

Proposed 10-Year Mental Health Plan for Public Hearing

Prepared for

**Division for Behavioral Health
Department of Health and Human Services**

November 2018

Center for Behavioral Health Innovation
Antioch University New England

Message from the Commissioner

The Department of Health and Human Services (DHHS) is pleased to release a *Proposed 10-Year Mental Health Plan* for public review and comment. In 2017, the Department was directed by the New Hampshire Legislature in House Bill 400 to facilitate the development of a new 10-Year Plan. This proposed plan was developed from a statewide stakeholder process that included input from hundreds of interested parties who took a critical look at the current system. Input came from focus groups, workgroups, and public sessions held in recent weeks. The proposed plan addresses the needs of individuals and families across the continuum of care, and provides innovative models to meet the evolving environment and increasing complexity of the mental health system. Not all the statements in the 10-Year Plan are findings of DHHS, but rather reflect stakeholder and public input. It is a product of that robust public process. And it represents the next step in the process of creating a final 10-year plan that will be informed as well by the Governor, legislature, the department and the public in the coming legislative session.

This proposal comes at a time of great opportunity given the resources that are being afforded to us through the federal and state governments, including the Medicaid Delivery System Reform Incentive Payment (DSRIP) Transformation Waiver, the Community Mental Health Agreement, new children's mental health initiatives, state opioid response funds, legislative appropriations, and other monies and programs that support our work to expand and integrate services to address whole-health needs. We hope that you will take the time to read the proposed plan and offer input. DHHS will hold a public hearing on the proposed plan in Concord on Monday, December 3, 2018, from 5:00 - 7:00 PM, at the Howard Recreation Center Auditorium, 99 Pleasant Street, on the Hugh Gallen State Office Park Campus.

DHHS looks forward to receiving continued input through the next phase of the hearing and comment process and then to working with all stakeholders in the upcoming legislative session to fashion an actionable final plan.

DHHS would like to express its sincere appreciation to the Center for Behavioral Health Innovation at Antioch University New England for its support and hard work in coordinating the public stakeholder process. The work of Megan Edwards, Jim Fauth, and George Tremblay was instrumental in this process. I also wish to thank the many mental health advocates, providers, and other stakeholders who participated in the process facilitated by Antioch, as well as the many persons with lived experience and their family members who attended our public sessions and told their stories, powerfully and heartfelt.

Jeffrey A. Meyers
Commissioner

Table of Contents

New Hampshire’s Mental Health Plan At-A-Glance.	3
To a Brighter Tomorrow for NH’s Mental Health System.	9
A Vision for New Hampshire’s Mental Health System.	10
Mental Health Equity	16
Coordinated Continuum of Care	19
Community Education	20
Prevention and Early Intervention	21
Outpatient Services	22
Step-Up/Step-Down Services	24
Crisis and Inpatient Services	26
Integration of Peer and Natural Supports	28
Infusion of Resources	30
Leadership	33
High-Quality Workforce	34
Technology and Infrastructure	36
Quality Assurance and Monitoring	37
Strategic Framework	38
Implementation Timeline and Milestones	40
Outcomes	42
Integration with Other State Plans And Entities	44
Appendix A: Planning Process and Contributors	46
Appendix B: Contributing Factors	48
Appendix C: Build the Foundation FY 2020/2021.	49
Notes	52

New Hampshire's Mental Health Plan At a Glance

NH's Mental Health System

Access to mental health services for different populations across the continuum of care varies greatly throughout the state. Long wait times for psychiatric hospitalization is one visible symptom of a stressed mental health system. Limited access to care, the difficulties inherent in navigating a complex and fragmented system, shortages and turnover in the mental health workforce, limited alternatives to the Emergency Department (ED), and the need to comprehensively address the social determinants of mental health are also common concerns raised about New Hampshire's (NH) mental health system. Underlying it all, in the minds of many, is the need to increase funding for mental health.

And Yet, Signs of Hope Abound

The resilience and spirit of New Hampshire's people and communities, along with the dedication and ingenuity of our many committed, dedicated mental health professionals, are major mental health bright spots in NH. Innovative projects that now serve as a foundation for NH's mental health system of the future include Assertive Community Treatment (ACT), the Families and Systems Together (FAST Forward) program, Multi-Tiered Systems of Support for Behavior and Wellness (MTSS-B) in our schools, and the statewide DSRIP project. NH's spirit of innovation and collaboration will serve us well as we continue to transform the mental health system.

From Bright Spots to a New Vision for the Mental Health System

This *Proposed 10-Year Mental Health Plan* (Plan) envisions a mental health system reorganized into a regional hub-and-spoke model with enhanced central accountability and oversight, supporting regional hubs in the delivery of a robust spectrum of evidence-based and promising practices in the communities where people live and work. Such a hub and spoke system could be aligned with existing regional efforts, such as the Integrated Delivery Networks (IDN) or the hub and spoke system now developing to address opioid treatment and recovery. A single phone number could allow all NH residents to access a regional specialist who will provide information; facilitate referrals to appropriate mental health, substance abuse, and/or other social services; and monitor outcomes and follow up as needed. Community-based delivery of mental health services must remain an important focus of the State's efforts.

Developing a Coordinated Continuum of Care for All NH Residents

The success of a regionally-based mental health service delivery system depends on a robust, well-coordinated web of services and supports. This Plan calls for access to a full continuum of care for all populations – community education, prevention and early intervention, outpatient supports, step-up and step-down options, and crisis and inpatient

services – across the state. Assistance with barriers to access and the social determinants of mental health, attention to the needs of special populations, enhanced school-based mental health, multiple alternatives to the ED and psychiatric hospitalization, more integrated primary care, supported transitions between “steps” in the continuum of care, and infusion of peer supports throughout the system are among the elements called for in the Plan.

Infrastructure Supports Bind the System Together

This Plan proposes funding benchmarks and strategies for securing the resources needed to continue to transform NH’s mental health system. Additional infrastructure and systems improvements, including enhanced use of technology, a more fully integrated data and quality assurance system, and a less burdensome regulatory system, will also be needed to continue the transformation of NH’s mental health system. Shared leadership – the Governor and Legislature, DHHS, advocacy and philanthropy organizations, providers, and grassroots support – will be key to continue the transformation of our mental health system. These additional resources, together with increased recognition of the importance of mental health, will help expand the necessary qualified workforce.

Strategic, Adaptive Implementation Leads to Improved System Functioning, Better Lives

Any 10-year plan requires the support and active collaboration of all interested parties, including government, providers, stakeholders, and the public. What follows are a number of potential action steps that would continue to improve the capacity and strength of the state's mental health system in the years to come. Review and adaptation of the Plan to changing conditions in concert with biennial budget cycles is critical to successful implementation. At the system level, all of us wish to achieve improved access, coordination, quality, equity, and cost efficiency. At the population level, all of us anticipate better lives for the residents of NH, in the form of fewer suicides, opioid overdoses, and other causes of early/preventable mortality; lower rates of abuse, delinquency, and incarceration; better care experience and satisfaction; enhanced social networks and relationships; and enhanced quality of life.

To a Brighter Tomorrow for NH's Mental Health System

The World Health Organization defines mental health as “a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” Not only individuals, but communities too, function best when all of their members reach their mental health potential, and when the agencies charged with supporting mental health have the infrastructure and tools they need to fulfill their missions.

The wellbeing of our population expressed in some current statistics are well known. Opioid overdose deaths in NH the past three years placed the state in the national news. In 2016, such overdose deaths were approximately 437 according to the federal government. In 2017, that number grew. While the overdose death rate appears to be on a downward trend in 2018, NH continues to experience some of the highest number of opioid deaths in the nation. According to the Centers for Disease Control, suicides have risen by more than 30% in NH in the last 5 years¹. Homelessness remains a persistent challenge², and several recent, well publicized critiques of NH's Division for Children, Youth and Families remind us of the challenges faced by our child protective system.

Substance misuse, suicide, homelessness, and child maltreatment are critical manifestations of distress, which collectively present mounting challenges to New Hampshire's public health system. To be sure, we are not alone – the dramatic escalation of substance misuse and suicide across our nation has contributed to the reversal of what had been a long-term upward trend in life expectancy. In a 2017 report entitled, “Pain in the Nation,” the Trust for America's Health called these losses “deaths of despair,” arising fundamentally from pain, disconnection, and lack of opportunity³. These burdens can fall disproportionately on segments of our population already bearing debilitating illness or other disadvantages.

One of the fundamental responsibilities of society is to support the wellbeing of all its people, including the less fortunate among us. We confront this moral imperative in virtually every facet of public life

(education, distribution of natural resources and perils, public safety and criminal justice), but particularly in the design and delivery of healthcare. And yet, society has proved highly susceptible to averting its gaze from this imperative – time and again – when it comes to mental health.

Psychiatric Care Wait Times: A “Red Flag” of System Stress

The past few decades have seen a dramatic decline in NH's psychiatric inpatient capacity, reducing beds in the state's psychiatric hospital (NH Hospital; NHH) even as community hospitals have simultaneously reduced or eliminated mental health units⁴. At the same time, the limited array of community supports in some areas means that too much of our current inpatient capacity is occupied by patients who might be able to be effectively treated in less restrictive and more economical environments⁵. The number of NH residents waiting in hospital EDs for admission to inpatient psychiatric treatment has more than tripled since 2014, exceeding 70 across the state on several days in the past year. In many cases, these individuals – including children – remain in hospital examination cubicles in hectic ED environments for a week or more before they are transferred to specialty psychiatric treatment⁶. EDs are not intended to serve as long-term waiting spaces. More importantly, these waits delay comprehensive therapeutic treatment.

Once they achieve admission to the psychiatric hospital, the treatment that patients receive is intended to stabilize them to the point where they no longer pose an imminent threat to themselves or others, then to discharge

them (after a median stay of about 10 days) back into outpatient care in their home communities. The effort to minimize inpatient stays is a legacy of the “deinstitutionalization” movement of the 1970s, driven by a vision of mental health in which persons with mental illness would not be segregated from the rest of society, but instead supported to reach their potential as members of their home communities. This enlightened treatment model hinges on the availability of community-based services and supports to help persons with mental illness sustain their wellbeing outside of the hospital. However, there are limited community-based services throughout some areas. As a result, patients discharged from inpatient care sometimes encounter gaps in the supports they need to remain well outside the hospital, and in the last fiscal year, a third of them were readmitted for inpatient treatment within 6 months of discharge⁷. Populations for whom finding appropriate supports is particularly challenging in NH include the elderly, children, rural residents, those with co-occurring substance misuse or developmental disabilities, and those with legal involvements.

The Need for Expanded Funding for NH's Mental Health System

Most stakeholders we have encountered believe that the fundamental cause of NH's inadequate mental health service array is insufficient and unreliable funding over a period of years. A steady stream of highly regarded policy recommendations, dating back at least to the 2008 10-Year Mental Health Plan, historically stalled against a deep national recession and other factors.

But starting in 2017, the State undertook an aggressive effort to expand funding of mental health services. HB 400 and HB 517 funded a series of efforts such as transitional housing, increased crisis services and a new children's Medicaid mental health benefit. This effort continued in 2018 with a targeted payment to Community Mental Health Centers and an increase in the mental health Medicaid fee schedule for the first time since 2006. While these initiatives are providing needed support, funding barriers must be overcome in order to realize a fully sustainable mental health system.

One major source of fuel for the mental health system is the fee structure that determines what providers will be paid for the services they deliver.

Recent analyses indicate that NH Medicaid, which funds most services provided through our community mental health system, reimburses mental health providers at about 58% of the rates paid for the same service by commercial (or private) insurance. Both Medicaid and commercial insurers pay less for mental health services in NH than they pay for the same services in surrounding states. Moreover, commercial insurers in NH pay a smaller fraction of the actual cost of delivering services for mental health than they do for other health specialties. Although DHHS implemented an 8% increase in state fiscal year 2019 to support select mental health services, the rate increase is temporary. The common perception of the combined effect of these fiscal realities is to attach less value to mental health in NH than our neighboring states do, less value to mental health than to other aspects of health, and the least value of all to the mental health of our most vulnerable citizens.

Low reimbursement rates translate into lower salaries, limited benefits, and ultimately, into migration of the needed workforce out of the state. The lowest salaries are found in agencies with the highest proportion of Medicaid patients. That means NH's community mental health centers are forced to compete with salary and benefit packages in the private sector, which, in turn, struggles to compete with the workforce marketplace in surrounding states. In April of 2018, the NH Community Behavioral Health Association reported that more than 10% of clinical positions across NH's public mental health system were unfilled, for a total of 244 vacancies⁸. The inability to recruit psychiatrists, in particular, is a constant concern, cited among the reasons why community hospitals have eliminated inpatient psychiatric beds and why agencies have not come forward to serve as designated receiving facilities for people with urgent psychiatric needs. On a per capita basis, CT, MA, and VT have 3–6 times as many psychiatrists and about twice as many clinical psychologists, social workers, and mental health counselors as NH⁹.

Stakeholders with whom we met were assertively skeptical of the power of any Plan to address our mental health priorities without a commitment to securing the resources needed to realize that vision. This Plan proposes benchmarks for additional funding. Enacting these fiscal changes will require determination, sound fiscal thinking and policy, and strategic allocation of resources.

Mental Health “Bright Spots” In NH

Despite the gaps in our current mental health system, bright spots also abound. Anyone who travels NH’s mental health landscape comes away humbled by the wisdom, passion, and commitment of administrators, clinicians, and staff alike to the individuals, families, and communities they serve – despite low salaries and otherwise stressful work conditions. This attests to a spirit of service that is part of NH’s rural can-do, communitarian tradition – any discussion of NH’s mental health bright spots needs to begin here. The commitment and ingenuity of our many committed, dedicated mental health professionals will surely play a pivotal role in driving the next iteration of NH’s mental health system, just as it underlies the other bright spots outlined below.

The State and NH’s mental health and substance misuse professionals, advocates, and funders have demonstrated the vision and skills to undertake innovative projects that will serve as guides for mental healthcare expansion under the new Plan. Three mobile crisis response teams provide community-based emergency services, including stabilization beds. The Housing Bridge Subsidy Program, for example, has provided safe, stable, and affordable housing for more than 800 individuals with severe mental illness statewide who are awaiting Section 8 Housing Vouchers. Assertive Community Treatment (ACT) teams that offer intensive, interdisciplinary support to help adults with serious mental illness avoid inpatient placement where feasible, and function more independently at work, home, and in community. ACT teams and Supported Employment are now in place across NH’s Community Mental Health Centers (CMHC). Similarly team-based and intensive, the Families and Systems Together (FAST Forward) program, launched in 2015, serves youth with serious emotional disturbances and their families throughout the state with complex needs that traditionally result in frequent – but often avoidable – out of home placements. Offering wraparound services to support youth and family guided goals, FAST Forward helps families navigate across mental health, education, juvenile justice and other systems to develop a coherent plan for success. The FAST Forward model is currently being

expanded in the Monadnock region and in school districts throughout the state. School districts, too, are beginning to address the social emotional learning and behavioral health needs of students, with trauma-informed, family-engaged implementation of the Multi-Tiered Systems of Support for Behavior and Wellness (MTSS-B). These child-focused efforts were accelerated when, in the Summer of 2016, NH’s legislature passed Senate Bill 534, directing the Department of Health and Human Services and the Department of Education to collaboratively develop systems of care to better meet the behavioral health needs of NH’s children and youth. The statewide DSRIP project is two years into a five-year demonstration project in rethinking the design, delivery, payment, and monitoring of services to address the behavioral health needs of NH’s entire Medicaid membership. As this report is being compiled, DHHS and regional partners throughout the state are envisioning a statewide hub and spoke network to improve access to treatment for Substance Use Disorders (SUD). Building off the DSRIP and SUD networks is a central feature of this Plan.

Several common themes that cross these bright spots are worthy of note because they have direct relevance to the Plan to follow. The first is a spirit of innovation; a willingness to invest in new ideas and cast aside the inertia of habit. The second is a drive toward integration of expertise and care pathways into a model organized around the needs and experience of the target population; a recognition that systems designed around professional specialties and institutional boundaries too often present barriers to care. The third is the ambition to pursue federal and foundation funding to launch demonstration projects, which then generate success stories that recruit more sustainable public investments. At the center of these efforts is DHHS’ leadership and collaboration with mental health stakeholders across the state. Many of the initiatives mentioned above began with grant funded partnerships between public and private partners. NH excels at these partnerships because we have a small enough population that the players either already are, or can easily become, known to each other.

