**

Does your state integrate the following services into a comprehensive system of care?

a) Social Services

b) Educational services, including services provided under IDEA

c) Juvenile justice services

d) Substance misuse prevention and SUD treatment services

e) Health and mental health services

f) Establishes defined geographic area for the provision of services of such system
Describe your state’s targeted services to rural and homeless populations and to older adults

Targeted Services to Rural and Homeless Populations and to Older Adults

Rural Populations

NH DHHS, through its Division of Public Health Services - Bureau of Community Health Services, Rural Health and Primary Care Section includes the Primary Care Office, the State Office of Rural Health, and Workforce Development. The mission and function of the Rural Health and Primary Care section is to support communities and stakeholders that provide innovative and effective access to quality health care services with a focus on the low income, uninsured, and Medicaid populations of New Hampshire. The Primary Care Office (PCO) works with other NH partners statewide to improve access to quality health care services especially for uninsured residents. The PCO is the location of the NH Health Professions Data Center and is responsible for federal health care shortage designations. The PCO also provides technical assistance for National Health Service Corps sites.

Rural Health Care

The State Office of Rural Health (SORH) offers technical assistance to rural health care providers and organizations and provides healthcare-related information to rural healthcare stakeholders. SORH serves as a liaison between rural healthcare organizations and many DHHS programs. It also includes the Medicare Rural Hospital Flexibility Program, which supports the Critical Access Hospitals and the Small Rural Hospital Improvement Program.

Workforce Development

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

National Interest Waiver Program

The Division of Public Health Services, Rural Health and Primary Care Section, has the responsibility within the State of New Hampshire to provide a Letter of Attestation in support of a foreign physician’s request for a National Interest Waiver from the US Citizenship and Immigration Services (USCIS). The foreign physicians’ work must be in an area that has been designated as having a shortage of health care providers by the Secretary of Health and Human Services, and must be deemed by the Division of Public Health Services to be in the public interest.

State Loan Repayment Program

The New Hampshire State Loan Repayment Program (SLRP) provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time). The allotment of funds is contingent on the availability of specified SLRP funding in the State budget for any given fiscal year. These medically underserved areas; identified as Health Care Professional Shortage Areas (HPSAs), Mental Health Professional Shortage Areas (MHPSAs), Dental Health Professional Shortage Areas (DHPSAs), Medically Underserved Areas/Populations (MUA/Ps), and Governor's Exceptional Medically Underserved Populations (E-MUP) are indicators that a shortage of primary healthcare providers exist, posing a barrier to access to primary health care services for the residents of these areas.

DHHS’s Bureau of Homeless and Housing Services provided funding to 43 programs that provided shelter to 4,013 homeless men, women and children in SFY ’16. These shelter programs act as a safety net for individuals and families who have run out of options and would otherwise be without a place to sleep. They are a critical component of the local homeless care network.
Describe your state's management systems.

By far the largest efforts in supporting recovery services are the Peer Support Agencies that are subsidized by the MHBG as well as State general funds. To maintain professionalism, the PSA system in New Hampshire remains heavily reliant on ongoing training of peers. Our ten Peer Support Agencies involve peers in their own care. They are peer-led (e.g., boards of directors), peer-driven (e.g., community meetings, team-building meetings) and partially peer-staffed. Some Peer Support Agencies offer peer crisis respite and peer transitional housing services, as well.

Staff members must be trained in Intentional Peer Support (IPS) and Wellness Recovery Action Plan (WRAP) (developed by Mary Ellen Copeland, PhD). Some staff need numbers here have also taken Whole Health Action Management (WHAM) training and received training as Recovery Coaches.

All staff also receive Sexual Harassment, Member Rights & Responsibilities, Mental Health First Aid, Warm Line and Crisis Prevention & Intervention Training (CPIT).

Additional trainings provided on an as needed basis have included, and will continue to include Warmline, WHAM, conflict resolution and others. These trainings offer vital opportunities for personal, professional and system-wide growth.

MATCH

MATCH-ADTC (or the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems) is a flexible, individualized approach for providing evidence-based cognitive behavioral intervention that addresses the most common presenting issues of the children and families served by CMHCs. The intervention has been rigorously tested and employed successfully to improve child outcomes in diverse CMHCs nationally.

All participating CMHCs will receive training and implementation support from Judge Baker over the course of the Learning Collaborative. To accommodate as many CMHCs as possible, the Learning Collaborative will be divided into two training cohorts, each lasting approximately 17 months. Intensive training, technical assistance, and support will be provided in all aspects of MATCH implementation, allowing sites to skillfully install the MATCH intervention in their programs, as well as sustain high quality implementation of the model beyond the term of the initiative.

The MHBG will be the sole source of funds for the MATCH training.

STAFFING FOR FEP – PROGRAM SUPPORT AND STAFF TRAINING COSTS

The MHBG funds set aside for the support of FEP treatment will be used for continued training and support of the HOPE FEP team at Greater Nashua Mental Health.

CANS & ANSA – PROGRAM SUPPORT AND STAFF TRAINING COSTS

These funds will also be used for the furthering of the CANS & ANSA data management contract with RCR Technologies. The CANS & ANSA will be used for FEP program screening and outcomes measurement. This will ensure reduction of administrative burden, since all Community Mental Health Centers are using the tool and will not need to administer additional tools to measure outcomes. Should they need to complicate their business processes by incorporating additional psychometric measures beyond those already employed, there will be resistance toward training and adoption of FEP modalities within their programs.

MHBG CANS & ANSA-targeted funds will also cover the costs of the issuing and compiling annual staff certification required for use of the instruments.