From Bright Spots to Transformation

This Plan emerged from extensive engagement with stakeholders in focus and work groups across the state, conducted throughout the Spring and Summer of 2018 (see Appendices for more on the planning process). The Plan also profited from the accumulated wisdom articulated in many NH proposals, white papers and reports over the past decade, including the *2008 NH Mental Health Plan*¹⁰ and the 2018 capacity assessment conducted by the Health Services Research Institute¹¹. Stakeholders who met in focus groups and cross-sector workgroups, both of which included participants with lived mental health experience, strongly reinforced the continued value of these existing analyses and proposals.

One emphasis in this Plan that has not been as visible in previous reports is a focus on high-level systems change. Facilitators of this planning process were encouraged at every step – by key advisors in prominent leadership

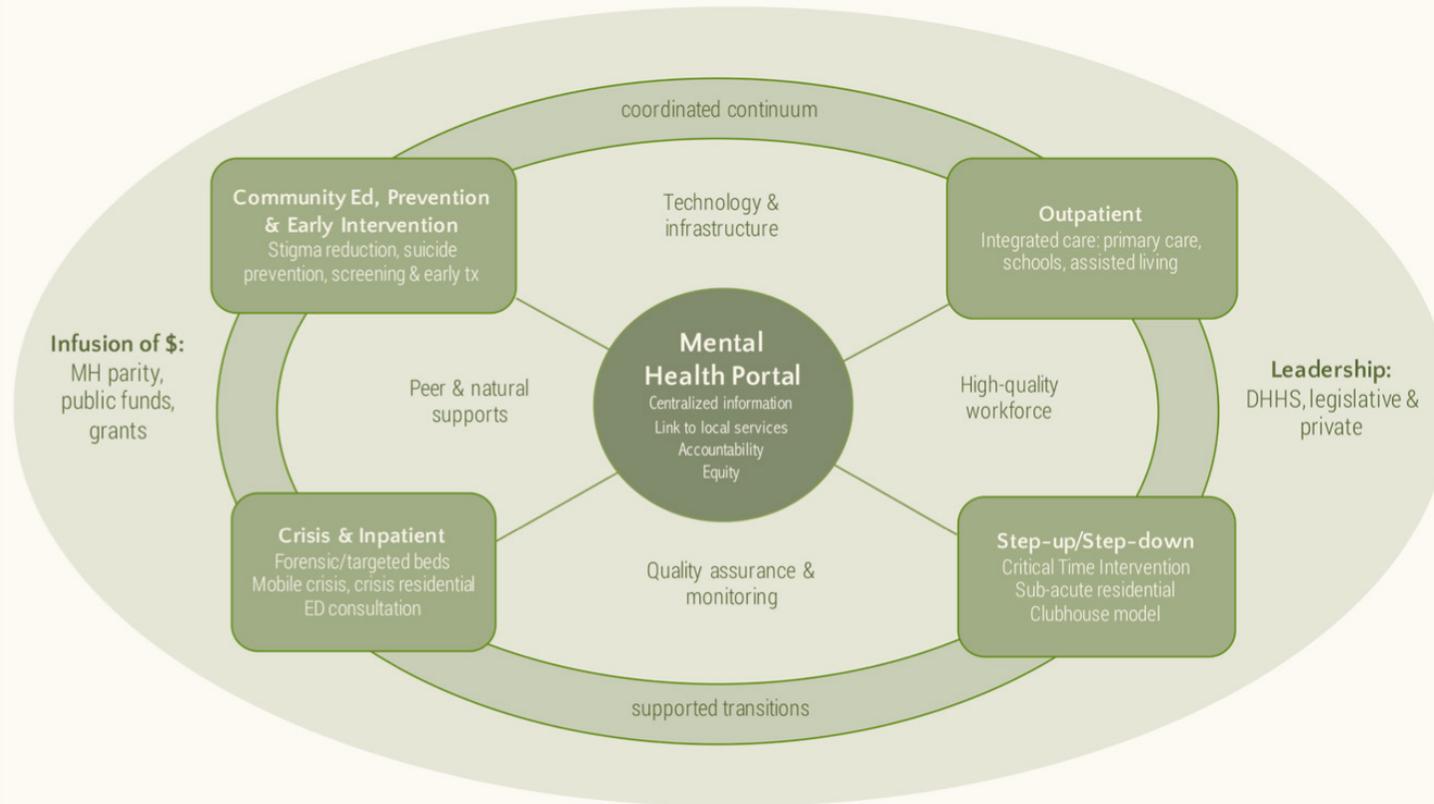
roles, practitioners, and those with lived experience – to bring ambitious, systems-level change to NH's mental health system. The result is a recommendation to reorganize the mental health system into a hub-and-spoke model with enhanced central accountability and oversight, supporting regional hubs in the delivery of a robust spectrum of evidence-based and promising practices in the communities where people live and work. If we make strategic investments, NH can reduce stigma, eliminate inequities in access to care, and offer all of its citizens a coordinated continuum of high quality services. Fewer people will need to seek mental healthcare at hospital EDs, and none of them will wait there for extended periods until specialty care becomes available. The problem of ED wait times is a recent phenomenon in NH and attention is now focused on it. The right care at the right time will reduce more severe manifestations of distress, manage them more effectively when they do arise, and nudge more of our population toward a state of personal wellbeing.

A Vision for NH's Mental Health System

Vision Statement: New Hampshire's mental health system will be robust and cohesive; will respect the dignity and centrality of the whole person; empower people, family, and community; and will reduce stigma while facilitating rapid access to a coordinated, high quality array of localized services and supports for all, through a centralized portal.

Imagine you are a parent with an adolescent in psychiatric crisis late at night, with no prior connections to a mental health provider. Who do you call? Do you dial 911, try calling the local community mental health center, or go straight to the hospital? Is there a mobile crisis service in your area? If so, how

do you access it? Is there a way to get your child the targeted help he or she needs without calling an ambulance, law enforcement, or waiting in an ED? NH's mental health system can be hard to access and difficult to navigate.



Blueprint for a New, Coherent System

The graphic on the previous page depicts the array of system supports, continuum of coordinated services, and linkages embodied in the envisioned system of care. At the heart of the system, a centralized mental health portal will direct consumers to information and appropriate localized services and serve as a locus of system accountability. Regional links across the continuum of care will support transitions to minimize service gaps and wait times. Strong leadership across public and private spheres will support resource infusion, advocacy, and sustainability for the mental health system. Infusion and alignment of financial, infrastructure, and human resources will ensure efficient and effective functioning. Cross-cutting technology, a high-quality workforce, ongoing quality assurance and monitoring, and infusion of peer and natural supports will further support this envisioned system of mental healthcare.

Improved Access, Services, and Follow-Up

In this new system, the foregoing family in crisis will pick up the phone and dial a short, memorable phone number to access the mental health system. They will be immediately connected via phone to a live person located within their regional hub, who works with them to assess their child's immediate needs and risk level, and the appropriate level of care and service. Once the options are discussed and the appropriate supports agreed upon, the services will be dispatched, and/or appointments made with local providers – with follow-up from the regional hub staff to track the family's engagement in and the outcome of services and make adjustments according to their plan of care.

Values and Principles Supporting the Mental Health Vision

Person-centered	The person (and his or her family) is the driving force in his or her healthcare decisions and an equal partner in planning and delivery of care. The unique values, preferences, and circumstances of the individual are honored, resulting in better engagement and treatment ownership/adherence, while protecting the dignity of the individual.
Whole person focus	Whole person care considers the complex intersections between physical, emotional, spiritual, and behavioral health. The focus is not just on behavior, the current mental health crisis, or diagnosis. Attention to social determinants of health is key.
Empowered people, families & communities	People are educated and aware of the resources available, able to navigate the system toward individualized supports and services, increasingly able to rely on natural supports in their home communities, and feel comfortable and heard in voicing preferences in their healthcare decisions. The centrality and power of families and natural supports in the healing process is recognized and supported.
Localized services	Community-based care is prioritized to ensure that, to the highest extent possible, individuals receive care in the areas closest to their homes, natural supports, and social networks, resulting in increased access to and satisfaction with care, and better community integration for individuals with mental health conditions.
Pooled resources, infrastructure & accountability	Organizations and providers share resources (e.g., common data platforms, shared training and professional development) to leverage financial and human resource capacity to provide the most efficient care. There is shared accountability for service delivery and outcomes.
Equity	The system works toward and holds itself accountable for eliminating disparities in social determinants of health, ensuring equal access to supports and services, and eliminating disparities in mental health outcomes for excluded or marginalized groups.

Mental Health Portal and Regional Hub and Spoke System

The Mental Health Portal (Portal) will serve as a single source of phone-based and online information and guidance. The Portal will be accessed by calling one memorable phone number from anywhere in the state, 24 hours a day, 365 days a year. Any individual, family member, teacher, health provider, friend, etc. will be able access the Portal to gain information about his or her condition and corresponding supports and services. This is consistent with the trend toward replacing traditional “inward” facing hub and spoke models that push patients from community-based services inward toward a central hub for more intensive and specialized care (i.e., the hospital) with “outward” models, in which centralized one-door access (portal) connects people to community-based care that meets their individualized needs (regional hub and spokes). Outward models allow individuals to be served where they live, increase accessibility of care, and minimize demand on hospitals through prevention and follow-up care at the local level.¹²

Once connected to the Portal, callers will receive a warm hand-off to a hub in their geographic region. Staff in each regional hub should assess and triage all callers to support a referral matched to each person’s level of need. The regional hub will maintain connection to a network of “spokes,” consisting of local outpatient mental health services, mobile crisis, peer support, and other localized services. Regional hub staff should have access to current residential bed availability through a centralized database, and the ability to facilitate referrals and support transitions into and out of more intensive care in other regions as necessary. Eventually, the hubs should offer brick-and-mortar walk-in triage, assessment, and facilitated referral services, along with 24-hour short-term crisis stabilization beds.

The Mental Health/SUD Portal should be administered and supported through DHHS – or another contracted system administrator – to provide underlying infrastructure supports for the regional hubs and the continuum of localized care. In addition to providing a central mental health access point for the public, the Portal should also serve the following functions:

Accountability	Transactional and population level accountability for the entire continuum of care
Shared measures	A shared measures platform to monitor performance and improve quality across the regional hubs
Education	A public awareness and stigma reduction campaign to be coordinated throughout the state
Training	A central training and professional development center distributed to providers regionally
Consultation	A central phone line through which primary care providers can receive expert consultation from a psychiatrist (financial and human resources can be pooled to staff the service)
Resource tracking	A data platform for monitoring available resources in real time (tracking beds, wait times in EDs, mobile crisis units and other services, etc.) to facilitate movement through the system, minimize backups, and prevent unnecessary wait times in EDs

Integrated with the Substance Use Disorder System

The Bureau of Drug and Alcohol Services (BDAS) is in the process of developing a very similar hub and spoke model for the SUD prevention and treatment system. Its model features a state-supported single phone/online access point, through which all NH residents will obtain information about available SUD services and supports. When calling in, individuals will receive a “warm hand-off” to one of nine regional sites distributed geographically throughout the state. Each regional site – consisting of a physical location as well as phone support – will offer screening, evaluation, and a facilitated referral to local SUD services.

Although NH has traditionally operated separate mental health and substance abuse treatment systems, the conditions are undeniably intertwined. Even effective treatment in both areas, if delivered in isolation, will not be enough to end the opioid epidemic or mental health system challenges. That is why it is believed that the mental health Portal’s central phone line and regional hubs should be combined with the proposed SUD system, to promote integration of SUD and mental health prevention and treatment and create efficiencies and economies of scale. The priorities of the proposed mental health and substance abuse treatment systems are well aligned, as represented in the figure below.



Built on the DSRIP/IDN Structure

The MH/SUD hub and spoke system should also leverage, extend, and sustain the infrastructure, networks, and successes of NH’s DSRIP. Funded by a grant from the CMS, the DSRIP project is designed to serve the behavioral health needs of NH’s Medicaid population. DSRIP is administered centrally, with a statewide focus on integrated care, workforce development, and information technology. DSRIP is implemented regionally through seven IDNs across the state, each serving approximately equal numbers of Medicaid recipients. Each IDN is implementing three community-driven projects. At least one community driven project in each region must focus on treatment of SUDs and most emphasize care coordination. The IDNs represent increasingly collaborative networks of mental health and substance use disorder treatment organizations and a growing infrastructure of supports (i.e., integrated care, workforce development, enhanced technology) that align with the goals and strategies of this Plan. Integrating the MH/SUD Portal and its regional hub and spokes within the IDN structure, while simultaneously extending the reach of the IDNs beyond the Medicaid population makes sense, as the IDNs seek sustainability beyond the current period of grant funding.

Journey Through the New Mental Health System

A 14-year-old middle school student – Daniela – has erupted into a rage in a North Country classroom. She is coming down from a hypomanic episode, experiencing an agitated mix of anxiety and depression that she tries hard – but not always successfully – to contain. After a chaotic childhood with substance-involved parents, Daniela lives with her financially-strapped and health-challenged but supportive grandmother, Gabriela. Daniela is one of the only Latina youth in her school and community, which, together with her mental health condition, leaves her alienated, scared, and alone.

Situations like this have repeatedly landed Daniela in handcuffs in the local hospital emergency department and – sometimes after days in a small emergency department room with limited treatment – NHH. With the school at wit's end, out of district placement is on the table. With specialty psychiatric care at NHH, Daniela usually stabilizes quickly and is discharged within a few days with a revised medication list and a referral to the local community mental health center. Neither Gabriela nor Daniela have felt particularly comfortable at the local community mental health center, where the ever-changing counselors, though clearly dedicated, makes it hard to stay connected. Lacking access to a child psychiatrist, Gabriela takes Daniela to her family doctor, who tries valiantly to manage a complicated mental health condition for which she received little preparation in medical school. Eventually, Daniela stops going to the doctor, sleeping enough, and/or taking her medication, and the cycle repeats. Her school staff, primary care physician, CMHC staff, Gabriela and Daniela feel increasingly helpless, frustrated, and resigned to perpetual failure.

But things are different now. This time, the new school social worker – Jackie – is called into the classroom. Jackie has been connecting with Daniela and her grandmother as part of the school's implementation of Multi-Tiered Systems of Support for Behavioral Health and Wellness. She de-escalates the situation to the point that Daniela, though still agitated, can walk to Jackie's private office. Together, they call her grandmother. When Gabriela arrives, Jackie helps them contact their regional mental health hub. After a phone-based assessment, the regional hub triage specialist suggests that they come in for short-term crisis stabilization and offers safe transport for both of them. After 24 hours, Daniela can safely return home and to school. Before leaving the hub, Gabriela and Daniela are connected to Wraparound services – family-driven and youth-guided care coordination. Wraparound helps them develop a plan of care, expand their network of natural supports, and connect with in-home and other services that Daniela – and her grandmother – need. Through Wraparound, Daniela receives trauma-informed treatment and gets connected to a youth peer support specialist, who helps her feel understood and hopeful. Gabriela meets another grandmother/guardian who can offer support and guidance through the trials and tribulations of caring for a troubled grandchild. Daniela's physician gains access to specialty psychiatric teleconsultation, and results in improvement of Daniela's medication management and self-care.

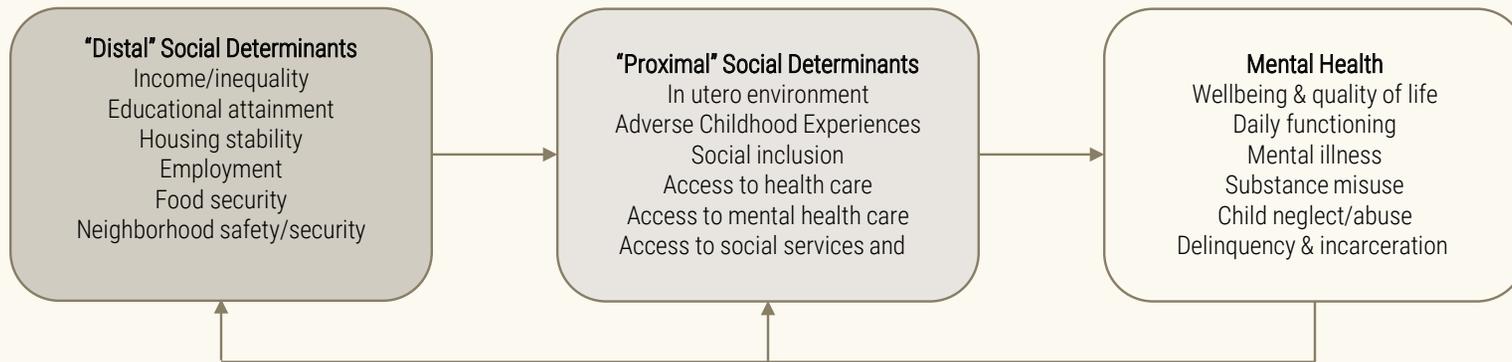
Daniela continues to struggle with her mental health condition, but with a network of professional services and social supports wrapped around her, her engagement and behavior at school improves. She experiences increments of success in academic progress and peer relationships, two significant indicators of future success. Long, lonely rides to NHH become much less likely in that future.

Mental Health Equity

Where, to whom, and when you were born ... what you look like ... where you live and work ... these conditions of daily life play bigger roles in determining our mental health fortunes than many of us would like to acknowledge, and some subpopulations are particularly vulnerable to these social determinants of health. Throughout the planning process, stakeholders implored us to take the social determinants and the needs of specific subpopulations into account. In this section, we describe how social determinants and the needs of specific populations relate to mental health and how we might address them in this Plan and beyond.

Social Determinants of Mental Health

The environments where we grow, work, and play set the stage for our mental health and wellness; social and economic inequities in our living conditions are root causes of mental illness. These factors are sometimes referred to as “social determinants” of mental health. Some social determinants are “proximal” – they impact our mental health directly. These include adverse childhood experiences, social inclusion, and access to services. Other social determinants are “distal” – they exert their influence indirectly, through the pressure they apply on the more proximal determinants. Examples of these distal social determinants include employment, food security, educational attainment, income/income equality, and housing stability.¹³



To improve the mental health of NH citizens, we as a state need to address these social determinants, starting before birth and extending throughout the lifespan. We can start at the individual level by better recognizing and addressing the basic needs of mental health consumers, such as employment, housing, food, etc. At the multi-system level, we can improve the service array so that all NH citizens can access the services and supports they need, regardless of where they live, how much money they make, or their mental health condition.

In the pages ahead, you will see a number of social determinant-informed recommendations for improving the continuum of care. Addressing adverse childhood experiences – such as abuse and family dysfunction – by infusing the mental health system, schools, medical settings, elder care, and other institutions with trauma sensitivity is just one example. Enhancements to the service array (for example, mobile crisis) for underserved populations are also critical, including increased access to housing for adults with severe mental illness. Other access barriers, including mental health discrimination,

transportation, childcare, and cultural and linguistic competence, are also system-level change targets.

The largest population-level impact, however, will come from prevention efforts and policy changes that address larger socioeconomic forces and that make the healthy choice the easy choice when making decisions about our lives. Addressing the social determinants at the population level will require social and economic policy changes beyond the scope of the mental health system. NH citizens should band together to advocate for changes in economic, housing, public health, and other policies to address the social determinants of mental health for all NH residents.¹⁴

Priority Populations

A robust healthcare system addresses the needs and wellbeing of all members of society in order to maximize every person's potential and ensure that our communities are served by the contributions of all. Some subpopulations are especially vulnerable to the social determinants; further, they often require services to be tailored and adapted to fully meet their mental health needs. During development of the Plan, members of focus groups, workgroups, and the Key Advisor team consistently identified the following priority populations as particularly vulnerable and in need of more focused attention.

Mental health services can support wellbeing **throughout the life cycle**. Early identification and intervention at the earliest ages (e.g., infant mental health programs) and high-quality early childhood care and education that supports healthy social-emotional development are essential to later childhood success. Young adulthood, as a stage of life in which mental health concerns often first begin to manifest (e.g., first episode psychosis), also requires particular strategies. At the other end of the spectrum, building systems to eradicate the social isolation commonly experienced by older adults and finding ways to keep older people engaged in their communities should be within the reach of a comprehensive, high-functioning mental health system.

Individuals with mental health concerns who are experiencing **co-occurring disorders**, such as substance use disorders, and/or dual-diagnosis of an

intellectual disability need particular attention to support wellbeing. Because co-occurring disorders can be complex and challenging to properly diagnose and treat, specialized expertise in the interplay of multiple dimensions of symptomatology are needed. When co-occurring disorders are un- or under-diagnosed and treated, elevated rates of homelessness, incarceration, medical problems, suicide, and early mortality can be the result.

Many individuals receive treatment for only one disorder, making integrated treatment vital for a whole-person approach to healing and management of multiple, often intersecting symptoms.¹⁵

Individuals are more likely to encounter law enforcement when experiencing a mental health crisis, resulting in disproportionate bookings into jails. Almost 15% of incarcerated men and 30% of incarcerated women have a mental health disorder, the majority of which have not (yet) been convicted of a serious or violent crime. **Legally-involved populations** with mental illness – whether currently incarcerated, transitioning from correctional settings back to the community, or managing other legal issues – experience a complex set of stressors. While incarcerated, individuals may not receive appropriate mental health treatment – and as a result, symptoms can become exacerbated, behavior more problematic, and jail and prison stays longer than necessary. When released to the community without sufficient transition plans and supports, many individuals with mental illness experience trouble finding work, housing, and mental health treatment, leading to homelessness, increased ED visits, and re-arrest and recidivism. This cycle might be broken with enhanced transition supports leading to increased functioning, healthy contributions to the community, decreased law enforcement costs, and ultimately, increased public safety.¹⁶

- Children (ages 0–18 years)
- Young adults (ages 18–24)
- Elders (ages 65+)
- Individuals with co-occurring substance use disorders and intellectual disabilities
- Legally-involved individuals
- Racial and ethnic minorities
- Immigrant and refugee populations
- Rural populations

Nationwide and regionally, **racial and ethnic minorities** experience a variety of mental healthcare access barriers. To fully meet the needs of an increasingly diverse population, the stakeholders believe that NH needs equal access, and culturally and linguistically competent services for all.¹⁷ Access issues can include transportation barriers, challenges with child care and time off work, language barriers, and inadequate healthcare benefits. More fundamentally, stigma, racism, and discrimination can pose significant challenges to equity in mental health access and outcomes.¹⁸

NH has welcomed over 7,500 **refugees** since the early 1980s, many of whom have settled in Concord, Manchester, Nashua, and Laconia. Their contributions have strengthened the NH economy and enriched our cultural diversity, representing over 30 nations and a wide array of ethnic minority groups.¹⁹ Refugee populations often leave their host countries under traumatic stress and experience harrowing and dangerous journeys en route to the U.S. Stressful resettlement experiences, resulting in frequent trauma, depression, anxiety, and adjustment disorders, especially in refugee children, are all-too-common occurrences. Stakeholders believe screening and use of culturally appropriate, evidence-based treatments for refugee populations (for example, Trauma Systems Therapy for Refugees), tailored to individual needs, are vital parts of community wellbeing.²⁰

Sparse populations, stigma, long distances between communities and services, and limited transportation, can make it difficult for **rural residents** to get the help they need. For example, mobile crisis services are unavailable outside of Manchester, Nashua, and Concord. Fewer patients mean fewer services provided and therefore fewer reimbursements from insurance companies and Medicaid, leading to less revenue overall and less money to provide a full array of services. It is harder and less lucrative to practice in rural than in more urban environments. The consequences of untreated mental illness in rural areas can ripple out from the individual and their family, through the social and economic fabric of rural areas, and the NH mental health system in the form of avoidable trips to the ED and/or a psychiatric hospital. The State needs to decrease stigma and expand access in rural areas for NH to thrive.

In the following pages, the strategies to create a robust, coordinated mental health system are described. The vulnerabilities and needs of each priority population cannot be addressed for every step and strategy in the Plan, although the Plan does highlight those populations that were prioritized by workgroup members. Robust implementation of the Plan will require careful planning to tailor services and supports to meet the needs of these priority populations, to ensure strong communities and a stable foundation for all members of NH society.

Coordinated Continuum of Care

GOAL

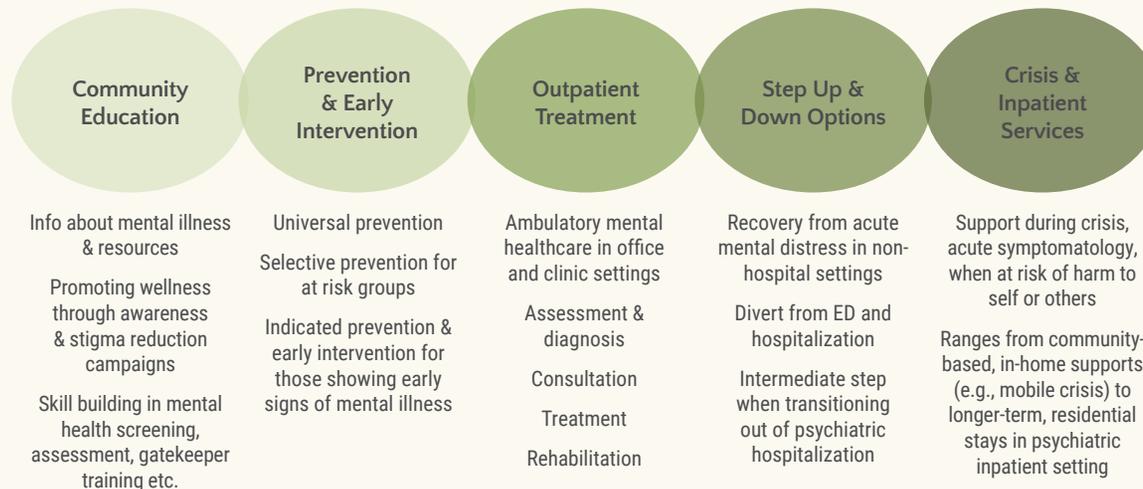
Expand a comprehensive, robust, and coordinated continuum of care with supported transitions between steps in the care pathway to meet the mental health needs of all NH citizens.

Coordinating services is largely up to each individual and his or her family in NH, which can be an overwhelming experience for someone in distress because NH's mental health system is fragmented and difficult to navigate. Communication and coordination is left to individual organizations, providers, and their patients (and families), rather than systematically supported and incentivized by the system.

prevention, treatment, and recovery along the care continuum, with linkages that support effective transitions between steps in the pathway. Integration of health, mental health, social service, and other relevant organizations and providers/supports; mapping of intentional care pathways; ongoing communication between providers offering "adjacent" services; and consistent use of facilitated referrals and follow up are hallmarks of coordinated care. Each of the following steps in the continuum of care is discussed in detail in subsequent chapters. For each step, we offer a set of strategies to close service gaps based on the collective knowledge and experience of a wide range of NH mental health stakeholders (see Appendix A).

Toward a Coherent, Coordinated System

This Plan will move NH toward a more intentional, coherent mental health system that encompasses a full array of services that support promotion,



ACTIONS

Fill gaps in service array

Create care pathways for common & complex conditions

Integrate substance, healthcare, social service, & long-term support sectors

Community Education

GOAL

Reduce mental health stigma and improve recognition and response to signs of mental distress in NH communities.

Stakeholders believe that, despite many knowledgeable and caring citizens, many NH communities remain ill-informed or indifferent about mental health, making them unwelcoming for people with mental illness. Community education is the best way to combat this problem, by increasing public understanding, awareness, and support for persons with mental illness. It builds grassroots support for mental health services and systems and improves community climate for those suffering from mental health conditions.

Eradicate Mental Health Stigma

To make our communities safe and caring places for those with mental illness, we need to eradicate the stereotypes, prejudice, and discrimination that are the hallmarks of mental health stigma. Mental health stigma undermines help seeking, contributes to the homelessness and un- or under-employment of individuals with mental illness, and leads to biased and ineffective public policy.²¹ Stigma reduction campaigns involve education to replace myths about mental illness with accurate knowledge, contact with people with lived experience or personal stories to promote connection and undermine prejudice, and protest or advocacy to engage the audience in meaningful action. Large scale stigma reduction campaigns in the U.S. and elsewhere improve knowledge, reduce prejudice, and increase social acceptance of

persons with mental illness.²² We recommend development of a universal mental health and substance misuse education and stigma reduction campaign, delivered in partnership with community-based organizations such as schools, CMHCs, and regional public health networks. Programs that could serve as models include the Change Direction NH program; NAMI's "In Our Own Voice" campaign; and Britain's "Time to Change" program.

Prepare Gatekeepers to Recognize and Respond to Mental Health Concerns

Community education can also elevate the understanding and skills of "gatekeepers" - non-mental health professionals whose roles (law enforcement and educators, for example) regularly bring them into contact with individuals experiencing emotional distress. Training and technical assistance can strengthen the ability of gatekeepers to recognize signs of distress, respond in a supportive and soothing manner, and connect the sufferer to appropriate supports. NH should expand and provide more gatekeeper training to non-mental health providers. Model skills training programs include MH First Aid (for adults and youth), Crisis Intervention Team Training for Law Enforcement, and NAMI's Connect Suicide Prevention program. Training for non-clinical workforce is also a critical component of the Zero Suicide model.

ACTIONS

Universal communication & stigma/discrimination reduction campaign

Deliver mental health training to MH gatekeepers throughout NH

Prevention and Early Intervention

GOAL

Intervene “upstream” to prevent the emergence of and halt the progression of mental illness.

Prevention and early intervention are crucial and cost-effective methods for addressing diseases, yet they are underfunded and underutilized. Prevention ranges from universal strategies appropriate for the entire population to early intervention to reduce current and future impairment and suffering among individuals with emergent mental health conditions.

Prevention Starts With the Social Determinants of Health

The social determinants of health are one such prevention target. As noted earlier, social determinants include socioeconomic status, education, exposure to environmental toxins, neighborhood and physical environment, stability of housing and employment, adverse childhood experiences, social support networks, and access to healthcare. These factors drive dramatic and persistent inequities in health across our population,²³ and inevitably emerge (particularly housing and transportation) in any discussion of barriers to wellbeing in NH. Stakeholders believe there needs to be a statewide health plan that addresses social determinants of health. Social determinants can be addressed from within the healthcare system, with multi-payer federal and state initiatives that specifically target social needs (for example, supported housing options or housing subsidies), and by shaping non-health policies and practices that promote health equity. The Centers for Disease Control and Prevention offers extensive guidance for addressing social determinants of health.²⁴

Expand Early Childhood Supports

The social and emotional capacities that children develop between birth and six years of age serve as the foundation for experiencing and managing emotions, creating stable relationships with peers and adults, exploring and learning in their environments, and acquiring developmentally appropriate competencies.²⁵ We recommend expanding early childhood/family strengthening programs, including access to home visiting services, to include screening and additional assessment of infants and caregivers in accordance with best practices. NH’s Family Resource Centers, distributed throughout the state and providing a broad array of family support services, are well positioned to expand access to such services with appropriate investment (for example, making these services eligible for reimbursement).

Intervene at the Earliest Signs of Mental Illness

The majority of individuals who develop serious and persistent mental illness show early signs in late adolescence or early adulthood. Early intervention can often mitigate progression of symptoms, improve functioning, and avert other negative impacts of mental illness. The National Institute of Mental Health concluded that findings from the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative “are so compelling that the question to ask is not whether early intervention works for first episode psychosis (FEP), but how specialty care programs can be implemented in community settings throughout the United States.”²⁶ NH should expand coordinated specialty care for FEP and early serious mental illnesses.

ACTIONS

Advocate for statewide attention to social determinants

Enhance early childhood & family strengthening programs

Expand early intervention for mental illnesses

Outpatient Services

GOAL

Support people with mental health conditions safely and effectively in their home communities.

High quality, community-based outpatient services are the key step in the care continuum for most individuals experiencing mental distress. Easy access to high quality outpatient services helps to keep individuals in their communities, prevents unnecessary hospitalization and residential care, and helps them recover from mental illness. Our conceptualization of outpatient care extends beyond traditional services offered in CMHCs and private practice settings to integrated mental health services in primary and elder care settings, school-based services, and supported housing.

Integrate Mental Health Services Into Primary Care Settings

The primary gateway to mental health and substance misuse care for most adults is primary care, which is often ill-equipped to recognize and treat mental health and substance misuse disorders. Integrated primary care – the provision of behavioral health services and expertise in primary care and vice versa – can improve mental health access and outcomes and, in the long-term, can produce cost-offsets in the form of reduced ED and inpatient visits.²⁷ Many strategies are available to support these outcomes, including expert psychiatric consultation for pediatricians and primary care physicians as well as increasing telepsychiatry services in outpatient mental health settings. All of this could reinforce and extend the DSRIP's emphasis on infusion of behavioral health expertise and supports throughout the healthcare and social service system. Federally Qualified Health Centers (FQHCs), which receive funding to expand behavioral health services, are a particularly ripe context for integrated primary care for underserved patients. For persons with severe mental illness, CMHCs tend to be the most appropriate healthcare home, and therefore, the site for integration.²⁸ For older individuals, integration in elder care settings is helpful. Key integration strategies across settings, especially in rural areas, are tele-medicine and tele-consultation.²⁹

Implement Multi-Tiered System of Supports in All NH Schools

Between 14 to 20% of children and adolescents experience a mental, emotional, or behavioral disorder; only about half of these children receive treatment; and most of those who do are served in a school setting.³⁰ NH's Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model was designed to promote the behavioral health of NH public school students. MTSS-B blends research-based school mental health practices and social-emotional learning with Positive Behavioral Interventions and Supports (PBIS; see <http://www.pbis.org>). PBIS teaches school-wide behavior expectations at the universal level (Tier 1), offers targeted group support for at-risk students (Tier 2), and provides intensive, individual services for the highest-need students (Tier 3). MTSS-B increases access to both school- and community-based behavioral health supports and services for students, including intensive school-based services such as wraparound care coordination. It improves school climate, reduces problem behaviors and truancy, increases instructional time, and improves the mental health of high-risk students. MTSS-B is currently implemented in nine school districts; stakeholders recommend large-scale adoption of MTSS-B.

Integrate Treatment for Co-Occurring Disorders

Many people with serious mental illnesses have a co-occurring substance use disorder within their lifetime. Integrated treatment for co-occurring mental health and substance abuse disorders simultaneously addresses both conditions so that individuals do not get lost, excluded, or confused going back and forth between different mental health and substance abuse treatment programs. The goal of this evidence-based practice (EBP) is not simply abstaining from substance use, controlling symptoms, or complying

with mental health treatment but to pursue a personally meaningful life. Integrated treatment specialists understand how mental illness and substance misuse interact and are trained in skills that have been found to be effective in treating consumers with co-occurring disorders. Integrated treatment specialists support and empower consumers to define and achieve their individual goals.³¹ We need more integrated treatment programs throughout NH.

Housing Assistance for Those with Mental Illness

Permanent supportive housing (PSH) is an evidence-based intervention that combines non-time-limited affordable housing assistance with supportive services for people with mental health conditions who are experiencing homelessness. In the PSH model, housing is linked to voluntary and flexible supports and services designed to meet individual needs and preferences.³² Lack of supportive housing emerged time and again in our discussions with stakeholders that informed the drafting of this Plan – stakeholders believe that NH needs to increase the supply of supported housing options. A particularly promising practice combines the Housing First and Assertive Community Treatment (ACT) models.³³ Collaboration between EDs/hospitals and Public Housing Authorities around coordinated entry mechanisms and exploration of Medicaid options for housing supports are additional considerations. A centralized/ coordinated housing registry and coordinator would also be useful.

Scale Up Evidence-Based Practices

Irrespective of setting, it is critical that individuals have access to high quality services tailored to their mental health conditions and other needs. Wide-scale adoption of EBPs, when implemented with fidelity, helps ensure access to high quality outpatient services. While support for and implementation of ACT, Supported Employment, and, much more recently, the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH) are promising, other EBPs have not been as systematically supported. NH should expand the high-fidelity implementation of EBPs in outpatient settings including new technologies that support and extend traditional outpatient services. Training and technical assistance as well as funding would be needed to support the implementation, expansion, and sustainability of targeted EBPs, such as Dialectical Behavioral Therapy, Motivational Interviewing, Child Parent Psychotherapy, Cognitive Behavioral Therapy, Integrated Treatment for Co-occurring Disorders, MATCH, Evidence Based Supported Employment, and ACT.



Step-Up/Step-Down Services

GOAL

Support people at risk of hospitalization safely and therapeutically in their communities while reducing avoidable psychiatric hospitalization and readmission.

You have just been discharged from NHH. Still in the throes of major mental illness and not far removed from being in immediate danger of self-harm, you are thrust back into the community with a new prescription to fill and a referral to your local CMHC, but little else in the way of professional and natural supports – let alone a permanent and safe place to stay. It takes little to imagine the myriad scenarios that could lead you right back to the hospital in such a situation.

Step-up and step-down services help transition people discharged from inpatient settings back into the community, reducing readmissions to the hospital. They also help people experiencing acute distress recover in non-hospital, community-based settings, thereby diverting them from unnecessary ED or inpatient stays. Step-up and step-down services can include short-term, sub-acute residential settings; respite beds; clubhouse peer support programs; and evidence-based interventions that support transitions from more restrictive settings into the community. NH has few step-up and step-down service options.

Supported Transitions Reduce Readmissions to Inpatient Care

Currently, about one-third of discharged patients are readmitted to NHH within six months, a statistic that highlights the need to do a better job supporting transitions back into the community. Supported transitions are a relatively low cost, high impact way of preventing avoidable readmissions to inpatient psychiatric settings. They involve linking a person who is at greatest risk for psychiatric hospital readmission with a transition coordinator who engages with the person and his or her family prior to discharge, helps

develop and support implementation of the discharge plan, and facilitates linkages/hand-offs to key community-based professional services and natural supports.³⁴ Critical Time Intervention is an evidence-based supported transition model³⁵ that is already being implemented in several regions through NH's DSRIP Program, and which could be expanded throughout the state. In addition, NHH has a discharge coordinator who works with youth at risk of suicide and readmission; this program could also be expanded to serve additional at-risk youth and adults.

Clubhouse Models Offer Daily Structure and Support

Clubhouses are strengths-based, member-run, therapeutic working communities for adults with serious mental illness. They offer members access to vocational and educational resources and support a work-ordered day during which each member's talents and abilities are recognized and utilized. Clubhouses do not offer on-site clinical services, although linkages to community providers are encouraged. Clubhouses are considered a promising practice for promoting employment, reducing psychiatric hospitalization, and improving quality of life.³⁶ NH currently has only two Clubhouses, located in Portsmouth and Manchester. Expansion of this model throughout the state would offer a useful adjunct to outpatient services and an empowering alternative to psychiatric hospitalization for individuals with serious mental illness.

Peer Respite Offers a Familiar, Safe Space

Peer respites are voluntary, short-term, overnight programs that provide community-based, non-clinical crisis support to people in acute distress.

They operate 24 hours per day in homelike environments. Peer respites are staffed and operated by people with lived experience of mental illness.³⁷ NH currently has three peer respites that are significantly underutilized; we recommend expanding knowledge of, access to, and utilization of peer respite across the state.

Sub-Acute Residential Programs are an Alternative to Inpatient Stays

Sub-acute residential programs provide beds for individuals experiencing acute psychiatric distress in an open, home-like environment with 24-hour staffing, including clinical support. Sub-acute programs accept

individuals who are preparing for discharge from psychiatric hospitalization as a transitional service to prepare them for living in the community (step down). They also accept individuals for whom a short stay in a residential rehabilitation program would help prevent psychiatric hospitalization (step up). Sub-acute residential program outcomes are similar to those seen with psychiatric hospitalization –at lower cost and with higher patient satisfaction.³⁸ Models to support these transitions include partial hospitalization and therapeutic day programs. Stakeholders recommend collaborating with housing authorities to develop sub-acute programs around the state for youth and adults.



Crisis and Inpatient Services

GOAL

Stabilize and support individuals experiencing mental health crises and acute psychiatric episodes while reducing avoidable inpatient stays.

The most immediate way to reduce wait times in EDs is to enhance services that divert avoidable hospitalizations, support transitions to the community, reduce readmissions, and facilitate outflow from inpatient settings. Crisis services stabilize and reduce the distress of individuals experiencing psychiatric emergencies and transition them to appropriate follow-up care. Such services can prevent avoidable psychiatric hospitalizations and facilitate engagement in the least restrictive treatment setting. Psychiatric hospitalization is the treatment setting of last resort for individuals whose mental illness is so acute or severe that they are in danger of harming themselves or others. Psychiatric hospitalization is also an important part of the continuum of care and its goal is to quickly stabilize individuals for a safe return to their communities.

Psychiatric Consultation and Peer Navigation Enhance Mental Healthcare in EDs

Enhanced consultation and support in EDs, through the use of psychiatric consultation and peer support specialist navigators, can help stabilize and expedite safe discharge of mental health-related ED admissions. Psychiatric consultation helps elevate care for mental health crises in EDs. Given the psychiatrist shortage nationwide and in NH, videoconference technology is the most feasible way of bringing this expertise into EDs. The stakeholders recommend establishing 24/7 videoconference access to psychiatric consultation for complex mental health-related cases in EDs. One gold standard telemedicine program out of the University of Mississippi, for example, has installed videoconferencing screens in every ED patient room, with both “regular” and “stat” consultation options. In another location, two psychiatrists staff a room equipped with monitors that allow them to

view each ED, facilitating telepsychiatry consultation on a 24-hour basis to multiple EDs.³⁹

Experiencing a mental health crisis or concern in the ED – especially if it is accompanied by long wait times – is a harrowing process. Being supported by a peer with both lived mental health experience and knowledge of the system can mitigate these stressors, as peers often establish credibility and form relationships with patients quickly, addressing barriers to care and disparities in access.⁴⁰ Peer navigators can provide mental health education and coaching, advocacy, and linkages to community services. They can conduct triage, assessments, and contact a patient’s case manager and treatment team. Use of navigators in EDs can help to reduce gaps in care and serve as a basis for supported transitions to appropriate community services, diverting transfer to more restrictive levels of care and ultimately, contributing to a reduction in individuals waiting in EDs.⁴¹ Stakeholders believe that embedding peer support specialists as health navigators in EDs, who can administer psychological first aid, assess mental health status, support patients beyond the ED, and promote use of Peer Support Agency services.

Provide Access to Mobile Crisis for All Ages, Throughout NH

Mobile crisis teams provide 24-hour, rapid response mental health crisis stabilization and assessment to people in their homes or other non-clinical locations. While many mobile crisis teams serve as a liaison between people in crisis and the ED, they can also effectively divert ED admissions when community linkages are both available and

prioritized as alternatives to the ED. Mobile crisis is effective at diverting individuals from inpatient psychiatric admissions, connecting individuals experiencing suicidal ideation with appropriate supports following ED discharge, and engaging those experiencing mental distress in outpatient services.⁴² Currently, NH operates three mobile crisis teams for adults in Concord, Nashua, and Manchester, as per the NH Mental Health Settlement Agreement. We recommend expanding the three extant mobile teams with sufficient training, expertise, and resources, to serve children and youth and expanding mobile crisis services into the more rural areas of the state.

Short-Term Crisis Programs and Residential Settings Divert People in Crisis from Jails and Emergency Departments

Short-term crisis residential services deescalate the need for hospitalization through safe and contained 24-hour observation and supervision – helping a person stabilize, resolve problems, and connect with sources of ongoing support. Programs such as 24-hour psychiatric urgent care centers can serve as alternatives to jail and EDs and as places where police could bring people in crisis. Crisis residential services offer longer-term stays and can include psychiatric assessment, daily living skills training, social activities, counseling, treatment planning, and connecting to services. Crisis residential care is as effective, lower-cost, and results in higher patient satisfaction than inpatient care.⁴³ Short-term crisis residential programs and beds should be considered to be added throughout NH as an alternative to inpatient care, perhaps through the regional hubs.

Targeted Increases in Inpatient Beds Helps Eliminate Wait Times in EDs

To eliminate wait times, we recommend a targeted increase in inpatient psychiatric bed capacity centered in new or expanded community based designated receiving facilities for patients requiring long-term stays.. Dedicated, long-term beds for the forensic population, many of whom require 18–21 month stays, is a promising way of improving NHH outflow. The stakeholders support NH’s current Request for Information regarding the development of a new self-contained forensic unit. Relatedly, free-standing, high-security residential treatment sites would also greatly improve bed availability for the general population. These settings are costly and have the potential to stoke “Not in My Back Yard” reactivity; at the same time, they effectively support rehabilitation, re-entry to community settings, and reduce risk to public safety.

In addition, increasing the availability of voluntary psychiatric beds across the state would provide greater access to this necessary level of care for individuals in their communities and decrease the wait times in EDs.



Integration of Peer and Natural Supports

GOAL

Integrate peer and natural supports throughout the continuum of care to empower consumers, reduce reliance on professional supports, and reduce avoidable ED and inpatient visits.

Fear and isolation are common feelings for people leaving inpatient settings. Connecting with someone who has coped with mental illness, successfully navigated the mental health system, and recovered a meaningful, purpose driven life can be enormously comforting and empowering to individuals living with mental illness. What is more healing than the soothing presence of someone who has been there, done that? That is why we think Peer and natural supports should be integrated at every step along the care continuum.

Consider, for instance, the following experience of one NH resident:
When I left the hospital, I felt scared and alone. I eventually discovered peer support and knew I had found my community. I met people who understood what I was going through and they helped me rediscover hope and optimism; I felt connected to a supportive community and learned new skills, all of which has helped me stay healthy and out of the hospital. Peer support has been transformative for my recovery.

Peer Supports Draw on Personal Experience to Promote Healing in Others

Peer supports draw on their personal experience to help others cope, problem-solve, and manage mental health and/or substance misuse conditions. Peers promote hope and resilience, foster skills and insights, facilitate the development and use of recovery-based goals and care plans, encourage treatment engagement, and facilitate connections with natural supports. Peers can be trained to deliver conventional interventions (e.g.,

case management, even psychotherapy) or interventions uniquely suited to the peer role (e.g., intentional peer support). Peer support services are generally as effective as professional services, and more effective in engaging difficult to reach patients, reducing psychiatric hospitalization, and decreasing substance use among individuals with co-occurring disorders.⁴⁴

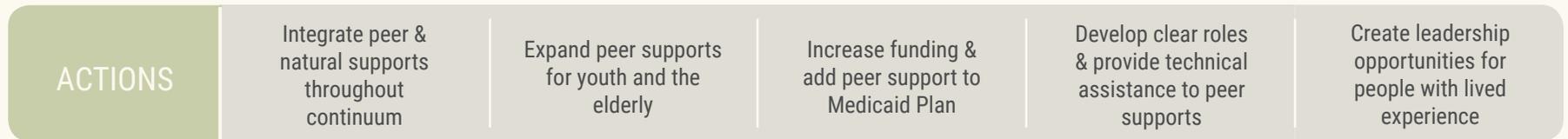
Availability of Peer Support Services Currently Limited in NH

Some peer support services are already available in NH: NAMI Connection, NAMI Family Peer Supports, NH Chapter of Youth Move, Depression and Bipolar Support Alliance (DBSA), Clubhouses, CHMCs, and Peer Support Agencies (PSAs). NAMI's Connection program offers peer-led, recovery-oriented support groups around the state. The DBSA provides support groups to people with depression and bipolar disorder as well as other mental health conditions. NH has two Clubhouses in Manchester and Portsmouth that offer strengths-based, member-run, therapeutic working communities for adults with serious mental illness. PSAs are not-for-profit, consumer-run organizations located around NH. They practice Intentional Peer Support to help mental health consumers feel more empowered and less dependent on the mental health system and move toward fulfilling lives. PSAs are currently contracted through DHHS and funded through a combination of the Community Mental Health block grant and general fund dollars.⁴⁵ These programs are only a starting point for future enhancement.

Infuse Peer Supports Throughout the Mental Health System

Peer supports should be fully integrated throughout the care continuum, where they can serve as powerful advocates and public educators, provide recovery-oriented outpatient care, and support individuals as they transition into and out of EDs and psychiatric hospitals. Peer support services should also extend to older children, adolescents, and the elderly through Youth

Move NH and other groups. This would require additional funding as well as adding peer support to the list of reimbursable services in the NH Medicaid Plan. Successful peer support requires clear role/job descriptions along with training, education, and coaching for peer and professional staff alike. The mental health system would also benefit from creating more opportunities for people with lived experience to occupy leadership roles.



Infusion of Resources

GOAL

Infuse the resources needed to support a robust mental health system.

An infusion of resources will be needed to expand a more efficient, effective, and just mental health system in NH. This section addresses direct sources of funding leverage in the form of third party payer reimbursements and investments to strengthen our mental health infrastructure, opportunities for public-private partnerships and grant funding, “cost offsets” from mental health interventions, and data to guide expectations for mental health funding.

Low Reimbursement Rates are Constricting NH’s Mental Health Service System

While general fund money and the DSRIP Waiver have provided additional funding, most treatment for serious mental illness is delivered through NH’s

public mental health system and paid for through the Medicaid program. One window into the resource pipeline for NH’s mental health system is to examine our Medicaid reimbursement rate structure. Expert consultants currently engaged in claims analysis for the NH Department of Insurance were able to compile some instructive data.⁴⁶ Medicaid fees for a sampling of mental health services, depicted in the table below, reveal that NH offers markedly lower reimbursement than surrounding states (Medicare rates, often regarded as an approximation of actual service costs, are provided in the first two columns as a comparison).

Sampling of MH service codes	2018 Medicare rate		2015 Medicaid rate (AAP Survey)					
	NH	US	NH	CT	MA	VT	Low	High
90791 Psych DX evaluation	\$137.74	\$136.44	\$87.82	\$147.50	\$117.42	\$104.13	\$66.26 (SC)	\$182.31 (AR)
90792 Psych DX eval w/med svcs	\$154.27	\$152.64	\$65.00	\$147.50	\$95.06	\$115.63	\$65.00 (NH)	\$239.69 (NE)
90832 Psychotherapy 30 min	\$66.80	\$66.24	\$32.50	\$61.51	\$48.53	\$51.55	\$29.48 (IL)	\$77.22 (AR)
90837 Consult w/family	\$-	\$-	\$72.00	\$135.19	\$90.29	\$100.96	\$43.21 (NJ)	\$166.31 (OR)

Source: American Academy of Pediatrics 2015 Medicaid Reimbursement Survey, https://www.aap.org/en-us/professional_resources/Research/Medicaid%20Reimbursement%20Reports/medicaid_reports_national_all.pdf

Beyond inadequate Medicaid funding, NH’s mental health system is not being appropriately reimbursed by commercial insurance providers. As illustrated in the table below, commercial insurance typically reimburses at rates substantially higher than the cost of providing services, which helps to offset

below-cost Medicaid rates, supporting the solvency of the healthcare system as a whole (left column). Commercial payers in NH follow this pattern for most health specialties (center column) yet reimburse only at cost for mental health services (right column).

	Typical US Provider	NH Other Specialties	NH MH
	Payment as percentage of estimated provider cost		
Medicare	~100%	~100%	~100%
Medicaid	72%	58%	58%
Commercial	140%	160%	~100%
Self-pay	Negligible	Negligible	?
Overall	Positive margin	Positive margin	Large negative margin

This combination of lower Medicaid and commercial insurance reimbursement rates is the most fundamental funding challenge for NH’s mental health system, constricting access to care by first limiting the services that our public agencies can afford to deliver and driving the mental health workforce out of NH in search of higher wages. According to analyses by health economists with BerryDunn,⁴⁷ raising NH Medicaid mental health reimbursement rates to meet the modest goal of the national average would infuse \$22 million per year to into NH’s mental health system, only half of which would need to be covered by NH’s general fund, with the remaining 50% borne by matching Medicaid funds. Pursuing parity between commercial insurance fees for mental health and other health specialties, as well as parity with other states’ fees, would contribute an estimated additional \$65 million per year, with the cost distributed across insurers, employers, and employees who pay insurance premiums. Together, these two strategies would boost NH’s mental health funding by 38%, enhancing the capacity of agencies to elevate the quantity and quality of our mental health workforce, restoring the productivity we are currently losing to high staff turnover, all inevitably converging on greater access to mental health services.

Beyond Reimbursement Rates: Additional Investments to Reshape NH’s Mental Health Infrastructure

The costs of community education, technology, and other infrastructure would not be directly covered through enhanced reimbursement rates. Some services not currently covered under existing billing codes, such as Peer Support, should be added to the State Medicaid Plan. Other activities, such as interprofessional communication and certain forms of care coordination, are recoverable through new alternative payment models, to the extent that they enhance population level performance metrics. The state should also cultivate public-private partnerships to invest in initiatives that align with the missions of non-government agencies. Community education efforts, for example, align well with the goals and existing commitments of private coalitions and community hospitals. Coordinated training functions could be supported by a centralized coalition, supported by membership dues from agencies that already invest in the professional development of their staff. Employers could invest in mental health initiatives that touch their workforce, reaping measurable returns in employee wellbeing and productivity.⁴⁸

Still, the primary responsibility for launching infrastructure improvements will fall, at least initially, to the State. Such ambitious initiatives are going to require infusion of human resources, both internal and contracted, into the current, thinly staffed environment of DHHS. When programming is added or expanded, such as through Plan implementation, additional staff will be needed to provide ongoing oversight and monitoring to ensure efficient use of public tax dollars. In order to address the complex needs of priority populations, governance and coordination between DHHS and the Departments of Corrections (DOC) and Education (DOE) should also be strengthened. One way to achieve this is to establish liaison positions. Liaisons will leverage opportunities to achieve more effective funding, policy, and programmatic alignment that will, in turn, decrease the burden to all systems and improve individual health outcomes. As recounted in the “Bright Spots” section of the introduction to this Plan, DHHS and other state entities have demonstrated the skill and initiative to undertake major innovations and secure substantial federal funding, but they also have passed up promising opportunities for lack of staff capacity.

Estimating Adequacy of Mental Health Funding

How much more funding should decisionmakers aim to infuse into NH’s mental health system? We have already identified one benchmark in the form of reimbursement rate comparisons with other states (for Medicaid) and health services (for commercial insurance). Beyond reimbursement rates, we can also

“zoom out” to examine total Medicaid spending levels for NH and other states, using the population adjusted metric of expenditures per member per month (PMPM). According to claims analyses provided by BerryDunn, NH’s Medicaid spending in 2017 was just over \$24 PMPM, whereas states with lower median incomes but more generous mental health benefits were spending up to twice that amount (\$47 PMPM). NH may wish to compare NH’s Medicaid benefit plan to those of other states, with a provider supply and performance profile to which they aspire.

What this Plan aims to achieve is better health impact per dollar invested.⁴⁹ In addition to the immediate benefits of any particular intervention, research demonstrates that investments in mental health services can yield reductions in downstream healthcare costs^{50,51} and welfare spending,⁵² as well as increases in workplace productivity.⁵³ Reductions in downstream expenditures effectively offset the net cost of providing mental health services. Reliable and readily accessible evidence exists to guide NH planners toward services that can be expected to yield the greatest cost offsets. In general, these services involve preventing the progression of chronic and severe conditions into intensive treatment settings through early recognition, evidence-based interventions, and coordination across a care continuum and with other social services. Cost-offsets support the case for – and can be reinvested in – alternative payment models that shift the aims and incentives in the system toward population-level outcomes.



Leadership

GOAL

Compelling vision, strong state leadership, strategic advocacy, and grassroots support creates commitment among law and policy makers to expand resources and support for NH's mental health system.

Strong, boundary-spanning leadership will be needed to generate the momentum, buy in, and resources needed to enact the envisioned mental health system and priorities outlined in the Plan. Leadership will need to come from a number of quarters, including DHHS, across state government, private foundations, advocacy organizations, and citizens and communities across the state. Alignment across DHHS and other state related efforts, such as between DCYF's adequacy plan, the Children's Behavioral Health Collaborative strategic plan. DOE's System of Care efforts for kids is another critical leadership function.

Leadership from the Governor's Office and DHHS Mobilizes Support and Resources

The stakeholders recommend that DHHS and the Governor's Office embrace and prioritize implementation of this Plan, while communicating it in a compelling and consistent fashion. DHHS leaders and staff will be pivotal to spanning internal and external stakeholders, advocating for and mobilizing resources, monitoring progress and making mid-course corrections each biennium, and removing barriers to implementing the Plan.

Cultivating Legislative Champions Improves Policy, Funding Environment

DHHS, along with advocacy groups like New Futures, NAMI NH, Children's Trust and others will need to leverage existing and cultivate

additional legislative champions to commit to, appropriate sufficient funding for, and pass enabling legislation in support of the Plan. One possibility to create and sustain ongoing commitment to and advocacy for the Plan is to establish a multi-partisan Mental Health Caucus in the NH Legislature.

Support from NH Foundations Strengthens Plan Implementation

NH is fortunate to be rich in private foundations, such as the Endowment for Health, New Hampshire Charitable Foundation, and HNH Foundation that recognize and prioritize mental health and substance misuse through their philanthropic work. They can play a key role by convening stakeholders and aligning their funding and capacity building priorities with those embodied in this Plan.

Grassroots Support is Key

And finally, the State needs a groundswell from the grassroots – citizens, businesses, non-profit organizations, and communities everywhere standing up to demand and support a more robust, just, and effective mental health system. A social marketing campaign to educate and stimulate the public, improving community awareness and support for mental health throughout NH, would be useful in that regard. The Frameworks Institute has useful guidance for messaging social issues in a way that resonates and connects with the public.

ACTIONS

Disseminate & prioritize the Plan

Cultivate law and policy maker champions

Create a legislative mental health caucus

Develop social marketing campaign

High-Quality Workforce

GOAL

Improve the recruitment, retention, and quality of the mental health workforce.

NH is fortunate to be home to providers and peer supports who dedicate themselves to promoting mental health and helping others heal and recover from mental illness. It is time to take better care of the hard-working mental health service and support providers we have, reducing the burdens and increasing the benefits associated with doing their jobs, while significantly adding to their ranks.

Improving NH's Mental Health Workforce

NH faces shortages of psychiatrists and other mental health professionals, along with high turnover rates. Approximately 10% of clinical positions in NH's public mental health system were unfilled in April of this year. Psychiatrists are particularly rare in NH, yet six times as common (per capita) just across our border in VT. The distributions of clinical psychologists, social workers, and mental health counselors, too, are all uniquely sparse in NH compared with neighboring states.⁵⁴ Lower pay, large caseloads, demanding productivity expectations, excessive documentation, and limited opportunities for professional development and advancement are but a few of the factors driving the workforce shortage.

Coordinate Existing Workforce Initiatives

Several statewide workforce initiatives are underway. One supports the development of the overall behavioral health workforce through NH's DSRIP. Another, led by Antioch University New England, addresses behavioral health workforce needs in primary care settings. A third, headed by the Institute on Disability at the University of New Hampshire, is focused

on building the children's behavioral health workforce.⁵⁵ The stakeholders recommend development of an oversight body to foster collaboration and learning across existing initiatives and to develop a comprehensive statewide workforce action plan.

Enhance Recruitment and Retainment By Improving Compensation, Reducing Barriers, Minimizing Burden

A number of strategies can boost recruitment and retention of the mental health workforce. The first is improving salaries through higher reimbursement rates and (eventually) alternative payment models. Health and other employment benefits might also be improved by having CMHCs and other mental health service providers band together to purchase more affordable, better, and more equitable benefits. Other strategies, such as student loan repayment programs, housing vouchers, licensure reciprocity, manageable caseloads that minimize clinician burnout, and career ladders that allow for upward mobility could create incentives to enter and remain in the NH mental health workforce.

Support Quality Through Professional Development and Technical Assistance

Workforce quality and competence (and retention) could be enhanced through more robust, high quality training and professional development in EBP and specialized populations (e.g., dually diagnosed), supervision and coaching, and other professional development. Creating a centralized training and technical assistance center, administered through the Mental

Health Portal (see below) and delivered regionally, would be helpful in this regard. The reach of the training hub should extend beyond mental health professionals to mental health gatekeepers such as law enforcement and

other first responders, school nurses and teachers, correctional staff, and ED nurses, etc.

ACTIONS	Create workforce oversight body	Improve compensation & reduce burden	Enhance professional development	Create technical assistance hub	Apply other recruitment, retainment incentives
---------	---------------------------------	--------------------------------------	----------------------------------	---------------------------------	--

Technology and Infrastructure

GOAL

Improve the human resource, technology, and infrastructure capacity of the mental health system.

The DHHS Division for Behavioral Health (DBH) is currently understaffed and in pursuit of funding, contract administration, and a host of other leadership responsibilities are affected as a result. The many open positions at DHHS/DBH need to be filled. We also recommend adding two positions to oversee 1) operationalization, implementation, monitoring, and biennial updating of the Plan and 2) development of the central and regional hubs.

Update DHHS Data-Related Capabilities

DHHS' data-related infrastructure also needs updating. Current platforms are fragmented and siloed, in need of a common streamlined system or reliable connectors between existing systems. DHHS could make more meaningful and impactful use of data on service delivery, utilization, and cost, if such data could be maintained in one place and disparities between populations of interest (e.g., by socioeconomic status, race/ethnicity, etc.) could be examined.

Streamline, Enhance the Mental Health Policy and Rule Environment

The mental health system is rife with redundancies and inefficiencies that result from clunky administrative rules, policies, and procedures that need to be updated, streamlined, and reduced. Prominent among these are relieving administrative burdens on the CMHCs by lengthening the duration and streamlining development of state contracts, to reduce costs and delays associated with the contracting process. Other strategies for relieving administrative burden include use of a universal application and release of information, single entry claim/encounters, and reduced duplication across state-wide reviews. Similarly, NH stakeholders described mandatory trainings for providers as fragmented, burdensome, and duplicative. Another administrative barrier, for example, is the current CMS restrictions on provisions of care in certain settings, which potentially could be addressed through an expanded scope of practice across the mental health workforce, with billing codes to match.

ACTIONS

Enhance DHHS staff capacity

Review & revise DHHS rules, policies, and procedures

Improve DHHS data platforms

Quality Assurance and Monitoring

GOAL

Expand meaningful quality assurance and monitoring systems and procedures that provide real-time feedback and promote ongoing learning and continuous quality improvement.

NH stakeholders consistently report that the burdens associated with accountability are high, but the meaning and utility of the information for improving their work is low because it lacks the right kind of measures and feedback loops. We need to review the meaning to burden ratio of NH's global quality assurance system.

A Centralized, Streamlined Accountability System

DHHS or a contracted system administrator would provide centralized accountability and guidance for the mental health system through the Portal. While regional hubs maintain oversight of what occurs in their local systems, DHHS has oversight of an accessible, coordinated continuum of care throughout NH. Documentation requirements could be streamlined and synchronized as much as possible between DHHS, Medicaid, Medicare, and private insurers.

Collect and Use a Small But Meaningful Set of Shared Performance Measures

We recommend developing a set of shared performance measures at system and population levels. The focus should be on high leverage

measures of engagement in and experience of care, quality (fidelity to evidence-based models, for instance), and outcomes (such as quality of life and wellbeing). See the Outcomes section for potential performance measures. Regional hubs will be responsible for tracking and entering data relevant to these performance measures, which become the basis upon which the central administrator provides ongoing data-based feedback, recommendations, guidance, and support to regional sites as they engage in quality improvement efforts.

Common Data Platform Improves Data Integrity, Promotes Use

A common data platform would allow for consistent collection, management, and reporting of the aforementioned performance measures. The data platform should also be able to monitor available resources in real time (inpatient and crisis beds, availability of mobile crisis units, etc.) and track people waiting in EDs to ensure movement through the system and minimize wait times.

ACTIONS

Collect & use meaningful data

Accountability through DHHS or another system administrator

Shared performance measures

Build a common data platform

Strategic Framework

The figure on the next page depicts the logical chain of events that will equip the mental health system with the tools it needs to help all NH residents reach their mental health potential. In the figure, system-level strategies and associated outcomes are depicted in green boxes, practice-level strategies and associated outcomes are displayed in gray boxes, and core assumptions are provided in the box at the bottom. We provide a cursory overview of key elements here, with more detail to follow in subsequent chapters.

Develop Strong Systems and Infrastructure

Shared leadership – the Governor, Legislature, DHHS, advocacy and philanthropy organizations, professional organizations, and grassroots support – will be key to recruiting and aligning the resources needed to continue to transform NH’s mental health system. An infusion of resources will facilitate the creation of a mental health portal – a centralized source of information, triage, and referral to localized services, as well as accountability – and an enhanced mental health workforce. This hub will, in turn, nurture, support, and sustain better mental health systems and practices. Systems improvements will include enhanced infrastructure and use of technology; more meaningful and less burdensome quality assurance and monitoring; a more intentional and coherent set of coordinated services; and the infusion of peer, volunteer, and other natural supports throughout the system.

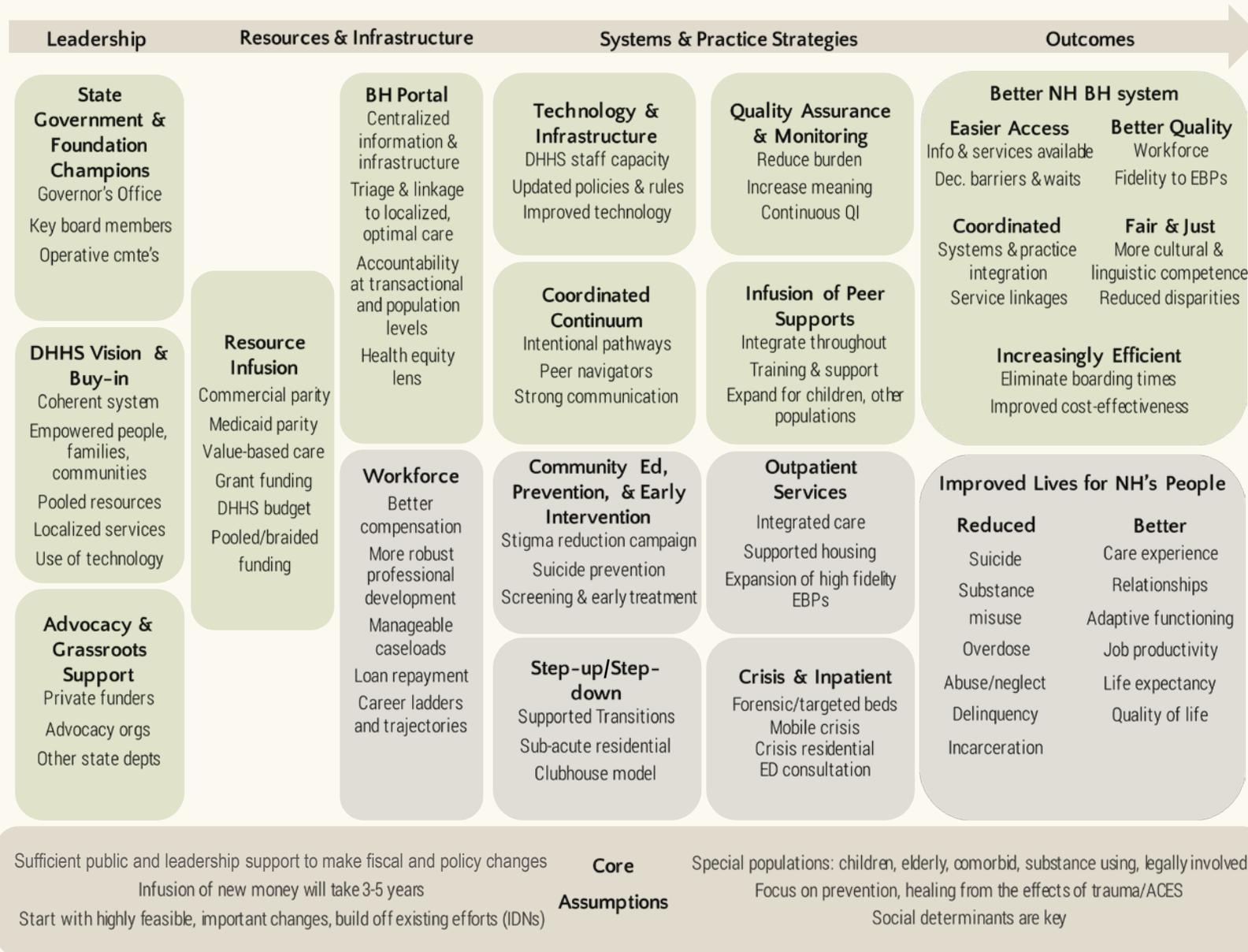
Fill Service Gaps and Increase Reach to Achieve Better Outcomes

These systems structures, combined with a more robust and qualified workforce, will help to fill practice gaps and enhance the reach and quality of existing services and supports. Together, these strategies will enhance outcomes at the system and population level. At the system level, improved access, coordination, quality, equity, and cost-efficiency is anticipated. At the population level, these changes will lead to fewer suicides, opioid overdoses, and other causes of early/preventable mortality; lower rates of abuse, delinquency, and incarceration; better care experience and satisfaction; enhanced social networks and relationships; and better lives at home, at work, and in school.

Strategic, Incremental Implementation Leads to Success

The stakeholders believe that all of this is predicated on the notion that sufficient support can be marshalled, and that the planned infusion of resources will take about five years to fully come to fruition. As such, we will have to start off by addressing the “low hanging fruit” while expanding the foundation for a more robust mental health system. In addition, we are aware that the system needs to attend and adapt to urgent needs of particular populations including children, the elderly, dual diagnosed and co-occurring populations, and those with legal involvements. And finally, we understand that social determinants are implicated in most mental health (and substance misuse) problems and as such, must be attended to and addressed.

NH 10-Year Plan Strategic Framework



Implementation Timeline and Milestones

The figure on the following page depicts Plan implementation milestones across four domains (Leadership, Resources and Infrastructure, System Strategies, and Practice Strategies) and three time periods (state fiscal years 2020–2021, 2022–2026, and 2027–2028). Greater specificity is provided in the near term due to the difficulties inherent in forecasting long-term, ambitious plans such as these. It is imperative to review implementation and progress and adjust the Plan accordingly on a biennial basis, in concert with state funding cycles, to adapt to emerging evidence and changing conditions.

2020–2021: Quick Hits to Reduce Wait Times in EDs; Stand Up the Portal and Hubs; Resource Infusion in Motion

The first two years should balance low-cost, quick-hitting system and practice strategies with those that set the foundation for long-term success. Relatively low-cost, high-gain strategies that will immediately mitigate wait times in EDs (such as Peer Navigators in EDs and Critical Time Intervention) are the first order of business. By the end of this period, wait times in EDs should be reduced significantly, if not eliminated altogether. Standing up the basic functionality of the MH Portal and regional hubs in concert with the SUD hub and spoke system should be another priority. By the end of 2020, the following functions of the MH Portal and regional hubs should be in place: a centralized number for MH information; assessment, triage, and facilitated referrals to localized services; expand accountability and quality improvement systems. Cultivating buy-in and commitment from a variety of stakeholders (especially law and policy makers), allocating existing resources to the most easily implemented system and practice strategies, and setting parity levers in motion to infuse the system with resources in subsequent years set the foundation for future success. Building DHHS capacity to target high leverage grant funding opportunities and review rules and administrative burdens will also be key activities during the initial implementation phase. See Appendix C for budget estimates for this time period.

2022–2026: Full Infusion of Resources; Regional Hubs Add Physical Presence; Continuum of Care Accessible to All

The full infusion of additional resources should hit the system during the middle years (2022–2026), allowing for robust implementation of the Plan. Leadership will remain crucial, as will internal DHHS prioritization of the Plan, regular public updates regarding the Plan's progress, and review and adaptation of the Plan in alignment with the biennial funding cycle. During this phase, the regional hubs should add a brick and mortar presence, capable of providing 24-hour walk in and crisis stabilization services in locations around the state. With higher reimbursement rates and pooled benefits, compensation should increase, improving recruitment, training, and retention of a high-quality mental health workforce. Practice gaps should be filled, and a full, coordinated continuum of care should be well established by the end of this time period. Wait times in EDs and wait times should quickly become a thing of the past.

2027–2028: Reflect on Progress, Celebrate Successes, Identify Deficiencies, Look Forward to Next 10 Years

The final two years of Plan implementation should be reserved for communicating, celebrating, and sustaining what works, discontinuing systems and practices that are ineffective or inefficient, and adapting to changing conditions and emergent promising and EBPs. The Mental Health Portal and its integration with the SUD hub should be mature, setting the stage for further integration with other systems (e.g., social services). Data collection practices and platforms should be robust enough at this time to demonstrate outcomes, generate lessons learned, and foster continuous quality improvement at both system and practice levels. All of this should expand NH's mental health system and set the stage for subsequent 10-Year plans.

Immediate Next Steps

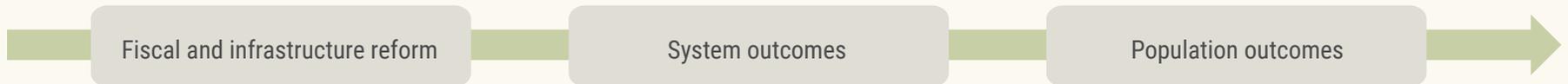
Between now and the beginning of the state's next fiscal year, what is most needed is leadership and a fully operationalized workplan. Appointing a DHHS State Plan Coordinator with sufficient authority and time to oversee development and implementation of the workplan should be a priority. The Coordinator, in turn, should assemble an implementation team, to help create and carry out the work plan, with stakeholder input along the way. The State Mental Health Planning and Advisory Council that oversees the allocation of SAMHSA Block Grant funds might contribute suitable

stakeholder input, given the alignment of their function and priorities with those of this Plan. This leadership team could be charged with securing the implementation expertise and data necessary to specify a full operational plan. The leadership team should partner with legislative advocates to recruit a mental health caucus that will lend its perspective and influence to advancing the Plan. Recruiting business and industry allies will be important for building a broad base of support, and also for identifying opportunities for partnership on components of the plan.

NH MH Plan Milestones	Build foundation 2020–2021	Establish the system 2022–2026	Reflect, look forward 2027–2028
Leadership	<ul style="list-style-type: none"> Build internal knowledge and buy-in Disseminate to public Create implementation plan Develop social marketing plan Foster legislative champions 	<ul style="list-style-type: none"> Continue to prioritize plan internally Review and adapt plan biennially Update the public regularly on progress Implement social marketing plan Continue to educate and foster legislative champions 	<ul style="list-style-type: none"> Review and disseminate results Celebrate, maintain successes Identify problems & gaps Foster legislative champions
Resources & Infrastructure	<ul style="list-style-type: none"> Resources to low cost strategies, grant funding for demo projects, set parity levers in motion MH Portal: Basic information, services, integrated with SUD Workforce oversight, pooled benefits, loan repayment 	<ul style="list-style-type: none"> Impact of parity levers felt, allocate resources to highest impact strategies, phase in alternative payment model MH Portal fully deployed: walk-in, crisis stabilization Better compensation, professional development for workforce 	<ul style="list-style-type: none"> Reallocate cost offsets, refine alternative payment model Integrate MH Portal with other systems Workforce: manageable caseloads, career ladders and trajectories
System Strategies	<ul style="list-style-type: none"> Review rules & administration Review DHHS data systems Fill DHHS positions Envision coordinated continuum Add peer support to Medicaid Plan 	<ul style="list-style-type: none"> Streamline rules & administrative procedures Enhance DHHS data systems Maintain/reinforce DHHS staff capacity Create intentional service/support pathways Integrate peer supports at every point in continuum 	<ul style="list-style-type: none"> Maintain, reinforce DHHS staff capacity Use enhanced data systems to promote continuous quality improvement Refine service/support pathways Demonstrate peer support outcomes
Practice Strategies	<ul style="list-style-type: none"> Plan stigma reduction campaign, enhance suicide prevention, expand early intervention for psychosis Primary care integration, school-based mental health, solidify current EBPs Expand supported transitions, Clubhouses Extend mobile crisis to children 	<ul style="list-style-type: none"> Fully deploy stigma reduction, state suicide plan, extend early intervention to other conditions Supported housing, integration for pediatrics & elderly, expansion of EBPs Open sub-acute residential settings Consultation & navigators in EDs, crisis residential, additional forensic/targeted inpatient beds 	<ul style="list-style-type: none"> Continue to refine, expand successful practices Re-examine gaps in service array, need for additional beds Incorporate new knowledge, emergent promising and evidence-based practices

Outcomes

This plan represents an ambitious set of recommendations that, if implemented in a thoughtful, strategic, and coordinated way, should lead to a host of system and population outcomes – from the infusion of fiscal resources and infrastructure modernization, to improved mental health systems and practices, and ultimately, to better lives for the residents of NH.



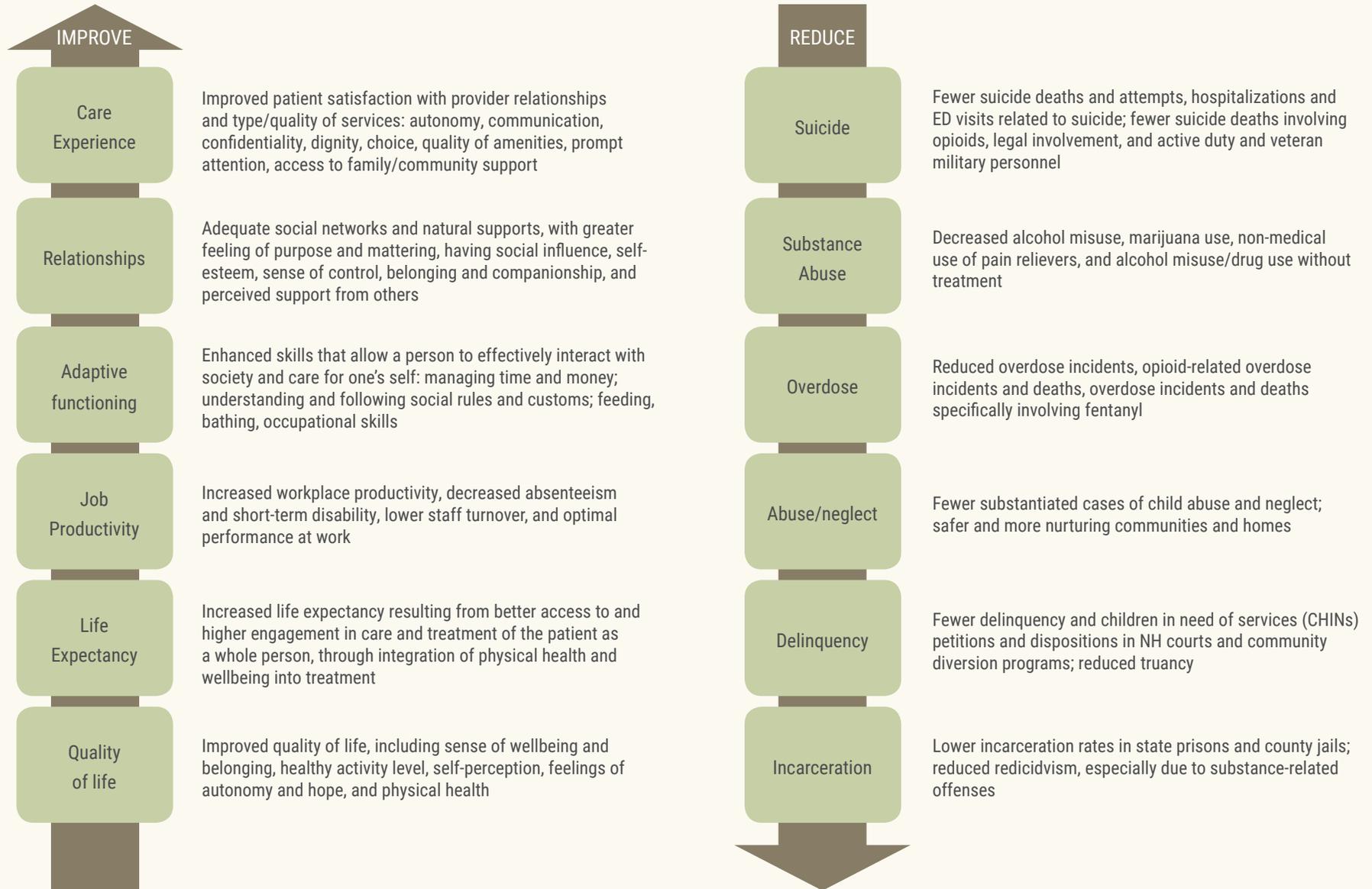
System Outcomes

The following system-level outcomes are expected to result from an infusion of resources and implementation of infrastructure, technology, and workforce development actions, as well as development of the centralized Mental Health Portal.⁵⁶

Easier access Info & services available Decreased barriers	Improved access to information for providers and consumers; more empowered consumers; more intentional stratification of consumer needs with service types; increased availability of service types, locations, and times that meet consumer needs
Better quality Workforce EBPs	Improved recruitment of qualified professionals and peer supports; fewer unfilled positions; lower turnover rates; higher job satisfaction and decreased burnout; improved upward job mobility; increased fidelity to and outcomes of evidence-based and promising practices
Coordinated Integration Service linkages	Higher levels of integration among health, mental health, social service, and other relevant providers/supports; more intentional care pathways; enhanced communication between "adjacent" services; increased use of facilitated referrals and follow up
More Fair & Just More CLC More equitable	Increased cultural and linguistic competence (CLC) of service organizations/providers; more equitable mental health access and outcomes; more participation of underrepresented populations in mental health governance and leadership positions
Increased efficiency Wait times in EDs Cost-effective	Elimination of wait times in EDs and wait lists for psychiatric beds; no more than a one-week wait for community-based services; reduction in avoidable use of EDs and psychiatric hospitals; higher frequency of delivering the right care at the right time in the right place

Population Outcomes

Implementation of a robust continuum of care should result in the following outcomes for NH residents.⁵⁷ Where appropriate, these outcomes have been aligned with those of state-level plans relevant to mental health, including suicide prevention, substance misuse, child welfare, and public health. See “Overlap with other state plans & entities” for a more detailed description of plan overlap.



Integration with Other State Plans and Entities

This section examines integration with the Mental Health Plan and the plans and interests of other NH entities, to identify opportunities for alignment and coordination of efforts. The figure on the next page represents a rough estimate of the shared stake in mental health outcomes among these entities.

Integration With Other Mental Health Plans

This Plan fully supports and encompasses the NH Community Mental Health Agreement that focuses on expanding outpatient services such as ACT teams, Supported Employment, Supported Housing, and Transitional Planning for adults with severe mental illness. And, Quality Service Reviews and Fidelity Reviews also tie in with this Plan. It is also consistent with and supportive of the *2017 NH Suicide Prevention Plan* and the *2013 Children's Behavioral Health Collaborative (CBHC) Plan*. Synergistic themes from the NH Suicide Prevention plan include adherence to the Zero Suicide model, the need for community education, encouragement of access to and utilization of services and improvement of workforce training as well as data resources and sharing.⁵⁸ Connections with the CBHC Plan are extensive, given its emphasis on financing and infrastructure; workforce development; community education; early identification and intervention, high fidelity Wraparound for high-need children and youth, integration of mental health in primary care; substance abuse prevention and treatment; evaluation and use of data; and incorporation of the Federal Family First legislation (i.e., independent assessment of need and level of care, quality residential treatment options for children, and mobile crisis for children).

Integration With Other DHHS Plans

This Plan aligns a great deal with the *2017 Substance Use Collective Action Plan*. Both emphasize leadership, financial resources, public education, workforce development, collection and use of data, and effective policies and practices, with the aim of increasing access to and utilization of treatment

and substance misuse. These shared goals and interests create fertile ground for the envisioned mental health/SUD integration. Common ground with NH's DSRIP initiative is also significant. At the system level, both focus on integration, improving health information technology, and developing the workforce. At the practice level, both focus on care transitions, treatment of SUDs, and integrated treatment of co-occurring disorders. This Plan is also well aligned with DCYF's adequacy and enhancement assessment, that recommends expansion of children's behavioral health programming such as FAST Forward and the incorporation of the Federal Family First legislation which speaks to the independent assessment of need and level of care, quality residential treatment options for children, and mobile crisis for children. This Plan has fewer overt connections with the *2013-2020 State Health Improvement Plan*; the main points of intersection are integrated care, injury prevention (e.g., suicide), and reduction of substance misuse.⁵⁹

Integration With Interests of Other NH Departments

Though the NH DOE 2015 Vision 2.0 featured neither mental health nor social emotional learning, the DOE was awarded several large federally funded grants from the Substance Abuse and Mental Health Services Administration to improve school climate, social emotional learning, and school-based mental health, starting in 2014. This grant-funded work paved the way for development of the Bureau of Student Wellness within the DOE. The DOE's collaboration with DHHS and the CBHC around children's behavioral health is now NH law with the passage of the System of Care Senate Bill 534, requiring these entities to jointly develop and maintain an integrated and comprehensive behavioral health system for children, youth, and young adults. In addition, the DOE's "iSocial" initiative to enhance social emotional learning in early childhood settings and the aforementioned MTSS-B work, are highly consistent with this Plan. The DOC's interest in the mental health and SUD systems is also clear. As NH's

mental health system has faced challenges, county jails and state prisons have become increasingly populated by individuals with un- or under-treated mental health and substance misuse disorders. Implementation

of this Plan should contribute to lower delinquency, incarceration, and recidivism rates.

Stakeholders recommend that DHHS/DBH seek support from leaders of these and other NH entities with a clear stake in the mental health system to allocate sufficient resources for implementation of this Plan. Establish an ongoing advisory board of leaders from these and other entities to encourage awareness of Plan implementation, explore joint interests in mental health, and seek counsel and consultation on areas of mutual interest.

Appendix A: Planning Process and Contributors

Operational Team

A core group of DHHS department leaders engaged with a team from the Center for Behavioral Health Innovation (BHI) at Antioch University New England to begin the planning process for the NH Mental Health Plan. This DHHS Operational Team led the process and served as a liaison between BHI, high level leaders within DHHS and beyond (see Key Advisors), and external stakeholders. BHI also provide input to the Operational Team on the direction and operationalization of the Plan.

DHHS Operational Team

Julianne Carbin Erica Ungarelli

BHI, Antioch University New England

Megan Edwards Jim Fauth George Tremblay

Consultation with Key Advisors

Throughout the development of the Plan, BHI and the DHHS Operational Team consulted with a group of Key Advisors who provided input on the planning process and early drafts. The Key Advisors group had input into the Plan as presented here.

Key Advisors

Rep. David Danielson	Lisa Morris	Donald Shumway
Jeffrey Meyers	Lori Shibinette	Katja Fox
Joseph Ribsam Jr	Yvonne Goldsberry	Thomas Pristow
Peter Evers	Ken Norton	Christine Tappan

Review of Gap Analysis and Existing Reports

In early spring of 2018, The Operation Team approved BHI to perform a review of the Human Services Research Institute's (HSRI) capacity assessment and other relevant NH mental health-related reports. The content of these reports was tracked and documented. Based on recommendations outlined in the HSRI report, the Operation Team approved BHI seeking and securing a health economist to provide financial analysis and consultation for the plan. The HSRI and other reports were also the bases upon which the factors contributing to wait times for psychiatric hospitalization and other challenges of the mental health system were drafted.

Understanding the Contributing Factors: Focus Groups

The Operation Team authorized and participated with BHI in soliciting input on the contributing factors to the current mental health challenge from existing NH mental health-related groups and committees. Using information gathered from the report review, a "fishbone" diagram (see Appendix B) was created to represent the factors contributing to challenges in the mental health system. The diagram served as a stimulus for focus group discussions, which in turn helped the Operation Team and BHI deepen their understanding of these and other contributing factors. The Operational Team and BHI identified and met with 15 focus groups from January through March of 2018:

Focus Groups

- Children's Behavioral Health Collaborative
- Peer Support Agencies Executive Directors
- Coalition on Substance Abuse, Mental Health and Aging
- Governor's Roundtable on ER Wait times in EDs legislative subgroup
- Emergency Services and Emergency Response providers

- NH Consumer Council & MH Planning and Advisory Council
- Community Mental Health Centers Executive Directors
- Hillsborough County Coalition on Mental Health & Justice
- Chiefs of Police Association
- Specialty Court Coordinators
- NH Suicide Prevention Council
- Integrated Delivery Networks
- New Hampshire Hospital Association
- DHHS Staff
- Pyramid Model Leadership Team

Identifying the Solutions: Workgroups

The Operational Team and BHI then developed cross-sector, solution-oriented workgroups in order to identify and vet promising system- and practice-level continuum of care solutions to the challenges and contributing factors identified from the focus groups, with special attention to high-priority populations. Five workgroups focused on the continuum of care, with one group per “step.” A sixth workgroup focused on operationalizing and financing the plan. The charge to each workgroup was to consider and prioritize high leverage solutions for each step – and transition/choke points between steps – for populations of interest (child/youth, adult, elderly, substance misuse, co-occurring/dual diagnosed, justice involved) and key contributing factors (people, services/supports, infrastructure, accountability, finances, systems).

Each workgroup was comprised of approximately 12 members representing differing populations of interest, care continuum “step” expertise, and lived experience. Workgroup members self-nominated through an online survey, indicating their area of expertise, interest, and availability to attend meetings. Members were selected primarily based on representativeness and their ability to attend a majority of the workgroup meetings. The operations and financing workgroup included the contracted health economist and others with expertise in this domain, including the DHHS Operational Team and executive and operational officers from CMHCs and other organizations.

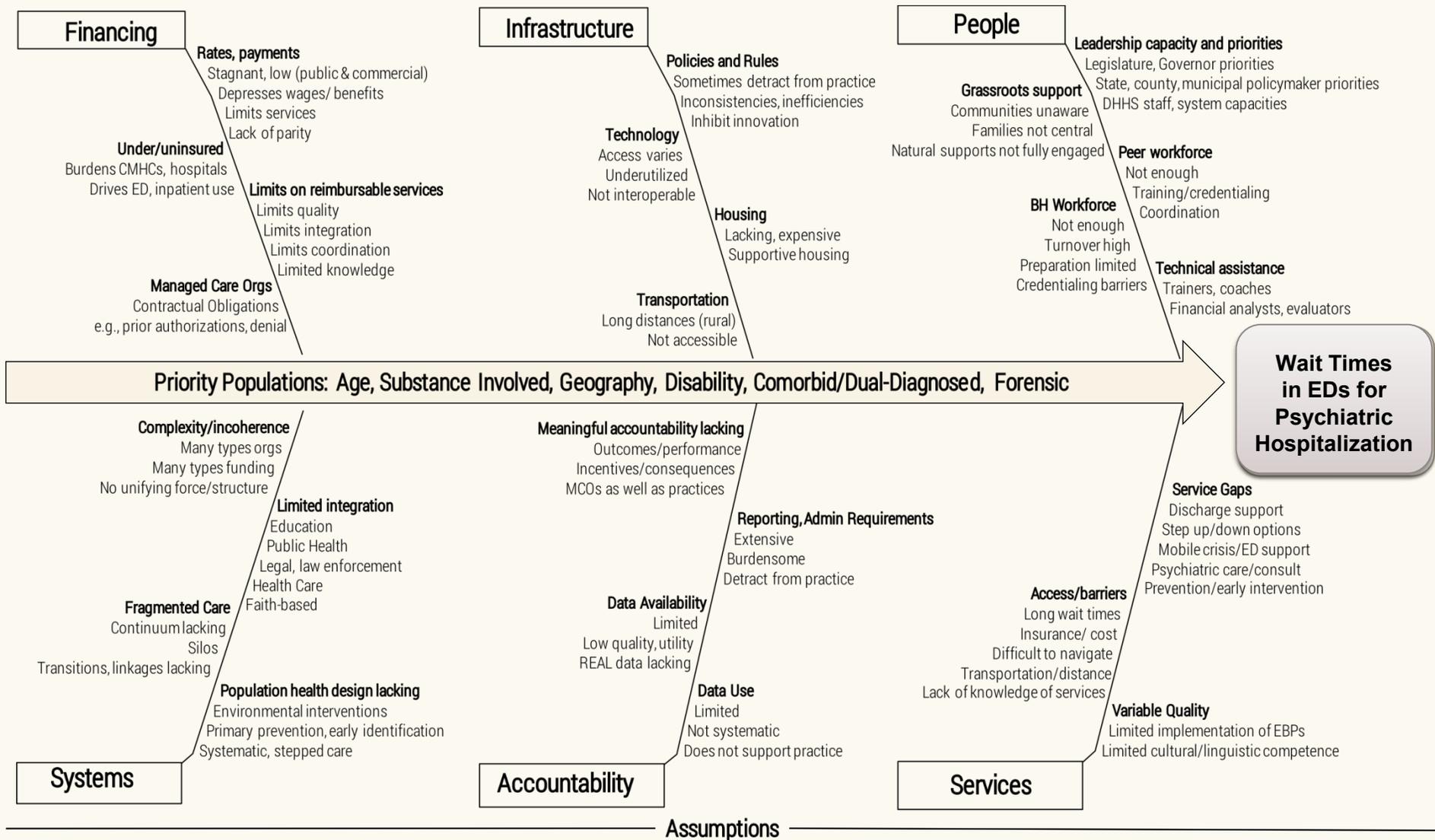
Each workgroup met four times in June–July of 2018, facilitated by members of the BHI team with participation from the DHHS Team members at each meeting. Potential solutions gleaned from the literature were shared to stimulate work group discussion and process, and to synchronize and integrate work between the groups. Each workgroup developed a prioritized

list of strategies for its particular step in the continuum of care. These lists have been used as the primary source of input in the development of this Plan. We are deeply grateful for all of the contributions of the following workgroup members to the development of this Plan.

Workgroup Members

Kathleen Abate Mary Forsythe-Taber	Katie Sawyer	Jay Couture
Susan Paschell	Greg Burdwood	Christine McKenna
Susan Allen-Samuel	Eve Klotz	Peter Starkey
Traci Fowler	Susan Schultz	David Danielson
Stephanie Patrick	Kathleen Butcher	Laura Mekinova
Sandy Alonzo	Chris Kozak	Susan Stearns
Joan Glutting	Susan Seidler	Alexander de Nesnera
Anna Pousland	Jessica Capuano	Patricia Mernin
Craig Amoth	Kristen Kraunelis	Ann Strachan
Shelly Golden	Kimberly Shepard	Susan Dionne
Barbara Publicover	Alex Casale	Ellen Minerva
Felicity Bernard	Diana Lacey	Daryll Tenney
Thomas Grinley	Lori Shibinette	John Dixon
Lauren Quann	Brian Collins	Lisa Mistler
Karl Boisvert	Jean Lewandowski	Jean Tewksbury
Bill Gunn	Rhonda Siegel	Mark Durso
William Rider	Jennifer Conley	Teresa Moler
Marty Boldin	Ken Lewis	Nick Toumpas
Brian Huckins	Mike Skibbie	Jon Eriquezzo
Lisa Riley	Rosemary Costanzo	Teresa Moulton
Travis Boucher	Jim MacKay	Michele Watson
Peter Janelle	Kendall Snow	Bobbie Erskine
Jonathan Routhier	Darlene Cote	Kathleen Murphy
Pamela Brown	Gildersleeve	Becky Whitley
Peter Kelleher	JoAnne Malloy	Kim Firth
Maureen Ryan	Brian Sousa	Rebecca Neal
Mary Brunette	Janelle Cotnoir	Rebecca Woitkowski
Camille Kennedy	Holly McCormack	Phil Wyzik
	Donna Stamper	

Appendix B: Contributing Factors



Wait time is a visible symptom of a system under stress, but outcomes like wellbeing and life expectancy are at least as/more critically important. Contributing factors on the left are more encompassing, contributing factors on the right are more focal and proximal to the wait-time problem. Social Determinants of Health underlie and intersect with most of the contributing factors.

Appendix C: Build the Foundation FY 2020/2021

These budget items are reflective of priorities identified through the 10-year planning process as foundational investments needed to support the mental health needs of NH citizens. They reflect essential investments needed in this biennium (20/21) in order to strengthen the foundation for future investments and growth.

Resources & Infrastructure \$13.4M Investment	Medicaid Rates	\$10,000,000
	An infusion of resources to bring Medicaid rates to the national average is needed to support a robust mental health system in NH. A \$10M investment of general funds will draw down an additional \$10M of federal Medicaid dollars.	
	Mental Health Portal	\$1,500,000
	In order to facilitate easy access to a coordinated, high quality array of localized services and supports for all, a centralized portal is needed. The portal will facilitate linkages across the continuum of care and serve as a locus of system accountability. The new funds will supplement existing efforts to create an integrated behavioral health portal.	
	Community Education	\$400,000
	In order to improve recognition and response to signs of mental distress in NH communities, statewide public education must take place. This will include a statewide public health campaign to make our communities safe and caring places for those with mental illness and to eradicate stereotypes, prejudice, and discrimination. These efforts could take place through a blend of public funds (\$400,000) and private match and be structured through a statewide coalition that sets priorities and advances the work.	
	Prevention & Early Intervention	\$1,000,000
	Early interventions can mitigate progression of symptoms, improve functioning, and avert other negative impacts of mental illness. We need to intervene upstream to prevent the emergence of and halt the progression of mental illness. Early Serious Mental Illness (ESMI) interventions are effective but not available statewide. Investing in the expansion of ESMI programs (\$800,000) could pair with federal block grant dollars to make services available statewide. Additional resources to support the Infant Mental Health Plan (\$200,000) are needed.	
Workforce Development	\$500,000	
Training and support for both mental health and non-mental health professionals who come into contact with people in emotional distress are essential. Training and technical assistance (\$300,000) for frontline workers for Crisis Intervention Team (CIT) for law enforcement, Mental Health First Aid for ER staff, and Youth Mental Health First Aid for teachers are a priority. This will allow for more universal recognition of emotional distress, supportive and safe responses, and smooth connections to appropriate supports. Suicide prevention training (\$200,000) in models such as Zero Suicide is one of the essential training components recommended for the target audience identified above.		

System Strategies \$600,000 Investment	QI & Monitoring	\$100,000
	New full time position to oversee implementation, quality, and monitoring of new system expansion efforts.	
	DHHS Capacity	\$500,000
	<p>DBH has oversight responsibilities for the programmatic and financial aspects of the mental health system. Staffing has been reduced at the same time funding has increased and the system has become more complex. Adding the following positions will allow for more effective and efficient implementation of the strategies herein. Each position is budgeted at \$100,000 per fiscal year:</p> <ul style="list-style-type: none"> • BMHS Housing Specialist: To improve the coordination of care and access to housing options for individuals with mental illness and co-occurring disorders, and increase cross departmental integration efforts, BMHS needs a dedicated Housing Specialist. • BMHS Liaison with the DOC: There is a significant need to better align efforts throughout the mental health, criminal justice, and correctional systems in order to more effectively divert people with mental illness from entering the justice system. A position dedicated to this end is necessary. • BCBH Infant & Early Childhood Mental Health Specialist: To address early prevention and treatment efforts, this position is necessary to build the expertise within the bureau as well as work with the multiple early childhood groups and initiatives already active. • BCBH Liaison to the DOE: There is a significant need to better align efforts throughout children’s mental health, DCYF, and education system to ensure children are identified and referred to early interventions. A position dedicated to this end is necessary. • DBH Access Coordinator: The inability to access services was cited as a significant barrier. This position would work in partnership with the Portal(s) and Division of Public Health to launch and oversee a public health campaign, education, and outreach regarding mental health that would increase public awareness of available treatment options and decrease unnecessary ED visits. 	

Practice Strategies \$9.95M Investment	Outpatient Services	\$4,200,000
	There is a shortage of housing services and supports for people with serious mental illness despite how effective these services are at helping people maintain stability and achieve recovery. It is necessary to expand the continuum of care by investing more in supported housing, including supervised housing for transition age youth, peer respite, and transitional housing for adults (\$3M); by expanding the Housing Bridge Subsidy program (\$1M) that currently has reached capacity and has a waitlist; and expanding the FAST Forward Program (\$200,000) to support children and families.	
	Step-up and Step- Down Options	\$2,000,000
	Transitional services for people leaving or at risk of being admitted to an inpatient setting reduces readmissions to the hospital and allows people to recover in a community setting, thereby diverting unnecessary ED or inpatient stays. Crisis residential programs for children and adults are greatly needed as well as expansion of therapeutic day programs and partial hospital programs.	
	Crisis and Inpatient Services	\$3,000,000 + unknown
	Mobile crisis is effective at diverting inpatient psychiatric admission and connecting persons experiencing mental distress to appropriate outpatient services. The creation of an additional crisis response team or center (\$1.5M) and the enhancement of current crisis services (\$1.5M) to offer integrated mental health and co-occurring response to adults and children is necessary. It was also identified that additional, targeted inpatient beds are needed. DHHS will build out budget projections for additional targeted in-patient beds. Additionally, options should be explored with private hospitals to consider reopening voluntary inpatient psychiatric beds in local communities.	
	Integration of Peers and Natural Supports	\$750,000
Relatively low-cost, high-gain strategies that will mitigate wait times in EDs, such as peer navigators in EDs, is cited as one of the top priorities. Expanding the availability of peers in a variety of practice settings and engaging youth ambassadors through the allocation of state and/or blended, state and private dollars is recommended.		
TOTAL Investment FY 2020/2021	\$23,950,000	

Notes

- 1 America's Health Rankings. Suicide in NH. Retrieved Aug 22, 2018, from: <https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/NH>; Stone, D.M., Simon, T.R., Fowler, K.A., et al. (June, 2018). Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. *Morbidity and Mortality Weekly Report* 2018; 67: 617–624. DOI: <http://dx.doi.org/10.15585/mmwr.mm6722a1>
- 2 NH DHHS, (2018). Homeless point-in-time data. Retrieved Aug 21, 2018, from <https://www.dhhs.nh.gov/dcbcs/bhhs/homelessdata.htm>
- 3 Trust for America's Health; Well Being Trust (2017). *Pain in the Nation: The Drug, Alcohol, and Suicide Crises and the Need for a National Resilience Strategy*. Washington DC.
- 4 NH Community Behavioral Health Association (2017). *New Hampshire's Community Mental Health System: A Path Forward*. White paper prepared by the NHCBA.
- 5 Human Services Research Institute (HSRI). (December 22, 2017). Final report: Evaluation of the capacity of the New Hampshire Behavioral health system. Retrieved from: <https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf>.
- 6 NH Community Behavioral Health Association (2017). *New Hampshire's Community Mental Health System: A Path Forward*. White paper prepared by the NHCBA.
- 7 Human Services Research Institute (HSRI). (December 22, 2017).
- 8 Miller, P. (2018). March 2018 HR Posting Analysis. Report prepared for the NH Community Behavioral Health Association, Concord, NH, dated April 10, 2018.
- 9 Occupational Employment Statistics, US Bureau of Labor Statistics.
- 10 Commission to Develop a Comprehensive State Mental Health Plan. (2008). *Fulfilling the promise: Transforming New Hampshire's Mental Health System*. Retrieved from: http://www.endowmentforhealth.org/uploads/resources/id69/MHC_Report.pdf.
- 11 Human Services Research Institute (HSRI). (December 22, 2017). Final report: Evaluation of the capacity of the New Hampshire Behavioral health system. Retrieved from: <https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf>.
- 12 <https://www.buxtonco.com/blog/the-future-of-healthcare-systems-a-new-hub-and-spoke-model>
- 13 Jessica Allen, Reuben Balfour, Ruth Bell & Michael Marmot (2014) Social determinants of mental health, *International Review of Psychiatry*, 26:4, 392–407, DOI: 10.3109/09540261.2014.928270; World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. Geneva, World Health Organization.
- 14 Koplan, C., & Chard, A. (2014). Adverse Early Life Experiences as a Social Determinant of Mental Health. *Psychiatric Annals*, 44(1), 39–45. <https://doi.org/10.3928/00485713-20140108-07>; Langheim, F. J. P. (2014). Poor Access to Health Care as a Social Determinant of Mental Health. *Psychiatric Annals*, 44(1), 52–57. <https://doi.org/10.3928/00485713-20140108-09>; Manseau, M. W. (2014). Economic Inequality and Poverty as Social Determinants of Mental Health. *Psychiatric Annals*, 44(1), 32–38. <https://doi.org/10.3928/00485713-20140108-06>; Shim, R., Koplan, C., Langheim, F. J. P., Manseau, M. W., Powers, R. A., & Compton, M. T. (2014). The Social Determinants of Mental Health: An Overview and Call to Action. *Psychiatric Annals*, 44(1), 22–26. <https://doi.org/10.3928/00485713-20140108-04>

- 15 <https://www.samhsa.gov/disorders/co-occurring>
- 16 <https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness>
- 17 Johnson, K. (2012). New Hampshire demographic trends in the twenty-first century. UNH Carsey Institute: Building Knowledge for Families and Communities Reports on New England, No. 4. Retrieved on September 28, 2018 from: <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1163&context=carsey>.
- 18 <https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care>
- 19 <https://www.dhhs.nh.gov/omh/refugee/facts.htm>
- 20 <https://refugeehealthta.org/physical-mental-health/mental-health/>
- 21 Corrigan, P.W., & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16–20.
- 22 Evans-Lacko, S., Corker, E., Williams, P., Henderson, C., and Thornicroft, G. (2014). Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–2013: An analysis of survey data. *The Lancet Psychiatry*, 1(2), 121–128.
- 23 Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health. Retrieved at <https://www.cdc.gov/socialdeterminants/> on September 5, 2018.
- 24 Ibid.
- 25 NH Association for Infant Mental Health (2009). *Mental Health Services for NH’s Young Children and Their Families: Planning to Improve Access and Outcomes*.
- 26 Heinsen, R., Goldstein, A., and Azrin, S. (2014). Evidence-based treatments for first episode psychosis: Components of coordinated specialty care. Downloaded from the National Institute of Mental Health Information Resource Center (<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis-components-of-coordinated-specialty-care.shtml>), on Sept 5, 2018.
- 27 Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., & Wilt, T. J. (2008). *Integration of Mental Health/Substance Abuse and Primary Care* (No. 09–E003). MD: Agency for Healthcare Research and Quality. Retrieved from <http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>
- 28 <https://www.samhsa.gov/disorders/co-occurring>
- 29 <https://www.integration.samhsa.gov/>; <https://integrationacademy.ahrq.gov/>
- 30 University of Maryland School of Medicine. (n.d.) *The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes*. Retrieved from <http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/CSMH-SMH-Impact-Summary-July-2013-.pdf>; Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, 3(4), 223–241.
- 33 Substance Abuse and Mental Health Services Administration. (2009). *Integrated Treatment for Co-Occurring Disorders: Building Your Program*. DHHS Pub. No. SMA–08–4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- 32 <https://www.samhsa.gov/homelessness-housing/poverty-housing#supportive-housing>
- 33 Aubry, T., Tsemberis, S., Adair, C. E., Veldhuizen, S., Streiner, D., Latimer, E., & Goering, P. (2015). One-year outcomes of a randomized controlled trial of housing first with ACT in five Canadian cities. *Psychiatric Services*, 66(5), 463–469. <https://doi.org/10.1176/appi.ps.201400167>https://www.rand.org/pubs/research_reports/RR1694.html?adbcs=social_20171205_1990021&adbid=938163576040144896&adbpl=tw&adbpr=22545453; Housing First. (n.d.). Retrieved May 23, 2018, from <https://endhomelessness.org/resource/housing-first/>

- 34 Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., & Susser, E. (2011). A randomized trial of critical time intervention to prevent homelessness in persons with severe mental illness following institutional discharge. *Psychiatric Services*, 62(7), 713–719. <https://doi.org/10.1176/appi.ps.62.7.713>; Wright, B., Vartanian, K., Holtorf, M. (2015). Intensive Transition Team: Analysis of program impacts. The Center for Outcomes Research & Education, Portland, OR. <https://www.criticaltime.org/cti-model/>
- 35 Herman et al. (2011).
- 36 McKay, C., Nugent, K. L., Johnsen, M., Eaton, W. W., & Lidz, C. W. (2018). A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(1), 28–47. <https://doi.org/10.1007/s10488-016-0760-3>; <https://clubhouse-intl.org/what-we-do/what-clubhouses-do/>
- 37 Croft, B., & svan, N. (2015). Impact of the 2nd story peer respite program on use of inpatient and emergency services. *Psychiatric Services*, 66(6), 632–637. <https://doi.org/10.1176/appi.ps.201400266>; <http://www.peerrespite.net/>
- 38 Thomas, K. A., & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: a systematic review. *Psychiatric Services*, 64(11), 1140–1149. <https://doi.org/10.1176/appi.ps.201200427>; <https://franciscanchildrens.org/mental-health/community-based-acute-treatment-program/>
- 39 <https://www.chcf.org/wp-content/uploads/2017/12/PDF-TelepsychiatryProgramsED.pdf>
- 40 <https://www.resourcesforintegratedcare.com/sites/default/files/Navigation%20Guide.pdf>
- 41 Ibid.
- 42 <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>
- 43 Ibid.
- 44 Fuhr, D. C., Salisbury, T. T., De Silva, M. J., Atif, N., van Ginneken, N., Rahman, A., & Patel, V. (2014). Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 49(11), 1691–1702. <https://doi.org/10.1007/s00127-014-0857-5>; Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, 11(2), 123–128.; Sledge, W. H., Lawless, M., Sells, D., Wieland, M., O’Connell, M. J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services*, 62(5), 541.
- 45 <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>
<https://www.dhhs.nh.gov/dcbcs/bbh/peer.htm> <http://www.intentionalpeersupport.org/what-is-ips/>
- 46 BerryDunn. Financing NH’s behavioral health 10-Year plan. Presentation to the NH 10-Year Plan Operations and Finance Work Group by James Highland, June 26, 2018.
- 47 BerryDunn. Financing NH’s behavioral health 10-Year plan. Presentation to the NH 10-Year Plan Operations and Finance Work Group by James Highland, June 26, 2018.
- 48 Flanagan T. (2016). America’s Highest Healthcare Cost in 2016? Mental Health. 2016 Sept 5. Healthcare Recruiters International.
- 49 Sassi, F. (2006). Calculating QALYs, comparing QALY and DALY calculations. *Health Policy and Planning*, 21 (5), 402–408. <https://doi.org/10.1093/heapol/cz1018>; Washington State Institute for Public Policy (2018). Benefit-Cost Results. Retrieved Sept 3, 2018 from: <http://www.wsipp.wa.gov/BenefitCost>.
- 50 Layard R. (2017). The Economics of Mental Health. IZA World of Labor 2017. Retrieved on Sept 10, 2018 from: <https://wol.iza.org/articles/economics-of-mental-health/long>.

- 51 Rost, K., Pyne, J., Dickinson, L., and LoSasso, A. (2005). Cost-effectiveness of enhancing primary care depression management on an ongoing basis. *Annals of Family Medicine*, 3, 7-14.
- 52 Layard R. (2017). The Economics of Mental Health. IZA World of Labor 2017. Retrieved on Sept 10, 2018 from: <https://wol.iza.org/articles/economics-of-mental-health/long>.; Unutzer, J., Katon, W., Fan, M., et. al. (2008). Long-term cost effects of collaborative care for late-life depression. *American Journal of Managed Care*, 14(2), 95-100.; Waxmonsky J.A., Thomas M, Giese A, et. al. (2012). Evaluating depression care management in a community setting: Main outcomes for a Medicaid HMO population with multiple medical and psychiatric comorbidities. *Depression Research and Treatment*. Retrieved Sept 10, 2018 from: <https://www.hindawi.com/journals/drt/2012/769298/>
- 53 Flanagan T. (2016). America's Highest Healthcare Cost in 2016? *Mental Health*. 2016 Sept 5. Healthcare Recruiters International.; Rost K, Smith JL, Dickinson M. (2004). The effect of improving primary care depression management on employee absenteeism and productivity. A randomized trial. *Medical Care*, 42(12), 1202-10.
- 54 Occupational Employment Statistics, US Bureau of Labor Statistics
- 55 Blount, A., Fauth, J., Nordstrom, A., Pearson, S. (2016). Who will provide integrated care? Assessing the workforce for the integration of behavioral health and primary care in New Hampshire. Center for Behavioral Health Innovation, Antioch University New England. Commissioned by the Endowment for Health.; Blount, A. (2017). New Hampshire primary care behavioral health workforce development plan. Center for Behavioral Health Innovation, Antioch University New England. Commissioned by the Endowment for Health.; <http://www.nh4youth.org/collaborative/workgroups/workforce-development-network> <http://www.nchnh.org/region7IDN.php?xpage=31>
- 56 <https://www.samhsa.gov/section-223/quality-measures>
- 57 Brunero, S., Lamont, S., & Fairbrother, G. (2009). Using and understanding consumer satisfaction to affect an improvement in mental health service delivery. *Journal of Psychiatric and Mental Health Nursing*, 16, 272-278.; Cleary, M., Horsfall, J., & Hunt, G. (2003). Consumer feedback on nursing care and discharge planning. *Journal of Advanced Nursing*, 42, 269-277.; Connell, J., O'Cathain, A., & Brazier, J. (2014). Measuring quality of life in mental health: Are we asking the right questions? *Social Science and Medicine*, 120, 12-20. Doi: 10.1016/j.socscimed.2014.08.026; Goetzal, R.Z., Ozminkowski, R.J., Sederer, L.I., & Mark, T.L. (2002). The business case for quality mental health services: Why employers should care about the mental health and well-being of their employees. *Journal of Occupational and Environmental Medicine*, 44, 320-330.; Ilyas, A., Chesney, E., & Patel, R. (2017). Improving life expectancy in people with serious mental illness: Should we place more emphasis on primary prevention? *British Journal of Psychiatry*, 211, 192-197. Doi: 10.1192/bjp.bp.117.203240.; Katschnig, H. (2006). Quality of life in mental disorders: Challenges for research and clinical practice. *World Psychiatry*, 5, 139-145.; Miglietta, E., Belessiotis-Richards, C., Ruggeri, M., Priebe, S. (2018). Scales for assessing patient satisfaction with mental health care: A systematic review. *Journal of Psychiatric Research*, 100, 33-46. DOI: 10.1016/j.jpsychires.2018.02.014; Thoits, P.A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52, 145-161. doi: 10.1177/0022146510395592.
- 58 New Hampshire Suicide Prevention Council. (2016). 2017-2020 New Hampshire Suicide Prevention Plan. Retrieved from: <https://www.sprc.org/sites/default/files/NH%202016-suicide-prevention-plan.pdf>
- 59 NH Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment (2013). Collective action, collective impact: New Hampshire's strategy for reducing the misuse of alcohol and other drugs and promoting recovery. Retrieved from: <https://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf>