

Frank Edelblut
Commissioner



Jeffrey Meyers
Commissioner

STATE OF NEW HAMPSHIRE

May 22, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Executive Council
State House
Concord, NH 03301

Dear Governor Sununu and Executive Councilors:

We are pleased to deliver to you Implementing a System of Care for Children's Behavioral Health in New Hampshire: Year 3 report pursuant to RSA 135-F:6. Senate Bill 534 passed in June of 2016 directs the Department of Health and Human Services and the Department of Education to develop a comprehensive system of care for children's behavioral health services. A steering committee comprised of over a dozen individuals with expertise in children's behavioral health has convened numerous times over the past year to discuss the formulation of this report. With representatives from our departments as well as public school districts, community mental health centers and advocacy groups in the state, our work has been informed by a diverse group of stakeholders, and we wish to thank them for their valuable contributions. Additionally, the Endowment for Health has funded the Vulnerable Families Research Program at the Carsey School of Public Policy at the University of New Hampshire to provide technical assistance.

This report again builds off of last year's report to look at estimates of expenditures for children's behavioral health services. This report also provides an update as to the progress made over the last year at both Departments. This work is strongly connected and integrated with other work happening at both departments including but not limited to; the 10-year Mental Health plan, the Child Welfare Transformation work, School Safety and a variety of currently pending bills.

This report represents the third of four annual reports required by RSA 135-F, we acknowledge that systemic improvements efforts are ongoing and the work of both departments over the past year and for years to come will be aimed at implementing and improving the system of care for children's behavioral health in New Hampshire.

We look forward to continued support from the State as we work towards ensuring the behavioral health of children in New Hampshire.

Respectfully,

Handwritten signature of Jeffrey Meyers in blue ink.

Jeffrey Meyers
Commissioner
NH Department of Health and Human Services

Handwritten signature of Frank Edelblut in black ink.

Frank Edelblut
Commissioner
NH Department of Education

Enclosure

cc: The Honorable Stephen Shurtleff, Speaker, NH House of Representatives
The Honorable Donna Soucy, President, NH State Senate
The Honorable Mary Jane Wallner, Chair, House Finance Committee
The Honorable Lou D'Allesandro, Chair, Senate Finance Committee
The Honorable Mel Myler, Chair, House Education Committee
The Honorable Jay Kahn, Chair, Senate Education Committee
The Honorable Lucy Weber, Chair, House Health, Human Services & Elderly Affairs Committee
The Honorable Tom Sherman, Chair, Senate Health and Human Services Committee



An Act to Implement a System of Care for
Children's Behavioral Health
in New Hampshire

Year 3 Report

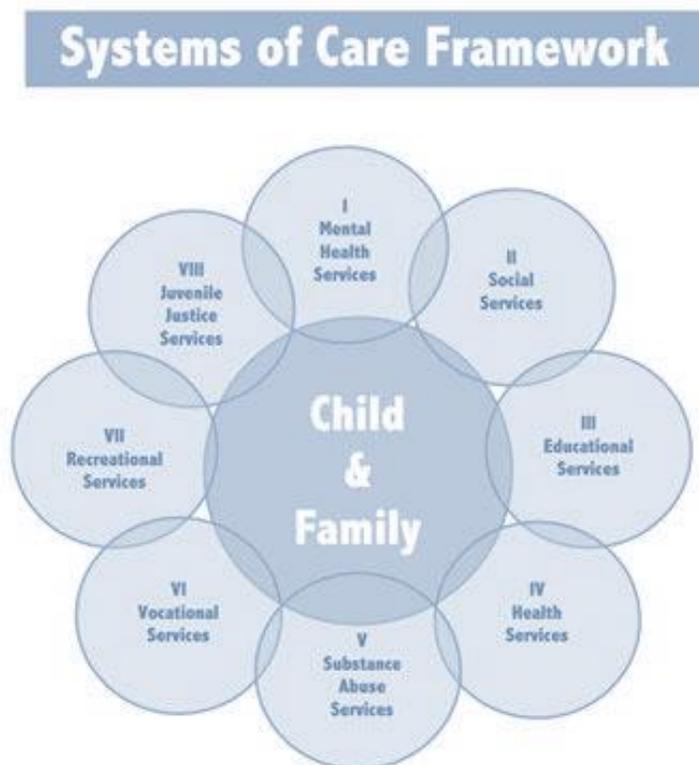
March 1, 2019

Executive Summary

In May 2016, the New Hampshire Legislature passed, and the Governor signed Senate Bill 534-FN which established the development of a comprehensive system of care for children’s behavioral health services in the state. In December of 2016, a [Year 1 Report](#) was issued, which described initial progress towards implementing a system of care as defined by this legislation. In fulfilling the statutory requirements, the [Year 2 Report](#) expanded upon this earlier work to outline continued progress towards a system of care for children’s behavioral health services. In this Year 3 Report, there have been critical improvements to the children’s behavioral health system of care, including: the expansion of the Medicaid to Schools program; the 2018-2019 state budget including funding for a new Medicaid benefit that allowed the Department of Health and Human Services (DHHS) to expand the provision of high fidelity wraparound and care coordination services to children with behavioral health needs, paving the way for further integration of high fidelity wraparound services beyond the FAST Forward program; the inclusion of children in the 10-year plan for mental health services; the expansion of the FAST Forward program to include eligible children and youth from the Division of Children, Youth and Families systems; the continued development of school-based behavioral health services through the Office of Substance Abuse and Mental Health Service Administration (SAMHSA) grants, and numerous other advances; the continued adoption of NH’s Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model by NH school districts; and the expansion of school based prevention efforts including social emotional learning and a focus on school culture and climate.

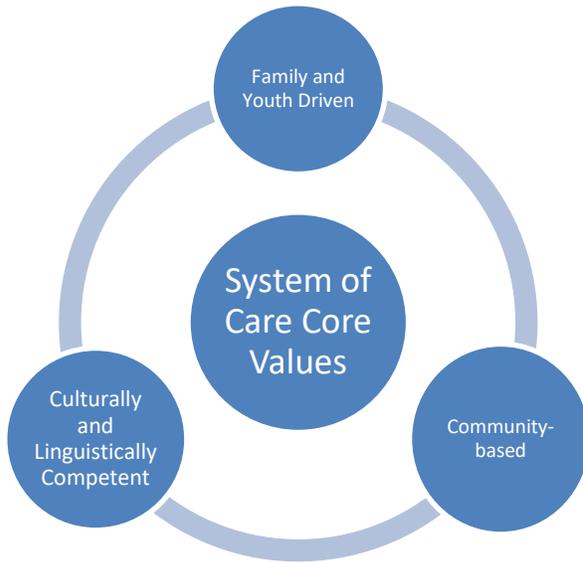
The NH Departments of Health and Human Services and Education remain committed to the development of NH’s system of care, an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to NH children and youth. Within this report, we will provide updates on the significant progress toward our goals and celebrate the immense success achieved across NH in three short years.

A System of Care is a spectrum of effective, community-based services and supports for children, youth and their families with or at risk for mental health challenges, that is



From Stroul, B. & Friedman, R. (1986 rev ed). *A system of care for children and youth with severe emotional disturbances* (rev. ed., p. 30). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health.

organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them to function better at home, school, community, and throughout life



SOC Guiding Principles

- Effective, evidence-informed service
- Individualized Wraparound service planning and service delivery
- Least restrictive environments
- Youth and families as full partners
- Integrated care
- Care management for service coordination
- Developmentally appropriate services
- Prevention, early identification and intervention
- Promoting advocacy and quality
- Non-discrimination

NH’s Department of Health and Human Services (DHHS) and NH’s Department of Education (DOE) continue to champion the adoption and expansion of the system of care core values below:

Family Driven and Youth Driven: Youth and Family driven, with the strengths and needs of the child and family determining the types and mix of *services* and supports provided. Family and Youth is the core of the work. Youth and families take a leadership role at the individual service delivery level as well as policy, planning and system levels.



Community Based: Services are provided at the community level with the youth and family in their home and community. Services provided also include, system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.



Culturally and Linguistically Competent: Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.



System of Care Core Values can be observed throughout the work that has been complete during Year 3.

Requirements and Organization

Per Chapter 135-F:6 of an Act to Implement a System of Care for Children's Behavioral Health in New Hampshire, there are four elements included in the Year 1 report that must also be included in subsequent releases (items A through D below). Four additional details were added in the Year 2 report (items E through H below). In year 3, the report must also include information on four additional categories (items I through L below).

- A. The total cost of children's behavioral health services.
- B. The extent to which the state's behavioral health service systems are consistent with a system of care.
- C. A description of any actual or planned changes in department policy or practice or developments external to the departments that will affect the implementation of a system of care.
- D. Any other available information that is relevant to progress toward full implementation of a system of care.
- E. A summary of the interagency agreement between the departments required by RSA 135-F:7.
- F. Identification of those actions which will be required to maximize federal and private insurance funding participation in the system of care, along with target dates for completion.
- G. Identification of changes to statutes, administrative rules, policies, practices, managed care and provider contracts, which will be necessary to implement the system of care.
- H. Identification of significant gaps in the array of children's behavioral health services, along with a description of plans to close those gaps.
- I. Projections of future demands for services in the system of care.
- J. Identification of shortfalls in workforce sufficiency affecting the full implementation of the system of care and plans for addressing those shortfalls.
- K. Identification of specific plan amendments and other changes to the Medicaid system required for full implementation of the system of care and plans for making those changes.
- L. A number of children and youth awaiting services in various categories.

Unlike the Year 2 Report, which detailed findings along major topical areas, this Year 3 Report is organized to emphasize the holistic and integrated nature of this work. To simplify the presentation of this report's findings, we collapse the eight statutory requirements into four areas:

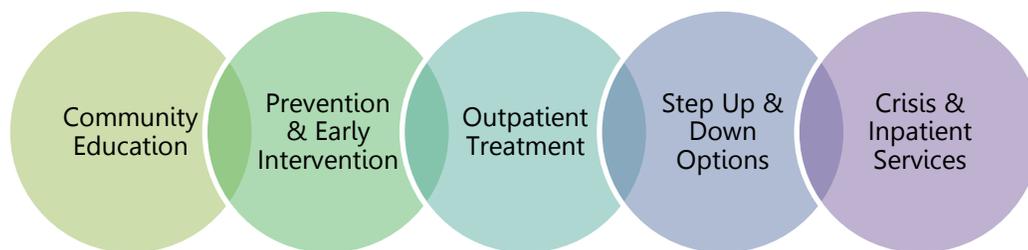
- Progress Update: DHHS
- Progress Update: DOE
- Expenditures in the System of Care
- Year 3 Requirements

Progress Update: DHHS

The following are key updates related to progress made by DHHS during Year 3.

10-year mental health plan

Following Governor and Executive Council approval on September 27, 2017, the New Hampshire Department of Health and Human Services (from now on “Department”) worked with Antioch University to facilitate the planning process. Attached is a visual representation of the process that has engaged a wide cross-section of stakeholders such as providers, families, individuals with lived experience, and elected officials. Building upon knowledge gained from extensive research and fifteen sector-specific focus groups, six multi-disciplinary workgroups commenced focussing on solutions. Workgroups were organized around the continuum of care pathway with an additional workgroup focused on operations and tasked to think creatively, consider alternative models of care, and develop strategies to operationalize system change.



Workgroups met four times and identified, prioritized, and begun operationalizing potential solutions/strategies to improve the continuum of care. Members were asked to consider solutions from a variety of perspectives and advice on goals, resources, strategies, outcomes, assumptions, and barriers that exist to accomplish various approaches. The recommendations put forward by the workgroups are being used as formative input in the development of the 10-year plan. Across workgroups, workforce, alternative payment models/enhanced rates, system-wide collaboration, and infusion of peer supports were cross-cutting themes. Proposed solutions generated by the workgroups have been brought forward to the vital advisory group. Drafting of the plan and feedback processes with stakeholders are underway.

The Department is committed to developing a comprehensive, operational plan that will ensure all New Hampshire citizens experiencing primary mental health issues and/or co-occurring disorders have full access to the continuum of high-quality mental health services when and where they need them. To ensure the plan accurately reflects the assessment, guidance, and input provided by stakeholders throughout the development process, the Department hosted public engagement forums in six locations statewide. The plan is published in a format that outlines the critical components of the plan. Input was sought through these civic engagement forums, and then a final plan was approved by the Commissioner and the Governor. The final version of the 10 Year Mental Health Plan can be located at <https://www.dhhs.nh.gov/dcbcs/bbh/10-year-mh-plan.htm>.

Infant mental health- discussion of ACES and early intervention

NH was selected to receive technical assistance from ZERO TO THREE, a national nonprofit that informs, trains and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers, to connect and develop strategies to advance state policy related to infant and early childhood mental health assessment, diagnosis, and treatment. The Core Team consists of 5 participants:

- Erica Ungarelli, Bureau of Children's Behavioral Health
- Patricia Tilley, Division of Public Health Services
- Henry Lipman, Medicaid Director
- Ellyn Schreiber, Riverbend Community Mental Health Center and the NH Association for Infant Mental Health
- Elizabeth Collins, Bureau of Special Medical Services

The NH application emphasized the importance of and need for an adequate array of services and supports for young children and their families from population-level approaches to assessment, diagnosis, and treatment for families with higher acuity. The focus of NH's efforts will be to use this technical assistance opportunity as a springboard for needed financing and policy changes.

It also noted that NH has multiple complementary coalitions and initiatives that are working to strengthen NH's infant and early childhood mental health system. To maximize the benefit of this TA opportunity a broader NH based team has been convened, as we create our comprehensive infant and early childhood mental health system.

The FAST Forward Program

The FAST Forward Program is a service provided within New Hampshire's System of Care which is designed to serve New Hampshire children, youth, and families experiencing difficulties in day-to-day life due to a severe emotional disturbance (SED) and are at risk for acute psychiatric hospitalization or placement in a residential treatment facility. Built on partnerships among service systems within the NH Department of Health and Human Services and community-based providers, FAST Forward offers access to individualized services, guided by a strengths-based, wraparound care coordination process.

NH Wraparound Model is central to FAST Forward's system of care strategy for improving children, youth and family outcomes. NH Wraparound is a youth and family-driven care planning and coordination process, delivered by highly trained FAST Forward coordinators (FFCs). Through NH Wraparound, a plan of care focuses on developing and utilizing youth/family strengths and building natural supports. Plan of Care strategies and services is established, endorsed, monitored, and improved to meet the identified needs and benchmarks of each youth and their family.

After a Behavioral Health Innovation at Antioch analysis, in which their team conducted a pre/post assessment of service utilization, the data helps begin to understand the service and cost impacts FAST Forward’s System of Care approach on New Hampshire state Medicaid expenditures, emergency room use, and hospital inpatient utilization. Significant findings showed a reduction in overall cost by 28 percent for the youth and families that were evaluated. (See Attached FAST Forward and Services Utilization report for in-depth reports of findings and subsequent literature review)

Sustainability and expansion have become the theme for Year 2, as well as, the current Year 3 reporting timeframe. With the original analysis, the FAST Forward program focused on sustainability and expansion to meet the needs of the children, youth and their families with whom it serves. In October 2016, New Hampshire’s Department of Health and Human Services, Bureau for Children’s Behavioral Health selected NFI North (NFI) as the Care Management Entity for the FAST Forward Program bringing high fidelity wraparound and wraparound components/services to communities across the state.

In October 2016, NFI began with three full-time FAST Forward Coordinators and by the end of the year of 2017, had seven full-time FAST Forward coordinators to support new youth and families. Between October 1st, 2016 and November 13th, 2017 FAST Forward has enrolled (73) new children, youth and their families. In that same period FAST forward has successfully transitioned (40) with a success rate of 50 percent rate or higher. Success rates are determined based upon the children, youth and family effectively meeting their family vision and team’s mission. (See figures below)

# of Referrals to FAST Forward *	# enrolled in FAST Forward	# Not enrolled in FAST Forward	# of Successful Transitions	Dominate Reason’s not enrolled in FAST Forward	Dominate referral source
237	120	124	84	Family Did Not meet eligibility criteria	NH State Psychiatric Hospital, Community Mental Health Centers, Schools
* Data from 8/2014 to 12/1/17-3.25 year period					

Since the end of the 2017 year, the CME and FAST Forward program continues to make significant growth and expansion. A milestone for the Bureau for Children’s Behavioral Health and NH System of Care, a 1915i state plan amendment was accepted on July 12th, 2018. The change has allowed for expansion to 12 care coordinators as of 11.1.18 and is projected to reach 16 by March 2019. Between November 13th, 2017 and March 1st, 2019, FAST Forward has enrolled (168) new children, youth and their families. This data shows, across referrals, enrollments and successful transitions, 100 percent overall increases. In that same period FAST forward has successfully transitioned

(118) with a success rate of 50 percent rate or higher. Success rates are determined based upon the children, youth and family effectively meeting their family vision and team’s mission. (See figures below)

# of Referrals to FAST Forward *	# enrolled in FAST Forward	# Not enrolled in FAST Forward	# of Successful Transitions	Dominate Reasons not enrolled in FAST Forward	Dominate referral source
305	168	137	118	Family Did Not meet eligibility criteria	DCYF Assessment Workers, NH State Psychiatric Hospitals, Schools, Community Mental Health Centers
* Data from 12/1/17 to 3/1/2019- 14 months					

The FAST Forward program continues to support families that are court-involved through DCYF. Expanding effective services that utilize a system of care approach, that have positive outcomes are part of the RSA 135-F requirements. FAST Forward is showing positive family and child level outcomes by offering intensive home and community-based services to children/youth in a home environment, a wraparound practice approach using NH Wraparound curriculum, and flexible services and service delivery to meet the needs of the child/youth and their caregiver. Identification of populations within DCYF includes: CHINS cases to serve in home or return home after an out of home episode (particularly current D2 examples), pre-adoptive cases: at time of identification of and placement in a pre-adoptive home to strengthen the adoption or identify any issues that may be of concern, post-adoptive examples: For cases coming back for post adopt services. To help serve this population effectively, NFI has focused on training all FAST Forward Care Coordinators in

Outside of FAST Forward’s focus on expansion, both programmatically and through DCYF expansion, the Bureau for Children’s Behavioral Health continues to provide technical assistance on multiple systems of care projects across the state. These projects include the Monadnock Region System of Care Grant, FAST Forward 20/20 (Department of Education’s System of Care grant), Integrated Delivery Network 2 Enhanced Care Coordination project, and Center for Life Management’s NH Wraparound Children’s ACT program. Many of these systems of care programs have begun to turn their focus on sustainability and to work closely with BCBH and FAST Forward to discuss options.

Monadnock Region System of Care has closely aligned to that of FAST Forward and data below illustrates the numbers of families that they have been able to support.

# of Referrals to MR SOC*	# enrolled in MR SOC	# Not enrolled in MR SOC	# of Successful Transitions	Dominate Reasons not enrolled in MR SOC	Dominate referral source
79	31	38	N/A	Family Did Not meet eligibility criteria	CMHC, Schools
* As of 11.1.18					

Department of Education’s System of Care (FAST Forward 20/20) have also closely aligned to that of FAST Forward, with the use of the NH Wraparound model eligibility criteria, and several components of High Fidelity Wraparound. In this project, school district employees are trained to deliver the service. They work collaboratively with partners at DHHS, NAMI NH, UNH IOD, and the Center for Behavioral Health Innovation at Antioch University and peers from other school districts to ensure fidelity to the model and to address challenges as they arise. District-based Wrap Coordinators have been able to leverage additional services and support within the school system to address the needs of those families who do not qualify for Wraparound. Data below illustrates the numbers of families that they have been able to support.

# of Referrals to DOE SOC*	# enrolled in DOE SOC	# Not enrolled in DOE SOC	# of Successful Transitions	Dominate Reasons not enrolled in DOE SOC	Dominate referral source
170	63	63	N/A	Family Did Not meet eligibility criteria	Schools
* As of 11.1.18					

With the expansion of all projects, there has been an increase of NH Wraparound Coordinators from 14 at the start of 2018 to 31 at the end of 2018. Expansion has directly impacted outcomes for families by increasing the capacity to support over 800 family members Statewide, through all projects in 2018. Findings include an increase of ‘in classroom’ time, reduction in psychiatric hospitalizations, the decline for a need for a higher level of care, and sustainable plans for success.

With the expansion of FAST Forward and NH Wraparound, Family and Youth Peer Supports have made significant growth in Year 3. As a vital component to FAST Forward and NH Wraparound, peer supports have impacted the success and needs of the families that have been supported. Additionally, collaboration with the Office of Health Equity has made significant positive impacts on how FAST Forward and NH Wraparound values cultural competency.

Family Peer Support is available in any part of the State of New Hampshire. NAMI NH has increased its Family Peer Support Specialist staff from 2 in January of 2017 to 15 team members as of November 2018. NAMI NH has developed workforce development strategies that resulted in the hire of two former Wraparound family members to be Family Peer Support Specialists. Family Peer Support provided by NAMI NH is working with 148 total children and 503 family members as of 11/27/18. Family Peer Support is being covered through several payment models. The most extensive support comes through the 1915i amendment through DHHS. Other payment models include SOC of grants with Cheshire County and the DOE. Family Peer Support has also expanded to work with two Integrated Delivery Networks (IDN); one in the Capital Region and the other in Nashua's pilot project. The Capital Region IDN is working with MAT and PAT populations, and the Nashua IDN is working with young adults up to age 26.

NAMI NH has developed a Family Peer Support Specialist certification process with the assistance of DHHS, DOE, NFI, and UNH/IOD. This certification is good for two years and requires a minimum of 128 hours of long and direct training with families to become certified. There is currently 6 Family Peer Support Specialist that is approved in Family Peer Support in NH. NAMI NH has provided technical assistance to New Mexico and New Jersey around this certification. NAMI NH also produced a national presentation on Family Peer Support at the Federation for Families Conference in Houston Texas in October.

Throughout Year 3, Youth Move NH has provided youth peer supports as a service for young people between the ages of 13-26 meant to break down the power dynamic barrier that generally exists between professional practitioners and youth and young adults being supported by providing an authentic opportunity for the young people receiving peer support to feel validation and develop healthier peer relationships based on similar lived experiences. Youth Peer Support Specialists (YPSS) actively model that successful life outcomes are possible and share practical skills for navigating the healthcare system and developing wellness tools. YPSS work collaboratively as a part of the Wraparound team and consistently communicate with Care Coordinators and Family Peer Support Partners to check-in as needed, prepare for and debrief team meetings. Also, YPSS encourage youth to be engaged in the Wraparound process by supporting them to actively participate in team meetings and other supporting programs/services. YPSS coach, support and prepare the young people that they are encouraging to become more involved in their health and treatment decisions and provide emotional support throughout the process.

In December of 2017, Youth MOVE New Hampshire employed 1 Youth Peer Support Specialist. In January of 2018, Youth MOVE New Hampshire employed two more Youth Peer Support Specialists for a total of 3. In April of 2018, Youth MOVE New Hampshire employed three more Youth Peer Support Specialists for a total of 6. In October of 2018, Youth MOVE New Hampshire hired a Youth Peer Support Specialist to replace one of the previous Youth Peer Supporters who left the state to go to college, and at this time Youth MOVE New Hampshire currently employs five trained Youth Peer Support Specialists.

Cultural and Linguistic Competency

The Office of Health Equity (OHE) within New Hampshire's Department of Health and Human Services (DHHS) is responsible for assuring access for racial/ethnic, linguistic, sexual and gender minority populations and individuals with disabilities to all DHHS programs and services, and for working in partnership to address disparities and promote health equity statewide. OHE is housed in the Office of the Commissioner, emphasizing the cross-divisional importance of OHE priorities, policies and initiatives across the entire Department, and its critical supportive function to all divisions, programs, and services. The DHHS Cultural and Linguistic Competence (CLC) Coordinator is key staff in the Office of Health Equity.

During 2018, the CLC Coordinator worked closely with the CLC Coordinators from the Monadnock Region System of Care (MRSOC) and the New Hampshire Department of Education (DOE). She provided training, support, and guidance to these colleagues to ensure that cultural and linguistic competence is addressed throughout New Hampshire's children's behavioral health system. Together the DHHS CLC Coordinator and the MRSOC CLC Coordinator created training on Cultural and Linguistic Competence 101 and presented it to the region's governance board. This presentation was also provided during the SAMHSA site visit.

In partnership, the DHHS CLC Coordinator and the DOE CLC Coordinator created training for school districts on the National Standards for Culturally and Linguistically Appropriate Services, commonly referred to as the CLAS Standards. They worked together to provide technical assistance to school health teachers who were updating/revising their standards and learning objectives. They met with school district administrators and staff in districts where racial incidents occurred to provide technical assistance and training.

Cultural and linguistic competence is growing within the Department. In partnership with DHHS's Organization Development and Training Services (ODTS) unit, the CLC Coordinator created training on Communicating Across Difference that is now part of the DHHS Supervisors Training Series. They also collaborated to expand the current DHHS Diversity & Cultural Competence half-day workshop into a full-day seminar that includes emotional intelligence content. This full-day training will be provided to all new hires as part of orientation beginning in January 2019. The training is also available to and encouraged for all current employees, with one full-day Emotional Intelligence & Cultural Competence in the Workplace workshop offered each month.

To roll out this new training across DHHS, the CLC Coordinator needed to build workshop facilitation capacity within DHHS. She conducted five Trainings-of-Trainers this year which resulted in the addition of 52 new facilitators for the D&CC workshop throughout the state, including people both internal and external to DHHS. These new facilitators include:

- 15 NH DHHS staff (including three EAP staff members who provide services to all NH Departments)
- 4 NH Department of Education staff
- 3 Nashua, NH Police Department staff
- 1 Youth MOVE staff

- DCYF CORE Academy training coordinator
- Hospital staff
- Mental health center staff
- Social service agency staff
- School district staff
- Community members

The DHHS CLC Coordinator also mentored/provided an apprenticeship opportunity for three individuals to become Master Trainers for the Diversity and Cultural Competence Train the Trainer:

1. A Member of the DHHS Organization Development and Training Services (ODTS) unit
2. The NH City Public Health Director
3. A member of a Community Mental Health Center staff

The CLC Coordinator, along with the Director of the Office Health Equity, has provided presentations and technical assistance on Becoming a Culturally Effective Organization. Organizations/events that received information and support on the seven elements of culturally effective organizations include: the New Hampshire Public Health Association Team Up Take Action conference, New Hampshire Children’s Trust conference, National Association of Social Workers New Hampshire conference, Spark NH Equity Task Force, Women Infant Children (WIC) NH conference, the Citizen’s Health Initiative-led Behavioral Health Integration initiative in NH, the HRSA Behavioral Health Workforce Catch the Wave conference, and the half-day Culturally Effective Organizations Framework Learning Forum for Organization Decision-Makers.

The CLC Coordinator and OHE Director also continue to work with SAMHSA-funded programs both within and external to the Department to assure integration CLAS guidance and CLC strategies, such as the ProHealth initiative out of the Division of Behavioral Health which will incorporate Community Health Workers for outreach to vulnerable populations, and the Department of Safety-led NH First (First responders Initiating Recovery, Support, & Treatment) project.

The CLC Coordinator continues to facilitate the Behavioral Health Equity Workgroup (BHEWG), a joint effort of the New Hampshire Children’s Behavioral Health Collaborative (CBHC) and the New Hampshire Health and Equity Partnership (H&EP). The BHEWG provides a forum for members to learn how to operationalize Cultural and Linguistic Competence in their respective organizations and works collaboratively in addressing behavioral health disparities by:

1. Providing a forum for learning and safe discussion
2. Improving equity in access to and use of meaningful behavioral health services
3. Promoting cultural and linguistic competence / culturally and linguistically best practices / responsive services

4. Supporting the improvement of systems, organizations, and individuals to work effectively to serve diverse populations

Cultural and linguistic competence remains a core value of the children's behavioral health system of care. Current efforts around strategic planning and organizational structure include efforts to assure CLC is operationalized fully.

DCYF: Adequacy assessment- improving the children's behavioral health system for all kids

In early 2018, the New Hampshire Department of Health and Human Services (DHHS), Division for Children Youth and Families (DCYF) contracted with Public Consulting Group, Inc. (PCG), the Alliance for Strong Families and Communities (Alliance), and the American Public Human Services Association (APHSA) to conduct an adequacy and enhancement assessment of New Hampshire's child welfare system.

The project team analyzed a variety of data sets and reports and sought input from a broad range of stakeholders to understand both the strengths and gaps in the current child welfare and juvenile justice system.

Key findings from the assessment included the following:

- Between 2014 and 2017, there was a 121% percent increase in foster care placements in New Hampshire.
- Between 2014 and 2017, there was a 166% increase in the percent of children removed with allegations of substance abuse, drug abuse, or poisoning/noxious gases. New Hampshire has the second highest rate of opioid overdose deaths per capita¹. Substance use disorder services have not kept pace with the increased need for services, which was noted as a significant gap in the service array.
- There is a lack of accessible and comprehensive mental health services for children, youth, and their families.
- DCYF is serving youth who would be more appropriately served in other systems, including children and youth with a significant intellectual disability, mental health, or special healthcare conditions.

DHHS envisions a system where children, youth, and their families are connected to services and supports that meet their unique needs, no matter the door through which they first seek assistance.

DHHS aims to develop a system that:

- provides more preventive, integrated, accessible, and useful services and supports for children, youth and their families in the community;
- mitigates the risk of abuse and neglect and juvenile delinquency, diverting children, youth, and families from DCYF intervention, and out of home placement, keeping families together, relieving stress on DCYF, and producing a better return on investment²;

¹ "How a Perfect Storm in New Hampshire has Fueled an Opioid Crisis", New York Times, January 21, 2018 retrieved from: <https://www.nytimes.com/2018/01/21/us/new-hampshire-opioids-epidemic.html>

² For example, Wraparound Milwaukee reduced the total child population use of psychiatric hospitalization from an average of 5,000 to less than 500 days annually and reduced its average daily residential treatment facility population from 375 to 100 youth and lengths of stay from over one year to under 120 days.

- Aligns to the provisions of the Family First Prevention Services Act (Family First)³ to improve the quality and effectiveness of services to children, youth, and families and to leverage federal funds to support the service system.

Planning for Change:

Residential Treatment: Residential treatment in New Hampshire has historically been available only through DCYF and school districts. The system itself has focused on the concept of placement and education with a lower level of care for the treatment aspect of this service. By aligning the delivery with the Families First Prevention Services Act (FFPSA <https://www.acf.hhs.gov/sites/default/files/cb/pi1807.pdf>) FFPSA guidance, residential treatment in New Hampshire can be transitioned to a model of effective shorter-term treatment and stabilization in the system of care that is available to all children and youth who require that level of care without engaging with DCYF. This can help children and youth avoid or decrease the use of psychiatric hospitals or emergency rooms. More children may be diverted from entering the DCYF system altogether by having this quality service available to them and their families when and where it's needed based on the unique needs of the child, youth and their family. Working with the current providers and through procurement processes, New Hampshire will align residential treatment with the quality standards outlined in FFPSA and have moved this critical part of the continuum of care for children's behavioral health to the Bureau for Children's Behavioral Health for oversight, development, and management.

Mobile Crisis and Stabilization Teams for Children: Mobile crisis and stabilization is a nationally recognized approach to help keep children and youth with behavioral health needs from leaving their home, community, and, school and decreases psychiatric hospitalization as well as residential treatment. In addition to assisting children, youth and their families with managing and stabilizing the crisis, a mobile crisis can work with children placed in foster care to help preserve the foster care placement in times of crisis, avoiding placement disruption. Mobile crisis and stabilization also provide parents and foster parents with opportunities for skill building.

Enhancing the current adult mobile crisis teams to ensure child and youth-based tools and approaches are the timeliest and efficient way of standing-up mobile crisis for children. The development and implementation of Mobile Crisis and Stabilization Teams for children will also create efficiencies within the DCYF community-based service array by lifting the requirement of those community-based services providers to have a 24/7 crisis phone response within each of their operations.

Expansion of the Care Management Entity Model – FAST Forward Program: High fidelity wraparound and intensive home-based services is a nationally recognized approach to best-serving children, youth and young adults in their own home, community and schools and helping to avoid out of home placements, psychiatric hospitalizations and improve placement stability within foster care. This model was implemented in New Hampshire in 2014 and is called the FAST

³ Family First is landmark legislation that expands Title IV-E reimbursement to certain preventive services and adds new requirements around claiming for residential placements, including certain program requirements and the completion and documentation of an assessment stating the need for residential placement. Changes to residential requirements take effect October 1, 2019, however, states may delay implementation for up to two years.

Forward program. Expanding the capacity of FAST Forward will assist DCYF in moving children and youth to less restrictive placements, and to facilitate in moving kids to permanency, either reunification to home or another permanent option such as adoption. The FAST Forward program is currently expanding capacity, and the Bureau for Children's Behavioral health is already working with DCYF on strategies transition children in residential settings to move to less restrictive placements through the FAST Forward program.



Creating Connections NH: A Treatment and Recovery System of Care for Youth and Young Adults with Substance Use Disorders (SUD), or SUD with Co-occurring Mental Health Disorders

The *Creating Connections – NH* initiative is funded through a Cooperative Agreement between the New Hampshire Department of Health and Human Services (NHDHHS, Bureau for Children’s Behavioral Health (BCBH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Adolescent and Transitional Aged Youth Treatment Implementation (YT-I) grant program. In accordance with the requirements of the grant, awarded in 2017, the Department is strengthening their statewide substance use disorder (SUD) treatment infrastructure and increasing access to evidence-based assessments, treatment models, and recovery services for youth ages 12-25 with substance use and/or co-occurring substance use and mental health disorders (SUD/COD) throughout the state. The goals of the project are to support at least 400 youth, including a focus on young people from underserved populations (such as youth of color or youth who identify as LGBTQ+. Using the System of Care framework, the project will focus on including child, family and community voice in all phases of implementation, using evidence-based and best practices such as Screening, Brief Intervention and Referral to Treatment (SBIRT), CANS (Child and Adolescent Needs Assessment), Medication Assisted Treatment, The Seven Challenges, and NH’s Wraparound model.

The NH Bureau for Children’s Behavioral Health leads the project in collaboration with family, youth, research, and content experts. There will be a minimum of four pilot sites chosen to provide a continuum of evidence-based treatment and recovery services to youth and young adults, serving as exemplars for future statewide scale up. The Creating Connections NH Interagency Advisory Council oversees the development and guides implementation of the project’s continuum of care and includes state policymakers and staff, youth, family, providers, university, and research representatives. A Workforce Management Team develops the training and technical assistance support for the pilot sites. The project’s Policy Committee identifies barriers to effective implementation and drafts regulatory and legislative proposals to address those barriers. There is a strong emphasis on building a sustainable system and breaking down service silos by building capacity across public and private provider systems, including strong family and youth peer supports, and using data to continuously improve the system for some of our most vulnerable youth and young adults.

The Interagency Council continues to have representation from youth and families with lived experience; including representation from Youth M.O.V.E NH, NFI North, NAMI NH and Choices (a youth SUD services group program that offers services for various levels of care). The Workforce contractor will conduct both family and youth focus groups throughout the state with the intention of gaining a youth perspective on what is needed to improve substance abuse treatment throughout the state. Additionally, a dedicated subcommittee has been convened to review existing

youth peer-to-peer support/recovery and family/caregiver support resources, identify gaps, and make recommendations for enhancements. Family and youth involvement has been present for each stage of program development. There are members with a lived experience that sit on the IAC and will be auditing the training for The Seven Challenges.

The workforce contract was approved by the Governor and Executive Council in May 2018 and was awarded to the University of New Hampshire, Institute on Disability in June 2018. In June 2018, the Governor and Executive Council approved and NHDHHS awarded the evaluation contract to The Human Services Research Institute (HSRI). HSRI will evaluate the implementation of the Creating Connections NH program.

Currently, the treatment provider Request for Proposal has been published, and proposals are due November 27, 2018. Once contracts are approved by the Governor and Executive Council, treatment providers will begin serving clients in early 2019.

Progress Update: DOE

NH's Department of Education (DOE) continues to champion the adoption and expansion of the system of care core values of:

1. Family driven and Youth-Driven, with the strengths and needs of the child and family determining the types and mix of services and supports provided
2. Community-based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports

The following are vital updates related to progress made by DOE during Year 3.

Statewide Early Childhood and School Safety Collaboration

The NH Department of Education closely collaborated with DHHS and other state agencies to continue to develop a comprehensive system of care for children's behavioral health. In Year 3 NH DHHS, NH DOE and The University of NH secured a 3.8 million dollar Preschool Development Grant - Birth Through Five through the U.S. Department of Health and Human Services federal grant to enable statewide alignment of the early childhood care and education (ECCE) system to better serve children in the Granite State. Through collaborations with early childhood stakeholders, providers, and families, the state will conduct a comprehensive assessment of the needs and strengths of its current approach to supporting young children and their families. The assessment will be used to generate a strategic plan that will guide the creation of a more effective and assessable ECCE system. This work will also extend the current and increased collaboration between the NH DOE and NH DHHS, under the guidance of NH DOE Deputy Commissioner Christine Brennan and NH DHHS Associate Commissioner Christine Tappan.

NH DOE representatives participated in the NH School Safety Task Force established by Governor Christopher Sununu in Year 3. The Task Force was charged with developing actionable recommendations to make NH Schools the Safest in the Nation and was comprised of members and work groups with representatives from NH Department of Education, NH Department of Health and Human Services, NH Department of Safety, NAMI-NH, Dartmouth Hitchcock, as well as local police, fire, school districts parents, students and other local leaders. The Task Force worked collaboratively to review pertinent laws and regulations, seek and evaluate public comment, research and discuss the most pressing issues involving school safety and security, conduct a comprehensive review of state, local, federal and private research. The collaborative work resulted in 59 recommendations to assist the Governor in prioritizing safety preparedness initiatives. The recommendations were organized in 7 topic areas that include legislation, mental health, planning, training, exercises, communication, and facilities which are meant to empower school staff and students by creating a culture that promotes and supports mental health and preparedness to respond to a threat or act of violence.

Office of Social & Emotional Wellness

The Office of Social & Emotional Wellness (OSEW), which is part of the Bureau of Student Wellness, Division of Learner Support, leads the efforts of the NH Department of Education as they relate to the creation of NH's system of care. Created in 2015, this office allows for the consolidation of policy development and the implementation of projects and programs that are focused on health and wellness-with an emphasis on behavioral health of all students, youth, and families. The NH DOE has been nationally recognized by SAMHSA and the Center for School Mental Health for innovative and effective implementation of these school-based grants, including embedding cultural and linguistic competency as a core principle in public schools, fostering collaboration between mental health providers and schools, and using innovative technologies to advance education dissemination including the creation of a mobile app and several web-based professional communities.

During year 3, in conjunction with a more substantial re-organization within the DOE, the OSEW redesigned its staff to better respond to the needs of local school districts and communities. Currently, the team includes:

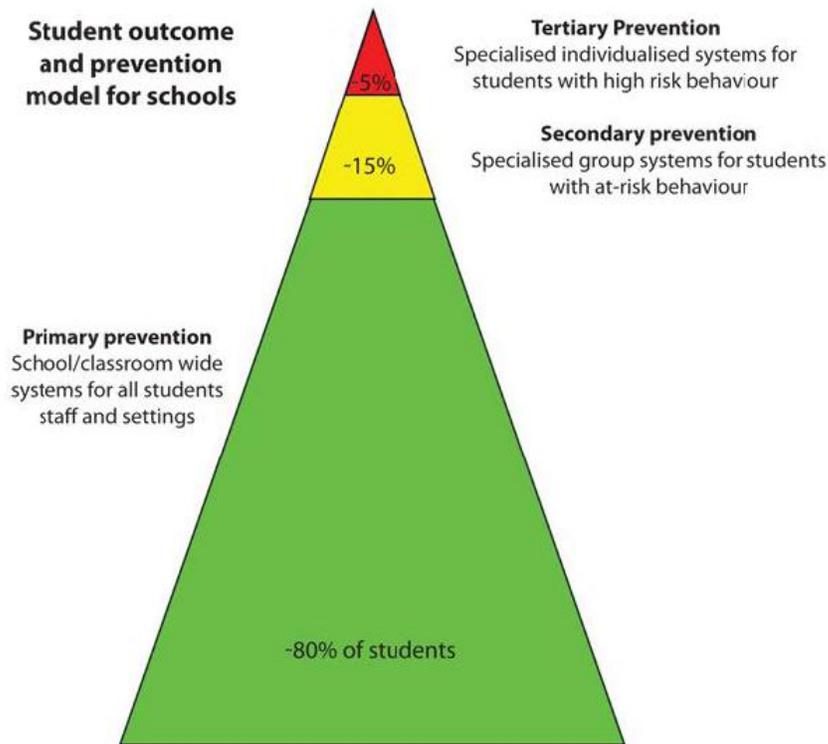
- Administrator
- MTSS-B Consultant
- Prevention Coordinator
- Training and Technical Assistance Coordinator

In addition to responding to specific requests for support, the OSEW lead the following grant initiatives: Safe Schools/Healthy Students, Project AWARE, System of Care Sustainability and Expansion, and Project GROW.

Multi-Tiered System of Support for Behavioral Health and Wellness (MTSS-B)

New Hampshire's Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) is a "way of doing business" that puts into place proven school- and community-based behavioral health practices so that every student can achieve health and wellness and be successful in school. MTSS-B employs a systemic, continuous- improvement framework integrating school behavioral health practices across all levels of the educational system for supporting every student.

School behavioral health practices (including mental health and substance misuse prevention and intervention) refer to a continuum of supports for school-age children (age 3-21) that are integrated throughout the school community: universal strategies to promote the social and emotional well-being and development of all students; targeted strategies for students who need additional supports; intensive, individualized support strategies for students with significant needs, including a streamlined referral process with community behavioral health providers to create a seamless services delivery model for children, adolescents, and their families:



NH’s MTSS-B model integrates research-based behavioral health practices with Positive Behavioral Interventions and Supports. The essential components are:

- Shared Leadership
- Data-based Problem Solving and Decision Making
- Layered Continuum of Supports for ALL students
- Evidence-Based Behavioral Health Instruction, Intervention, and Assessment Practices
- Universal Screening and Progress monitoring
- Family, School, and Community Partnering

Created with the support of the US Department of Education, Positive Behavioral Interventions and Supports or PBIS is an implementation framework for maximizing the selection and use of evidence-based prevention and intervention practices along with a multi-tiered continuum that supports the academic, social, emotional, and behavioral competence of all students.

The benefits of blending behavioral health practices into a multi-tiered school-based PBIS model include:

- A shared vision is established between school and community staff, families, and youth.
- Active, collaborative relationships are created between early learning, school, and community staff and families and youth based on team-based decision-making.
- Improved academic engagement and success.

- Improved effectiveness of the behavioral health interventions provided to students.
- Increased efficiency (staff time, financial resources, better utilization of programs and services).
- Common indicators and measures of success are established and shared among early learning, school, and community staff, families, and youth.
- Early learning, school, and community providers use common assessments to identify student need.
- Early learning, school, and community providers work together to choose and deliver evidence-based interventions that are matched to student need.

New Hampshire’s MTSS-B framework is a guide for organizing school- and early learning-based interventions and practices to improve the social and emotional health and wellness of all children and youth and to support families. The 3-tiered continuum of supports represents a system to deliver:

- Universal (tier1) interventions for all students
- Targeted (tier 2) interventions for children and youth with identified risk, and
- Intensive (tier 3) and individualized interventions or treatment for the highest need for children and youth and their families.

School and community behavioral health providers work together to identify, deliver and assess the effectiveness of research-based practices at each tier.

During year three, the expansion of the use of MTSS-B continued with the identification of the model as a best practice within NH’s Consolidated State Plan for the Every Student Succeeds Act, the report on the recommendations of the Governor’s School Safety Taskforce, and within DHHS’ 10 Year Mental Health Plan.

Safe Schools/Healthy Students

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a Safe Schools Healthy Students (SS/HS) grant to the New Hampshire Department of Education’s (NHDOE) Bureau of Student Wellness – Office of Social and Emotional Wellness (BSW-OSEW), with the involvement of three Local Education Agencies (LEAs): Concord, Laconia, and Rochester School Districts. The three LEAs encompass 23

SS/HS serves over 11,000 kids per year

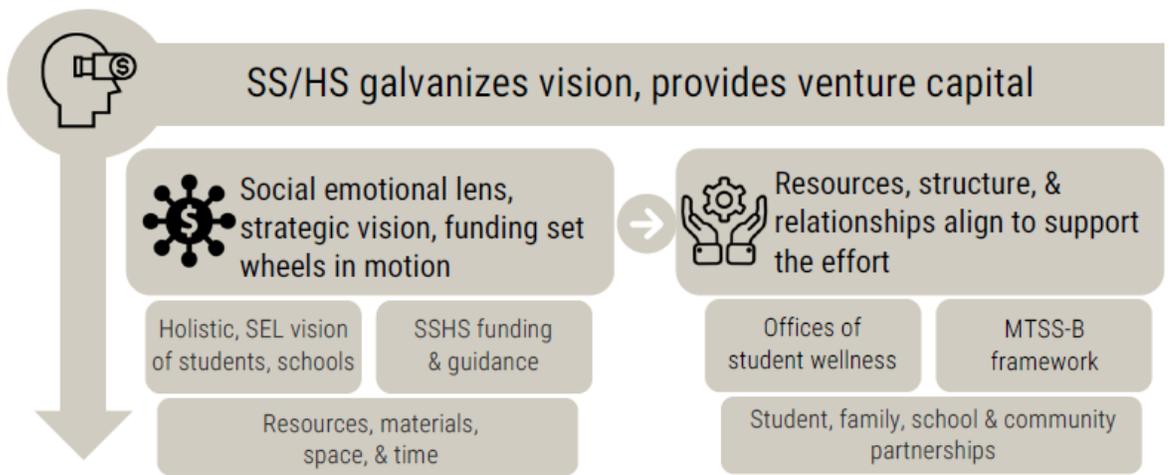
	'14-15	'15-16	'16-17	'17-18
Concord	4,737	4,674	4,624	4,546
Laconia	2,065	1,991	1,985	1,945
Rochester	4,381	4,355	4,251	4,224
Total	11,181	11,020	10,860	10,715

participating schools. The grant was designed to improve school climate and safety while promoting the emotional wellbeing of students by enhancing behavioral health access and supports in the school and community. The project identified objectives in each of the five Element areas as described in the SS/HS framework. NH SS/HS just completed its fifth and final, no-cost extension year, which focused

on enhancing implementation of objectives that began in 2014-15, after an initial planning year.

After the SS/HS project, external evaluators at the Center for Behavioral Health Innovation (BHI) at Antioch University New England issued a qualitative evaluation report to capture the impact of the project not just in the participating districts, but to NH’s system of care as a whole. The method used by BHI to capture this data is called Ripple Effect Mapping (REM). REM brings stakeholders together to map the intended and unintended outcomes of a program or project. In 2018, four REM sessions were conducted, one at the state and the others at the district level. During these sessions, key SS/HS stakeholders discussed the most essential SS/HS “ripples.” A ripple involves a change, its contributing factors, and its impacts or consequences. Three significant, intersecting ripples emerged, as depicted in the figure on the next page: 1) SS/HS galvanized social-emotional learning (SEL) paradigm shift in schools and provided venture capital to convert vision into action, 2) external facilitation and expertise helped transform school practice, and 3) changes in school practice improved the school, community, and student outcomes.

- NH SS/HS ripple effects**
1. Galvanized SEL vision, venture capital
 2. Shifted school practice
 3. Improved school, community, student outcomes



According to stakeholders, an SEL paradigm shift – already underway before funding – was the bedrock of SS/HS success. The SS/HS funding and framework served to consolidate, reinforce, and resource this more holistic, SEL-infused perspective. Funding also facilitated buy-in from state and district administrators who had not yet adopted the SEL mindset. SS/HS transformation was deepest and broadest where the SEL perspective was strongest before SS/HS funding – in those districts that were most “ready” for SS/HS.

SS/HS funding also resourced the shift from SEL awareness to action. Most tangibly, this resulted in the creation and staffing of the NHDOE’s Office of Social and Emotional Wellness (OSEW) to promote optimal social, emotional, and educational outcomes for children across the state. The OSEW directed the SS/HS project; more importantly, it embedded social-emotional wellness within the mission of the NHDOE, creating opportunities to leverage additional

resources for the SEL cause. At the same time, the OSEW intentionally developed a new way of relating to school districts, centered on guidance and support rather than compliance and control.

The OSEW structure was ultimately replicated at the district level. SS/HS funds were used to hire project managers at each district (Project Manager; PM). PMs, in turn, spearheaded SS/HS efforts in their respective communities and schools, to optimize the SEL of their students. The importance of these new student wellness structures at the state and district levels, along with the strategic hiring of project managers to champion the cause while leading SS/HS forward, cannot be overstated. SS/HS was most successful in those districts in which PMs were considered high-level administrators and given positions on the district-wide administrative team, with considerable decision-making latitude.

The OSEW and PMs used the SS/HS framework, gap analysis approach, goals, and performance measures to structure and strategically target the application of an SEL perspective around five elements: Early Childhood, Mental Health, Family Engagement, Prevention, and School Safety. A collective pursuit of goals structured around these elements created a sense of shared purpose, language, and understanding across SS/HS stakeholders.

The SS/HS framework also served as a springboard for the development of NH’s Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model. Spearheaded by the NHDOE’s OSEW, with assistance from PMs, external coaches, and other stakeholders, the 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

Laconia brings strategic SEL vision together with SS/ HS funding to create the first district office of student wellness, blends and braids funding to transform school practice, culture, and outcomes highest-need students (Tier 3). OSEW serves as the primary driver of the MTSS-B model and provides oversight, guidance, and support to NH districts across the state through the MTSS-B Toolkit, which was developed with the backing from SS/HS and continues to be refined.

The MTSS-B model, and most of SS/HS’s success would not have possible without the aligned

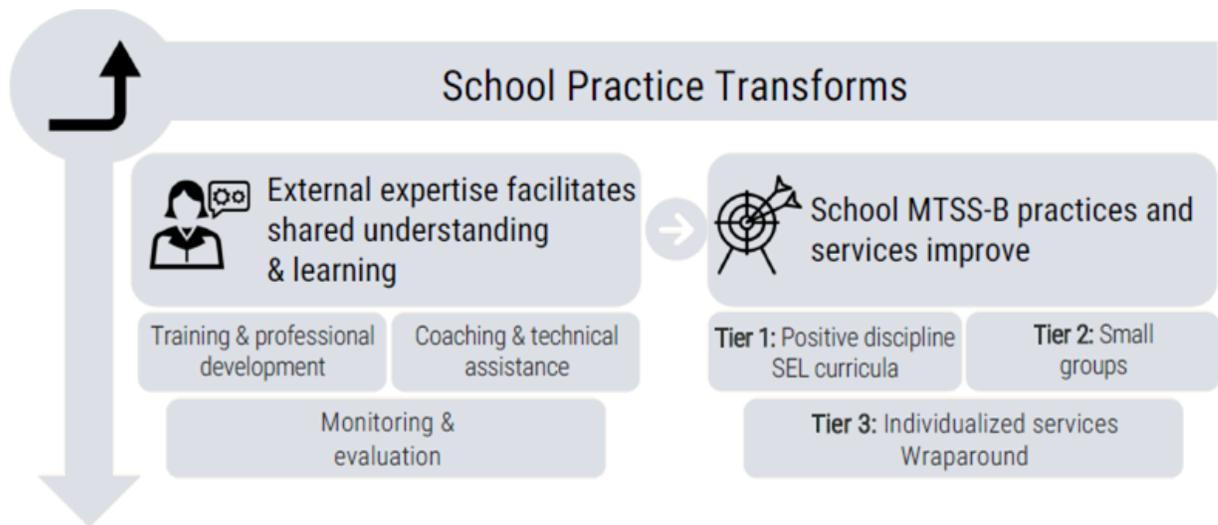
“It’s an understanding that until we get to behavior, we can’t move forward.”

been

efforts of stakeholders across NH. At the state level, the OSEW created the State Management Team (SMT), consisting of high-level leaders from across the state, to stay informed about SS/HS (and soon, another grant- and NHDOE-funded projects) and lead policy reform efforts in the state. A subset of this group – consisting of MTSS-B coaches from the University of New Hampshire’s Institute on Disability (IOD) and the Southeastern Regional

Education Service Center (SERESC), OSEW staff, PMs, and others – was central to the creation, implementation, and dissemination of the MTSS-B framework.

In another parallel, district-level Community Management Teams (CMT) were formed by PMs. These CMTs brought together school district leaders and staff with community organizations and individuals with a stake in student SEL and behavioral health. It was through the CMTs that the community was made aware of SS/HS and other SEL-related efforts, new alliances were formed, and better integration and utilization of community and school resources came about. Offshoots of CMTs included new and better SEL programming, interagency agreements such as MOUs, enhanced community, and family engagement, and better school community mental health integration.



Time and again, stakeholders – especially school personnel – emphasized the centrality of SEL-related professional development (PD) offerings in SS/HS’s success. They felt that the PD offered through SS/ HS was better matched to their learning needs than in the past. The most prominently mentioned PD topics were trauma-responsive schools, mindfulness, and responsive classrooms. In some circumstances, school staff was co-trained alongside their mental health peers/counterparts, which built rapport and common language, strengthening school-community mental health integration.

The support and guidance from the OSEW, especially the development of the MTSS-B Toolkit, was helpful to many SS/HS stakeholders. Another key to high fidelity implementation of MTSS-B was external coaching by external experts from the IOD and SERESC. External coaching supported a strategic, systematic approach to MTSS-B implementation by school teams. External coaching also helped develop the internal expertise for schools to sustain MTSS-B efforts beyond the period of grant funding.

Higher availability and use of data also contributed to SS/HS success. School-Wide Information System (SWIS) data helped MTSS-B teams strategically target behavioral “hotspots” in their schools (e.g., on the playground, between

classes, in particular classrooms, etc.), thereby maximizing their return on investment. Performance measures, targets, and evaluation tools helped structure and systematize the MTSS-B approach while keeping the end goal in mind. Dashboards and charts showing the process and outcome data reinforced the most productive methods, informed planning, and motivated quality improvement. Professional development, coaching, and evaluation, in turn, drove implementation of MTSS-B and other changes in school practice, measured annually by the Tiered Fidelity Inventory (TFI) and other indicators.

Most schools got started with MTSS-B implementation by (re)establishing a Tier 1 team to develop and implement school-wide positive behavioral expectations and disciplinary practices. SS/HS funding allowed districts to purchase materials to build awareness and reinforce positive/ expected behavior. Other universal Tier 1 practices included trauma-responsive and mindfulness-based approaches, responsive classrooms, mentorship programs, and family engagement and outreach. Most schools approached or exceeded the Tier 1 fidelity threshold by the end of the project.

Creation of Tier 2 programming for students who need additional support or skills to adhere to positive behavioral expectations, but don't require individualized services, was another major accomplishment of SS/HS. How schools got their Tier 2 (and 3) teams and practices going varied. For some, it was a significant focus from the start. Most, however, focused on Tier 2 implementation in years 3 and 4, after firmly establishing Tier 1 (see figure below). Mostly, Tier 2 services consisted of small-group, SEL skills-based interventions run by school staff (social workers, psychologists, counselors), but sometimes they were facilitated or co-facilitated by community-based behavioral health specialists. Tier 2 supports not only became more available but also better matched to student needs as a result of SS/HS.

School-based mental health facilitated referrals to community mental health care, and Wraparound care coordination highlight the individualized Tier 3 interventions implemented by schools. Whereas Laconia emphasized school-based mental health delivered by district-hired social workers, Concord focused on facilitating referrals to community mental health providers. Laconia began implementing Wraparound care coordination as part of another grant in 2017. Some SS/HS schools also implemented RENEW, a form of Wraparound for transition-aged youth. Despite considerable growth, room for Tier 3 improvement remains at most SS/HS schools. MTSS-B takes significant time and effort to implement fully.



Time and again, stakeholders pointed to improved school climate and culture as one of the most significant impacts of SS/HS. Clear behavioral expectations and positive disciplinary practices created a sense of predictability and order, instilling more proactive ways of encouraging and reinforcing pro-social student behavior. As professional development and MTSS-B implementation took off, staff came to feel more understanding and compassionate about the backgrounds and dynamics influencing student behavior, strengthening student-staff relationships. With staff knowledge, confidence, and access to behavioral health expertise on the rise, job satisfaction and burnout decreased. Reductions in office discipline referrals allowed administrators to spend more of their time on other priorities, such as supporting staff and effectively managing buildings and budgets.

As schools implemented MTSS-B, transforming their SEL practice, student problem behaviors decreased, increasing their time spent in the classroom. That, along with the aforementioned improved climate and culture, improved the overall academic environment. Though we don't have quantitative measures of these outcomes, stakeholders reported that as a result of the improved educational environment and access to behavioral health supports, student academic, SEL, and overall well-being also improved.

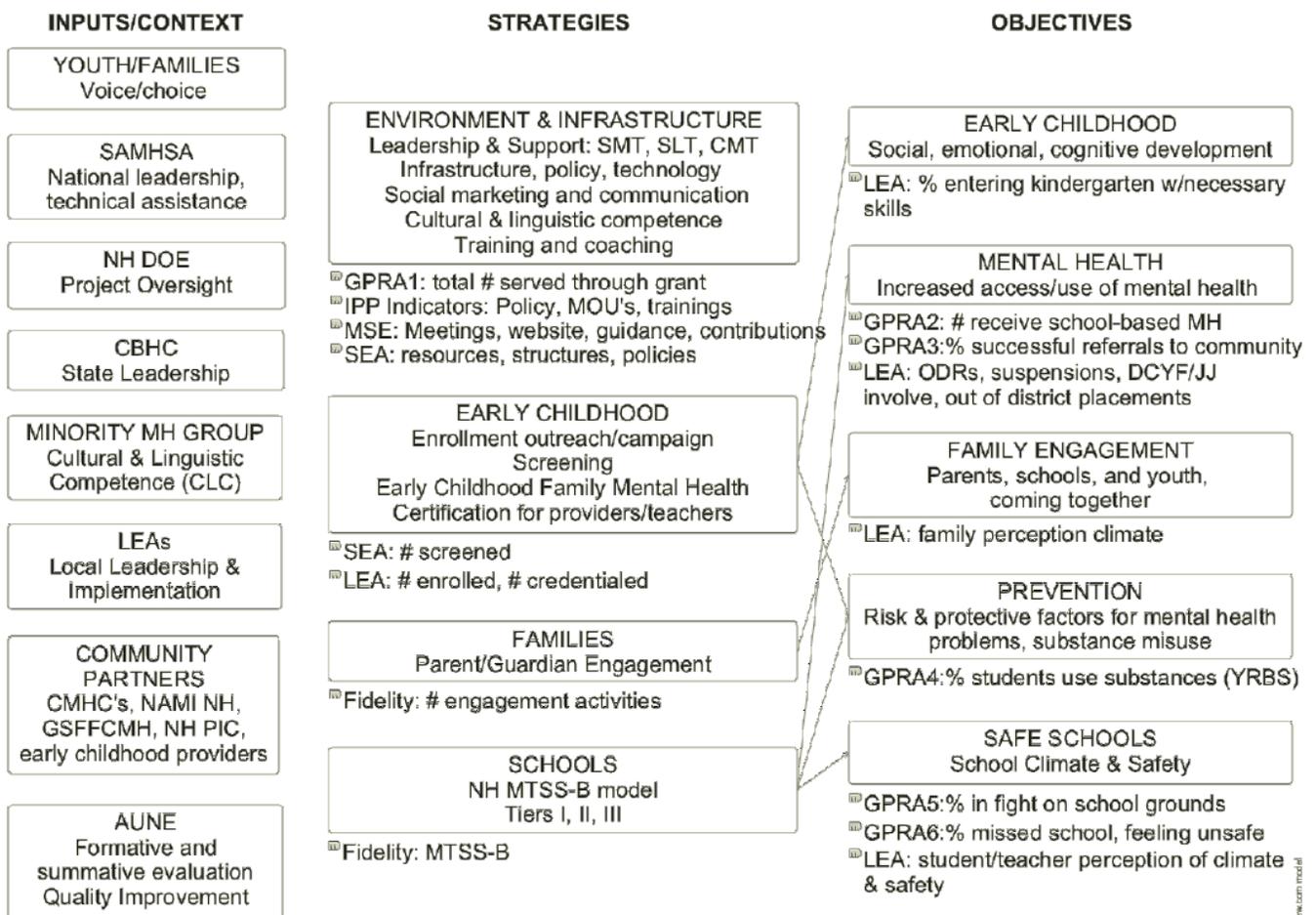
Another outcome of SS/HS has been more SEL supportive community and state environments. Stakeholders believe that SS/HS, by bringing together schools and districts via CMTs and other collaborations, improved community awareness and support for SEL and behavioral health supports and services for students. Through the work of the SMT, state government (NHDOE & Department of Health and Human Services [DHHS]), and other youth mental health advocacy organizations (Children's Behavioral Health Collaborative), the state policy environment was improved with passage of the "System of Care" bill, requiring NHDOE and DHHS to work together to create a system of care for youth with behavioral health needs in NH.

Project AWARE

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a Project

AWARE (AWARE) grant to the New Hampshire Department of Education (NHDOE), with the involvement of three Local Education Agencies (LEAs): Berlin School District, Franklin School District, and School Administrative Unit 7 (Colebrook, Pittsburg, and Stewartstown Public Schools). Together, the three LEAs contain 12 participating schools. The 5-year grant is designed to improve school climate and safety while promoting the emotional wellbeing of students by enhancing access to behavioral health supports in the school and community. NH AWARE identifies objectives in six goal areas. NH AWARE just completed its fourth year, which focused on enhancing implementation of objectives that began in 2015-16, after an initial planning year.

The figure below represents the NH AWARE theory of change. AWARE objectives are organized within five goals: 1) Promoting Early Childhood Social and Emotional Learning and Development (Early Childhood); 2) Promoting Mental, Emotional, and Behavioral Health (Mental Health); 3) Connecting Families, Schools, and Communities (Family Engagement); 4) Building Protective Factors and Reducing Risk Factors (Risk & Protective Factors), and 5) Creating Safe and Violence-Free Schools (School Climate). These objectives are achieved through a) developing a supportive environment/infrastructure; b) encouraging enrollment, screening, and positive behavioral practices in early childhood settings; c) enhancing family- and community-school engagement; and d) implementing the NH Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model.



The Early Childhood strategy is to enhance enrollment, social-emotional skills screening and referrals, certification of educators, and implementation of MTSS-B in district-run and community-based preschool settings. Key NH AWARE activities in this area include assessment and expansion of early childhood program capacity and implementation of universal social-emotional screening for children entering kindergarten. Professional development in early childhood education continued in 2017-18, though environmental scans were interrupted this year in at least one LEA, somewhat limiting the available data. Early childhood enrollment has remained relatively flat over time, though given the small rural areas of these LEAs, it is possible that preschool programs have sufficiently met the area needs; this needs more investigation.

LEAs have enhanced access to mental health by integrating behavioral health professionals in schools, adding district-employed counselors, and working closely with community mental health partners. Likely due to improved tracking systems implemented in LEAs in the past year facilitated referral success has increased in two LEAs. Though more variable, school-based mental health services remain above target and reflect continued efforts to enhance internal school-based mental health capacity. These more internal (school-based mental health services) and external (facilitated referrals to CMHCs) strategies are ultimately complementary and target students with differing levels of need.

Impacts in the area of family engagement have held relatively steady since last project year. LEAs have continued to reach out to families a great deal. In particular, LEAs have invested significantly in individualized outreach to families of at-risk students – with sharp increases in two LEAs this year in this area. These efforts appear to be paying off – families continue to rate their involvement in school positively. We believe that family engagement efforts would be even more effective – and more cohesive and efficient – if guided by an evidence-informed model or framework. Such a model would also help us develop more meaningful family engagement process (e.g., fidelity) and outcome measures. BSW-OSEW has recently adopted the Dual Capacity-Building Framework family engagement model, a set of research-based guidelines for developing active family engagement and home-school partnership strategies and practices. At the time of this report, we are in the final development phase of a fidelity tool based on this model, designed to measure both process and outcome indicators of family engagement practices in schools. Once finalized, we recommend that BSW-OSEW introduce the tool for use by NH AWARE LEAs in their sustainability efforts and disseminate it more broadly to other NH school districts implementing the model.

In support of student resiliency, the SEA has continued collaborative prevention efforts with Regional Public Health Networks and some LEAs are mirroring these efforts locally (e.g., Berlin’s grant-funded community coalition). All LEAs continue to invest in Positive Youth Development strategies to combat risk behaviors and build protective factors, among other individualized prevention activities. In previous years, trend data on risky behaviors was mixed – rising in two LEAs and falling in one – though two remained below the NH state trend, a promising finding given the underserved nature of these communities.

MTSS-B, especially universal Tier 1 strategies, are the primary NH AWARE means for creating safer and less violent schools. In addition to broad-based behavioral expectations reform and awareness building in the schools, noteworthy to date is the implementation of universal strategies such as a mindfulness program for all students. The School Climate Survey generally revealed positive perceptions of school climate, although students were consistently less positive about peer relations and disruptive behavior in the classroom – and we were not able to collect student-level school climate data in 2017-18 due to new state legislation limiting the use of non-academic student surveys in NH schools.

System of Care Sustainability and Expansion

In 2016, the New Hampshire (NH) Department of Education was awarded a four year, \$12 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The project, called NH Families and Systems Together (FAST) Forward for Children and Youth 2020, supports the expansion and sustainability of a state-level system of care (SOC) for children, youth, and their families.

NH FAST Forward 2020 is administered through the Office of Social & Emotional Wellness in partnership with the following school districts: Franklin, Winnisquam Regional, Laconia, Berlin, White Mountains Regional, SAU 7, and Claremont. Efforts are focused on several critical areas including early childhood social and emotional learning and development, prevention, safety, and support for mental, emotional, and Behavioral Health. The goals of FAST Forward 2020 include the following:

1. Create Regional Systems of Care collaborative teams in 3 regions of the state: the North Country, the Lakes Region, and the Claremont area.
2. Provide individualized Wraparound planning and an expanded array of services to the highest need for children and youth with mental health challenges.
3. Involve families and youth in all aspects of service delivery and support.
4. Improve the transition from pre-school to kindergarten and 1st grade for young children.
5. Improve the educational and social/emotional outcomes for children and youth.
6. Ensure that systems, supports, and policies are aligned with National CLAS standards.

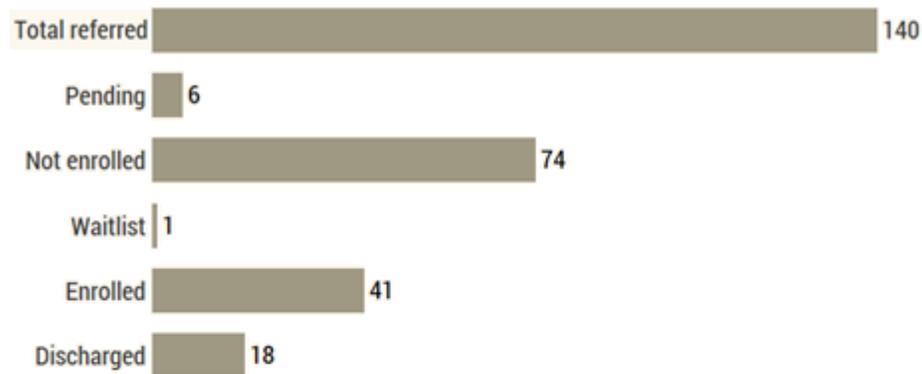
During year 3, progress has continued in building cross-agency collaboration among partners and in the building of systems. All work has been conducted through the lens of sustainability.

Monthly Implementation Team Meetings have been conducted bringing together LEA Project Managers, NH DOE staff, state-level partners, and our Evaluation Team from Antioch University New England's Center for Behavioral Health Innovation. These meetings have helped the team to identify areas for improvement as well as to discuss best practice and the implementation of Wraparound Services in the NH System of Care.

Great strides have been achieved in the development of a Multi-Tiered System of Support for Behavioral Health and Wellness in participating LEA districts with Wraparound Services incorporated into Tier 3 teams. Community Management Teams have been built in each LEA community with strong partnerships supporting the full System of Care implementation.

On a dashboard level, results from the System of Care work within school districts have shown promising results. Below is a snapshot of what school districts are experiencing from implementation of NH Wraparound and MTSS-B.

NH System of Care enrollment as of 12/19/18



	Total referred	Pending	Not enrolled	Waitlist	Enrolled	Discharged
Berlin	15	1	7		6	1
Claremont	33	2	19		9	3
Franklin	20	1	9		8	2
Laconia	10		4		5	1
SAU 7	16		7		5	4
White Mountains	16		7		5	4
Winnisquam	30	2	21	1	3	3

Child and Family Services/Supports take many forms within NH’s FAST Forward 2020 project. Participating LEAs have agreed to develop and implement a Multi-Tiered System of Supports for Behavioral Health and Wellness. New Hampshire’s Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) is a “way of doing business” that puts into place proven school- and community-based behavioral health practices so that every student can achieve health and wellness and be successful in school. MTSS-B employs a systemic, continuous- improvement framework integrating school behavioral health practices across all levels of the educational system for supporting every student. As a result of MTSS-B, LEAs develop a continuum of supports for school-age children (age 3-21) that

are integrated throughout the school community: universal strategies to promote the social and emotional well-being and development of all students; targeted strategies for students who need additional supports; intensive, individualized support strategies for students with significant needs, including a streamlined referral process with community behavioral health providers to create a seamless services delivery model for children, adolescents, and their families

Participating LEAs are delivering a variety of mental health services and supports within the Multi-Tiered System of Supports for Behavioral Health and Wellness that have been built in each community. Within the Universal Tier, Tier 1, several LEAs have begun utilizing mindfulness programming and various social-emotional learning curricula. The intent of these efforts to help “prevent” or lessen the impact of mental health challenges by giving students the skills they need to cope and be resilient in the face of challenge.

At Tier 2, small group interventions for those dealing with anxiety, parental divorce, and healthy relationships have been successful. Specifically, interventions such as Coping Cat and Check In, Check Out have made a significant impact on student success.

At Tier 3, participating LEAs have had a strong focus on developing a service delivery system for NH’s High-Fidelity Wraparound Service. This service has not historically existed within the context of the school environment. Districts have worked diligently to find, hire, and train staff, to develop relationships with NAMI NH as the provider of Family Peer Support Services, and to streamline referral and eligibility criteria.

Project GROW

In support of the expansion of NH’s system of care, the Department of Education has launched Project GROW (Generating Resilience, Outcomes, and Wellness) as a partnership between the Office of Social & Emotional Wellness, the NH Office of Special Education, and the Center for Behavioral Health Innovation at Antioch University. This project provides expert leadership in the development of trauma-informed schools and community systems. Project GROW supports NH school professionals with specialist training and consultation in the full implementation of a trauma-informed organizational self-assessment, staff professional development, policy and practice transformation, and program evaluation. The goals of the Project GROW include the following:

- Create school districts/systems that promote optimal social, emotional, and academic outcomes for students and staff.
- Conduct a Learning Community environment/process that equips participants with the knowledge, skills, support, and motivation to develop trauma-informed learning communities within their site.
- Increase staff capacity to deliver trauma-informed care.
- Provide a model for developing Trauma Sensitive Schools in NH for use by the OSW which includes “real world” experiences and benefits from the Continuous Quality Improvement process.
- Improve student and staff sense of felt safety, and relationships among students, staff, families, and the community.

- Decrease discipline referrals, suspension, critical incidents, and expulsions.

Communities participating in Project GROW include Bethlehem, Concord, Hampton, Hopkinton, Laconia, and Merrimack.

Title 4A

The Every Student Succeeds Act (ESSA) is the most recent reauthorization of the Elementary and Secondary Education Act of 1965 (ESEA). ESSA continues the civil rights foundation of ESEA, reflecting our nation's longstanding commitment to equity of opportunity for all students. The new law has a clear goal of ensuring our education system prepares every child to graduate from high school ready to thrive in college and careers. The 2015 reauthorization has many provisions that promote equitable access to educational opportunity including holding all students to high academic standards; ensuring meaningful action is taken to improve the lowest-performing schools and schools with underperforming student groups, and providing more children with access to high-quality preschool learning opportunities. As educators work to improve outcomes for students, the ultimate goal is to provide all students with a high-quality education.

Title IV, Part A, Student Support and Academic Enrichment Grants, or SSAE, of the Every Student, Succeeds Act supports New Hampshire's commitment to equity of opportunity for all students. The program is intended to ensure all children graduate from high school ready to thrive in college and careers by increasing the capacity of state education agencies (SEAs), local education agencies (LEAs), schools, and local communities to:

1. Provide all students with access to a well-rounded education,
2. Improve school conditions for student learning, and
3. Improve the use of technology to improve the academic achievement and digital literacy of all students.

The second purpose of the SSAE program is to improve school conditions for student learning. When students are healthy and feel safe and supported, they are more likely to succeed in school. Generally, the SSAE program funds may be used for any program or activity that fosters safe, healthy, supportive, and drug-free school environments, including direct student services and professional development and training for school staff. As indicated in the table below, the authorized LEA activities may be categorized by topic as 1) Safe and supportive learning environments; and 2) Student physical and mental health, including substance abuse prevention. Three of the authorized activities--mentoring and school counseling, school-wide positive behavioral interventions, and pay for success initiatives--are cross-cutting and apply to both topics.

Safe and Supportive Schools	Student Physical and Mental Health
<ul style="list-style-type: none"> • Preventing Bullying and Harassment • Relationship-Building Skills • School Dropout Prevention • Re-Entry Programs and Transition Services for Justice Involved Youth • School Readiness and Academic Success • Child Sexual Abuse Awareness and Prevention • Reducing Use of Exclusionary Discipline Practices and Promoting Supportive School Discipline • Suicide Prevention • Violence Prevention, Crisis Management and Conflict Resolution • Preventing Human Trafficking • Building School and Community Relationships • Culturally Responsive Teaching and Professional Development of Implicit Bias 	<ul style="list-style-type: none"> • Drug and Violence Prevention • Health and Safety Practices in School or Athletic Programs • School-Based Health and Mental Health Services • Healthy, Active Lifestyle, Nutritional Education • Physical Activities • Trauma-Informed Classroom Management • Preventing Use of Alcohol, Tobacco, Marijuana, Smokeless Tobacco, Electronic Cigarettes • Chronic Disease Management
<p>Cross Cutting Authorized Topics Mentoring and School Counseling Schoolwide Positive Behavioral Interventions Pay for Success Initiatives aligned with the purposes of <i>Title IV</i></p>	

*NOTE: This chart provides a summary of topics and is not an exhaustive list

In year 3, the NH DOE, through the Office of Academics and Professional Learning, issued Title IV-A Funding in the form of formula grants to districts. Funding amounts were based on the Title 1 funding formula and provided that no district received less than \$10,000.

NH Center for Authentic Family Voice

The NH Department of Education through its Office of Special Education has contracted with Scholastic Education to launch the NH Center for Authentic Family Voice. Year one of the three-year New Hampshire Scholastic Center for Authentic Family Voice project deliverables included Family Voice Assessments for 24 schools and Dr. Karen Mapp’s Family Engagement Workshop Series for Family Voice Teams in 24 schools. Year two of the project will focus on strengthening the practices of participating schools with book studies, literacy events, and an intensive focus on learning supports. Year three of the project will include professional learning as well as a reassessment to measure overall growth.

During the project development and launch, Scholastic staff worked closely with NH DoE staff to develop an application criteria and a process to select schools that were making the three-year commitment to participate in the project. Scholastic developed and led two live webinars and one recorded webinar to introduce the project. Once the selection was complete, Scholastic provided each participating district and their building-level leaders with a webinar to outline the objectives and the process of the Family Voice Assessment. Scholastic staff coordinated the delivery of

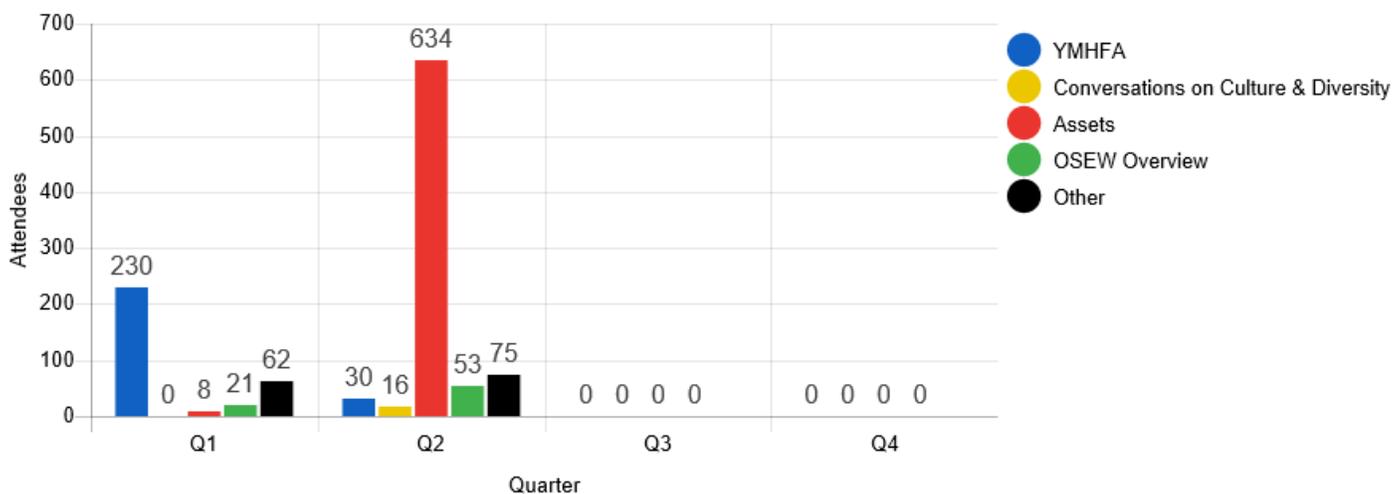
services for 24 schools in five districts, including dates and locations, and delivered make-up sessions when the weather prohibited attendance. Participating schools are listed below:

PLC	Districts	Schools
1	Contoocook Valley Regional SAU #1	ConVal Regional High, South Meadow, Great Brook Middle, Temple Elementary, Peterborough Elementary, Dublin Consolidated, Hancock Elementary, Greenfield Elementary, Francestown Elementary, Pierce Elementary, Antrim Elementary
2	Manchester SAU #37	Gossler Park Elementary, Northwest Elementary, Parker Varney Elementary, Parkside Middle, West High
3	Somersworth/Rollinsford SAU #56	Maple Wood Elementary, Somersworth Middle
3	Pittsfield SAU #51	Pittsfield Elementary, Pittsfield Middle/High
4	Fall Mountain SAU #60	Vilas Middle, Alstead Primary
5	Concord SAU #8	Broken Ground, Mill Brook

The purpose of the New Hampshire Family Voice Assessment (FVA) is to create a baseline assessment for measuring how welcome families are in our schools and in the learning process. An FVA was completed for 24 schools. The FVA included: (1) a physical walk-through; (2) a review of documents given to families; (3) a review of the school’s website and parent portal; (4) a review of social media; (5) a “shopper call”; (6) a survey of the building administrators; (7) a survey of school staff members; and (8) a survey of families. This FVA report incorporates all of the data and analyzes it to provide a full, 360° view of family voice at each school. The process is designed to help each school have a productive conversation about how well the school can help families support their children’s learning. The report includes ratings, commendations, and recommendations for three different goal areas—Building Relationships, Sharing Information to Support Learning, and Building Capacity to Support Learning.

Technical Assistance and Training

The Office of Social and Emotional Wellness has invested considerable time during Year 3 to delivering in-person and virtual training and technical assistance. This support came in the form of standardized trainings including Everyone is an Asset Builder, Youth Mental Health First Aid, Conversations on Culture and Diversity, Know & Tell Mandated Reported Training, and Threat Assessment Training. Tracked on the federal fiscal year (October through September), the following graph accounts for over 1100 interactions between the OSEW and professionals in the field between October 2018 and January 2019.



Everyone is an Asset Builder is designed to inform participants about the Developmental Assets framework created by the Search Institute and how it can be used to build supportive communities. The structure identifies a set of skills, experiences, relationships, and behaviors that enable young people to develop into successful and contributing adults. This training will determine the easy steps that anyone who interacts with children and youth can take to be effective asset builders.

Youth Mental Health First Aid (YMHFA) is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.

Conversations on Culture and Diversity is a facilitated conversation about culture and diversity in the Granite State. Participants begin to explore the concepts of culture and diversity as they relate to their personal beliefs and values and how those concepts influence their practices in education, health, and/or behavioral health. In this session, participants learn to: define "diversity" and "culture" and explain the similarities and differences between these two concepts, and how to relate to their work; identify their own cultural attitudes toward communication, time, health, authority, and work habits; describe how personal, cultural attitudes impact their daily interactions; identify behaviors that indicate a lack of cultural competence and those that indicate skill in cultural competence; and explain the importance of cultural competence in education, health, and/or behavioral health.

The OSEW is proud to partner with the Granite State Children's Alliance, the Chapter Organization for NH Child Advocacy Centers, to support this critically important effort. KNOW & TELL is a public responsibility movement to

educate all NH adults to KNOW the signs of abuse and TELL responsible authorities when they recognize them.

During this 2-hour, interactive training, an expert trainer will support participants to:

- KNOW the signs of child abuse
- LIMIT the barriers to reporting child abuse
- RESPOND to disclosure/outcry of abuse
- TELL in response to mandated reporting laws and policies
- PARTNER with your local Child Advocacy Center

Threat Assessment Training (TAT), offered in partnership with the REMS TA Center, reviews troubling or threatening behavior of current or former students, parents, school employees or other persons brought to its attention. The TAT contemplates a holistic assessment and management strategy that considers the many aspects of the person's life—academic, residential, work, and social. The TAT takes into consideration, as appropriate, information about classroom behaviors, various kinds of communications, not-yet substantiated information, any threats made, security concerns, parenting issues, or relationship problems that might involve a troubled individual. The TAT may also identify any potential victims with whom the individual may interact. Once the TAT recognizes an individual that may pose a threat, the team will determine a course of action for addressing the situation. This training was provided for Superintendents, School Administrators, and staff involved in emergency operations planning.

The OSEW has created a Lending Library to provide tools and resources to support local communities as they develop and strengthen their systems of care. Use of the lending library films is free, provided that viewers are not charged an admission fee of any kind to see the movie.

In addition to the myriad of technical assistance and training opportunities that support student wellness, the NH Department of Education promotes social and emotional learning through the free Choose Love Social and Emotional Learning Curriculum available to all schools. Use and promotion of the curriculum, also a recommendation in the Governor's School Safety Preparedness Taskforce, is a year-long, comprehensive pre-K through grade 12, evidence-based SEL classroom program that teaches children how to "choose love" in any circumstance. The curriculum is an approach that is considered preventative and is intended to reduce and eliminate school violence and bullying in schools. Schools and school districts across the state have been working directly with NH's Choose Love Coordinator who presents the curriculum and inspires schools to continue to propel the movement and adopt and implement it school and/or district-wide.

Expenditures in the System of Care

The 2016 report identified over \$100 million in expenditures towards behavioral health service. The year two report Expenditures are estimated to have increased slightly, to more than \$120 million. In 2018, this report aimed to better capture expenditures, particularly from local school districts and communities. As a result, an approximate total expenditure is calculated at \$126,398,723.

DHHS expenditures:

Here we present expenditures across four areas of DHHS including the Division of Children, Youth, and Families (DCYF), Division of Behavioral Health (DBH), and Bureau of Developmental Services (BDS) and Medicaid.

Additional information can be found in Appendices A through D.

Division for Children, Youth and Family

DCYF Non-Medicaid dollars		
Age 13 to 18		\$10,236,717.59
community based service		\$1,489,531.37
(E) Others (General Fund dollars)		\$177,603.91
(N) IV-A Assistance		\$1,279,191.09
(N1) IV-A MOE Abuse, Neg, CHINS		\$32,186.37
(NS) IV-A for Delinquent Services		\$550.00
out of home service		\$8,747,186.22
(A1) Group Home		\$1,544,072.01
(AP) IV-E for Placement		\$1,840.40
(E) Others (General Fund dollars)		\$3,059,923.80
(EP) GF for Placement		\$1,556.94
(N) IV-A Assistance		\$4,124,102.78
(N1) IV-A MOE Abuse, Neglect, CHINS		\$1,779.88
(NP) IV-A for Placement		\$13,910.41
Age 6 to 12		\$1,500,567.84
community-based service		\$248,089.43
(E) Others (General Fund dollars)		\$34,783.98
(N) IV-A Assistance		\$209,714.94
(N1) IV-A MOE Abuse, Neglect, CHINS		\$3,590.51
out of home service		\$1,252,478.41
(A1) Group Home		\$292,540.99
(AP) IV-E for Placement		\$5,663.81
(E) Others (General Fund dollars)		\$415,623.44
(EP) GF for Placement		\$178.68
(N) IV-A Assistance		\$538,471.49
SYSC Mental Health Services for youth at SYSC		\$23,224.09
General Fund Dollars		
Grand Total		\$11,760,509.52

DCYF Medicaid Dollars	
Ages 13 to 18	\$15,907,048.37
community based service	\$1,360,297.48
out of home service	\$14,546,750.89
Ages 6 to 12	\$7,876,833.22
community based service	\$2,087,996.20
out of home service	\$5,788,837.02
Birth to 5	\$2,350,552.73
community based service	\$1,365,237.28
out of home service	\$985,315.45
Grand Total	\$26,134,434.32

Medicaid Provider Payments for Children’s Behavioral Health Services

Age of children	Community-Based	Non-Community Based	Pharmacy	Total
0 to 5	\$4,229,881.00	\$301,483.00	\$188,366.00	\$4,719,730.00
6 to 12	\$19,365,813.00	\$2,515,768.00	\$7,711,342.00	\$29,592,922.00
13 to 18	\$14,858,211.00	\$5,438,720.00	\$6,679,393.00	\$26,976,324.00
19 to 20	\$2,404,101.00	\$1,610,219.00	\$1,115,695.00	\$5,130,016.00
Total	\$40,858,006.00	\$9,866,190.00	\$15,694,797.00	\$66,418,993.00

Notes:

Data Source: NH MMIS & NH PAP as of 10/30/18

Totals are based on provider payment amounts

Community-Based Includes Non-Residential Professional Services-including those provided in the school setting via the Medicaid to Schools program.

Non-Community Based includes Facility Services and Residential Professional Services

Pharmacy includes prescriptions with a behavioral health therapeutic class (no adjustment for off label or not BH use)

DCYF and waiver services are excluded

The below expenditures were funded by the Bureau of Drug and Alcohol Services using the federal block grant.

<u>Substance Use Disorder Prevention Programming Dollars</u>	
Age of children	Amount
6-12	\$323,608
13-18	\$1,284,220

<u>Drug and Alcohol Block Grant expenditures for treatment services</u>		
(Age of children)	Community Based (Amount)	Non- Community-Based (Amount)
Birth-5	\$0.00	\$0.00
6-12	\$0.00	\$0.00
13-18	\$20,448.00	\$100,468.04
19-21	\$139,780.00	\$77,334.80

DOE Expenditures:

Here we present expenditures across four areas of NH’s education system including selected federal title programs, federal competitive grant programs led by the Office of Social & Emotional Wellness, and a preliminary survey of NH school districts about expenditures to support the system of care at the local level.

A note on the limitations of the following numbers: Due to the role of local control in NH’s educational system, categorizing and reporting on the dollars spent in support of the system of care is challenging. The combination of federal entitlement funds, competitive federal grants (received both by the state and local communities, state education funding, local property tax dollars, private grant funds, and philanthropic donations are not reported on, tracked, or managed by any one entity. The following numbers are, in most cases, approximations based on known conditions and experiential estimates. The Department of Education, in collaboration with local school districts, has committed to strengthening the tracking process in support of RSA 135f and will work to expand this reporting in the year four report.

Federal Entitlement Programs

Title 2	\$	180,000.00
Title 4a	\$	1,240,000.00
Title 4b	\$	5,300,000.00
IDEA	\$	355,000.00
Total	\$	7,075,000.00

Federal Competitive Grants

Safe Schools/Healthy Students	\$	2,204,400.00
Project AWARE	\$	1,949,991.50
System of Care Sustainability and Expansion	\$	3,000,000.00
Total	\$	7,154,391.50

Local Expenditures

The following table reflects voluntary responses from a local school about the expenditures incurred expenditures to support the system of care at the local level. This was a voluntary survey and did not represent the full list of NH schools. It is also important to mention that although definitions for each category were given to respondents (see below), respondents identified a considerable grey area both in the categorization of expenditures and the connection between spending and the development or expansion of a system of care. These numbers are, therefore, approximate.

Expenditure category definitions:

Personnel: Creation of a System of Care - an estimate of costs incurred as your faculty and staff work to create a System of Care within your school. Examples include time spent on universal, tier 2, or tier 3 teams, Community Management Teams, and coordination and collaboration with community partners.

Contracts: Creation of a System of Care - an estimate of costs incurred as your faculty and staff provide services and supports to your students in the areas of mental, emotional, and behavioral health. Examples include: interventions delivered at the individual, small group, and universal levels, costs associated with social-emotional learning or other behavioral health and wellness curriculums, time spent providing education and enforcement of behavior expectations, mindfulness in schools, bullying prevention, and Responsive Classrooms

Personnel: Services and Supports to Students - an estimate of costs incurred as your faculty and staff provide services and supports to your students in the areas of mental, emotional, and behavioral health. Examples include interventions delivered at the individual, small group, and universal levels, costs associated with social-emotional learning or other behavioral health and wellness curriculums, time spent providing education and enforcement of behavior expectations, mindfulness in schools, bullying prevention, and Responsive Classrooms.

Contracts: Services and Supports to Students - an estimate of costs incurred as a result of contracts meant to provide services and supports to your students in the areas of mental, emotional, and behavioral health. Examples include interventions delivered at the individual, small group, and universal levels, costs associated with social-emotional learning or other behavioral health and wellness curriculums, time spent providing education and enforcement of behavior expectations.

Personnel: Professional Learning - an estimate of costs incurred as your faculty and staff participate in professional learning to support the creation of a System of Care in your school. Examples include Youth Mental Health First Aid, Childhood Trauma, Culture and Diversity, Responsive Classroom, family and youth engagement, and classroom management.

Contracts: Professional Learning - an estimate of costs incurred as a result of contracts meant to provide professional learning in support of the creation of a System of Care. Examples include: presentations and training by exemplars in the field, support materials, and conference registrations

School	SoC: Personnel	SoC: Contracts	Services: Personnel	Services: Contracts	PD: Personnel	PD: Contracts	Total
1	0	0	3,500	25,000	0	1,000	29,500
2	0	0	0	17,500	0	0	17,500
3	5,000	3,000	26,000	0	500	500	35,000
4	10,000	0	65,000	12,500	12,500	2,500	102,500
5	200,000	3,000	630,000	25,000	5,000	10,000	873,000
6	0	0	0	0	2,000	1,000	3,000
7	0	18,620	4,000	0	0	0	22,620
8	3,000	1,000	25,000	1,000	500	0	30,500
9	2,500	2,500	100,000	11,000	2,500	0	118,500
10	0	500	0	0	0	0	500
11	0	0	250	0	500	100	850
12	0	0	3,000	0	500	100	3,600
13	0	11,200	0	0	0	0	11,200
14	700	1,200	600	10,000	500	2,000	15,000
15	10,000	10,000	40,000	10,000	800	0	70,800
16	10,000	20,000	10,000	0	5,000	1,000	46,000
17	8,287	7,708	138,683	76,333	7,708	1,100	239,819
18	9,000	5,800	25,000	350,000	3,000	0	392,800
19	5,000	2,500	18,000	8,000	12,000	3,500	49,000
20	8,287	7,708	138,683	76,333	7,708	1,100	239,819
21	8,287	7,708	138,683	76,333	7,708	1,100	239,819
22	8,287	7,708	138,683	76,333	7,708	1,100	239,819
23	8,287	7,708	138,683	76,333	7,708	1,100	239,819
24	8,287	7,708	138,683	76,333	7,708	1,100	239,819
25	0	0	0	0	30,000	1,000	31,000
26	25,000	5,000	300,000	20,000	10,000	15,000	375,000
27	500	250	500	1,500	1,500	500	4,750
28	0	0	12,000	0	0	1,000	13,000
29	75,000	77,000	110,000	15,000	20,000	30,000	327,000
30	85,000	102,000	142,000	15,000	20,000	30,000	394,000
31	75,000	77,000	110,000	15,000	15,000	25,000	317,000
32	90,000	150,000	230,000	50,000	20,000	30,000	570,000
33	90,000	165,000	180,000	50,000	20,000	30,000	535,000
34	12,000	50,000		10,000	0	10,000	82,000
	757,420	751,818	2,866,950	1,104,500	228,048	200,800	5,909,536

Year 3 Requirements

Projecting Future Need

To assist the Departments with their planning around the System of Care, the Carsey School of Public Policy, with funding from the Endowment for Health, is providing some data analyses around estimating the potential future need for services in New Hampshire. In this memo, we support this goal by first projecting changes to New Hampshire’s child and young adult population (those aged 0-21). We next summarize national statistics on the prevalence of specific behavioral health issues to estimate the share of the projected New Hampshire youth population who might need supportive services through a system of care. We conclude with a general summary of our findings.

1. Projecting New Hampshire’s Youth Population

We rely on data from the U.S. Census Bureau both to estimate the New Hampshire population under age 22 (“the youth population”), and to evaluate the change in that group over time. As shown in Table 1, the Census Bureau counted 361,875 New Hampshire youths at the time of the 2010 Census, and based on that number, estimates 333,459 NH youths by 2017. We use these two numbers to calculate mean yearly change between 2010 and 2017, and then apply that rate of change calculation to future periods. For example, the NH youth population declined by 28,416 people, or 7.9 percent between 2010 and 2017, representing a mean yearly decline of 1.1 percent. Multiplying this rate change by five and subtracting it from the base 2017 number provides an NH youth population estimate for 2022. Table 1 shows the results of these projections.

Because our projections assume a static rate of change from year to year, it is important to note that these projected population estimates are not necessarily the most likely or even a probable outcome for these future periods. For instance, birth rates and the number of women in their childbearing years change over time and can dramatically affect the number of children that are born in a given year. With no change in birth rates or the number of women of childbearing age, we find that, since the youth population in New Hampshire declined between 2010 and 2017, it will continue to decline for each projected time point into the future. This pattern holds for younger and older youths within the broader youth population.

Table 1. New Hampshire Youth Age 0-21: Census Count and Population Projections Over Time

Source	Population	Change from Previous Period
2010 Census Count	361,875	n/a
2017 Census Estimate	333,459	-28,416
2018 Projection	329,400	-4,059
2022 Projection	316,162	-13,238
2027 Projection	292,865	-23,297
2037 Projection	252,270	-40,595

Source: Carsey School of Public Policy analysis of 2010 Decennial Census data and 2017 U.S. Census Bureau Population Estimates.

Note: Projections are based on an annual rate of change between 2010 and 2017.

2. *Estimating System of Care Need for New Hampshire Youth*

To estimate how this changing population interacts with a changing need for services through the system of care, we conducted a literature review to explore national- and NH-level trends in various mental health and substance misuse trends for the population in this age group. As New Hampshire-specific data on these indicators are often lacking, national findings become especially important in the estimation process. Further, existing data do not always align with the age group of interest here (those 0 to 21), making projections among the 0-21 age group difficult. Still, even when outside the specified age range, the data detailed below can be instructive in crafting possible estimates of need.

Regarding specific indicators, we compiled national rate estimates of the need for outpatient mental health care, mental or behavioral health diagnoses, children served under the Individuals with Disabilities ACT (IDEA), depression or bipolar diagnoses, depressive event in lifetime or past year, diagnosed with ADHD, mental health hospital visits, suicide, and illicit or binge drug use. In addition to existing research, we also estimate New Hampshire-specific rates of poverty by age and the share of children with a disability, using the most recent data from the Census Bureau's American Community Survey. These estimates are instructive because (1) child poverty is associated with many of the mental health outcomes of interest here; and (2) the share of children with a disability is one primary estimate of the need for care across the state. Using these national- and state-level rates, we use the projected population estimates from above to then estimate the number of New Hampshire children that would be potentially impacted by each indicator for each future time point. Please note that each of the indicators applies to subgroups of the youth population (e.g., 6- to 17-year-olds), based on the availability of existing data by age (for full estimations of the population size for each age group, see Appendix table).

The results of this analysis are presented in Table 2. For outcome 1—outpatient mental health care—existing literature has estimated the prevalence among 6- to 17-years-old and tracked change among this group between the late 1990s and the 2010-2012 period (years pooled together into a single time point). By the 2010-2012 period, 13.3 percent of 6- to 17-year-olds had required some outpatient mental health care, an increase of 4.1 percentage points over time. We first use these estimates to calculate an annualized rate of change—an increase of 0.29 percentage points per year—which we then apply to the projected age-specific population. For example, with an annual increase of 0.29 percentage points each year since 2012, outpatient mental health care rates would be 15.1 percent in 2018. Based on the projected population of children aged 6-17 (see Appendix Table), this suggests that nearly 27,000 children would need outpatient mental health care in 2018. A similar method is applied for the periods into 2022, 2027, and 2037, and the remaining indicators in Table 2.

Table 2. Prevalence of Behavioral Health Outcomes for Specific Age Groups, and Projected Impacts Over Time

Outcome Number	Behavioral Health Outcome	Age Group Studied	Period Studied	Share of Youths Affected at Study's Most Recent Datapoint	Change in Rate Over Study Period (percentage points)	Projected Age-Specific NH Population Affected*			
						2018	2022	2027	2037
1	Outpatient mental health care ^a	6 to 17	1996-98 to 2010-12	13.3%	+ 4.1	26,837	27,523	27,344	25,708
2	One or more diagnosed mental, behavioral, or developmental disorders ^b	2 to 8	2011-12	15.4%	n/a	14,253	13,443	12,432	10,409
3	Depression or bipolar disorders ^c	13 to 17	2015 to 2017	14.3%	+ 3.1	12,510	16,256	20,030	24,551
4	Provider diagnosed anxiety or depression ^d	6 to 17	2003 to 2011-12	8.4%	+ 3.0	18,180	19,491	20,068	19,913
5	Major depressive event in life time ^e	12 to 17	2010-11	12.8%	n/a	12,029	11,251	10,277	8,330
6	Major depressive event in past year ^e	12 to 17	2010-11	8.1%	n/a	7,612	7,120	6,504	5,272
7	Ever told they have ADHD ^f	3 to 17	2007-08 to 2011	8.4%	+ 1.2	22,285	23,524	23,921	23,289
8	Mental-health hospital visit ^g	1 to 17	2006-11	0.5%	n/a	1,237	1,159	1,062	869
9	Suicide rate ^h	15 to 19	2010 to 2016	10/100,000	+ 2.5/100,000	9	10	10	11
10	Have ever used an illicit drug ⁱ	12 to 17	2016	23.0%	n/a	21,615	20,216	18,467	14,969
11	Have used an illicit drug in past month	12 to 17	2016	7.9%	n/a	7,424	6,944	6,343	5,141
12	Have binge alcohol use in the past month	12 to 17	2016	7.4%	n/a	6,955	6,504	5,942	4,816
13	Percent poor under age 6 ^j	Under 6	2013 to 2017	11.5%	n/a	8,816	8,374	7,820	6,714
14	Percent poor age 6 to 11 ^j	6 to 11	2013 to 2017	11.7%	+ 2.4	10,262	11,096	11,838	12,320
15	Percent poor age 12 to 17 ^j	12 to 17	2013 to 2017	7.9%	- 1.8	7,086	5,362	3,453	456
16	Percent low income under age 6 ^j	Under 6	2013 to 2017	24.0%	+ 12.2	29,623	35,242	41,210	49,625
17	Percent low income age 6 to 11 ^j	6 to 11	2013 to 2017	16.3%	+ 10.6	24,451	29,511	34,508	40,082
18	Percent low income age 12 to 17 ^j	12 to 17	2013 to 2017	19.2%	+ 4.5	23,119	24,787	26,255	27,139
19	Percent with a disability	Under 18	2013 to 2017	5.3%	No change	13,550	12,727	11,697	9,638
20	Served under IDEA Part B ^k	3 to 5	2014-15 to 2016-17	8.9%	No change	3,455	3,222	2,930	2,347
21	Served under IDEA Part B ^k	6 to 21	2014-15 to 2016-17	9.8%	No change	24,869	23,650	22,126	19,079

* Based on projected population change for specified age group (column c) and rate estimated in the specified study; see

Appendix table.

Note: some of these estimates (i.e., outcomes 2, 5, 6, and 8) are based on pooled data over multiple years. Even though numerous years appear in the "period studied" column for these outcomes, there is no change to the rate.

a. Olfson, Druss, and Marcus 2015

f. Perou et al. 2013

k. US DOE 2016-2017

b. CDCa. 2018

g. Torio et al. 2015

c. Child Mind Institute. 2018

h. CDCb. 2016

d. Bitsko et al. 2018

i. NSDUH. 2016

e. Perou et al. 2017

j. ACS 2017 1-Year Estimates

As with Outcome 1—outpatient mental health care—most indicators in the table for which it was possible to identify the change in rates over time increase in prevalence. In fact, except for the share of 12- to 17-year-olds who are poor, the rate of children affected by all other assessed behavioral health indicators has increased over time. However, because the NH youth population is projected to decline, the number of children affected by any given indicator may be anticipated to be less in 2037 than in 2018. In other words, although the share of children affected by behavioral health issues explored in Table 2 may increase over time, based on the available data, the absolute number of children affected by any given indicator is expected to decline. Some broad patterning suggests that there may be increases in the number of children of all age groups who are low income (Outcomes 16, 17, 18), and in the number of children diagnosed with a depressive disorder (Outcomes 3, 4). However, the changes in both the population and the share affected by behavioral health challenges, along with the lack of New Hampshire-specific data, and data for the broad 0-21-year-old age group make it difficult to precisely document the potential needs for a system of care into the future.

3. *Technical / Substantive Notes*

Please note that, as mentioned above, because the New Hampshire youth population declined between 2010 and 2017 in each age category, and we use a static rate of change for our projections, the number of children we project to require services will decline over time, regardless of the indicator of interest. However, in our forecasts that account for a rate change and population change, we do see some increases in our projected need, depending on whether or not we expect the share impacted by each indicator to increase over time.

Also, note that our estimates do not take into account any direct impacts of the rise in opiate use and misuse over the past several years, except for any indirect implications this has on the indicators studied here. It is yet unclear how this rise in opiate use will impact the system of care needs for New Hampshire children.

Identification of Shortfalls in Workforce

The behavioral health system's workforce issues are being addressed through the Workforce Task Force workgroups associated with the 1115 waiver or IDN work. The Workforce and training group has split into four sub-committees, and they have all been working on various goals that were determined around 18 months ago. There are four sub-committees:

- Policy
- Education and Training
- Recruitment and Hiring
- Retention and Sustainability

Our Policy sub-committee has been testifying on legislative issues and putting pressure on the guilds to speed up their processes. They have also been vocal in making sure that we got the 60-day waiver for a clinician coming into the State to practice.

We have also given testimony on the many Tele-Health Bills and also the SLRP increases in the summer. IDN's and also help to pay the employer match for SLRP in 3 different regions.

Education and Training have been working with Antioch and Sandy Blunt's team to grow Integrated Health clinicians by creating sites within the IDN's for practicums. They have also worked with the AHEC's on updating all their materials that they circulate to include Integration sites and opportunities.

The other two subcommittees have worked together on some items.

There was a benefits comparison done in NH to establish what competition is out there in all industries and this was shared with all IDN members. Interesting finds were that more and more enterprises are offering an unlimited vacation to millennials. Other efforts in this area include:

- IDN 2 Raised money and trained 30 new MHFA instructors
- The committees have engaged CHI to work on maximizing billing codes
- The committees have worked with the Aimes Institute in NJ to optimize coding

We are also planning a celebration for the workforce in December for all people who work in Human Service, and this will result in a proclamation from the Governor and Op-Eds in all regions.

Identification of Specific Plan Amendments

1. New Medicaid Benefit

DHHS has written and received approval for a change in the NH Medicaid State Plan specifically for children and youth who have a severe emotional disturbance and who require supportive services in addition to clinical services to remain in their own home. These children are at risk for repeat hospitalization as well as out of home treatment and DCYF involvement. This Medicaid benefit includes supportive services to the program known as FAST Forward. These services are;

- Wraparound coordination
- In-home respite
- Out of home respite
- Youth Peer Support
- Family Peer Support
- Customizable Goods and Services

The benefit will allow for continued expansion of the program to reach and serve more children who are found eligible. Additional funding requests in the next biennium budget have been made to support children who may not qualify for Medicaid or have insurance that will not cover this programming, for further expansion. Expansion of this programming is happening in two other ways in the state, through the Department of Education and the Cheshire County, System of Care work. Expansion of this programming is discussed earlier in this report, in the FAST Forward reporting section

2. ***Medicaid to Schools Program***

The Department is in the process of amending the Medicaid to Schools rule to allow schools to be able to bill Medicaid for children who do not have an IEP, but have a 504 plan or other written care plan. This is a change that will broaden the school’s ability to draw Medicaid funds for Medicaid services they provide to these children. The program has been limited to children with IEP’s until now. This change will help to support and encourage schools to provide school-based behavioral health services to children who need them.

Number of Children and Youth Awaiting Services

1. ***Wait times for Services:***

Wait times for services can delay a person’s treatment for their mental health condition. Delays in appropriate and effective treatment can cause the need for more intensive treatment and support later on, usually in the form of crisis services and acute inpatient stays. Early and effective treatment is essential in getting a person with a mental health condition on the road to recovery. In discussions about the waitlist, the mental health safety net system of the community mental health system is the system with the most significant workforce issue as described above, which translates to wait times. The tables below show the relative wait times for different services for those centers who responded to a survey.

Community MH Centers	Current wait time: Emergency	Current wait time: Urgent	Current wait time: Standard	Gap between 1st and 2nd Session	Open Access?	# Open Positions: Therapists	# Open Positions: Case Managers
Northern	within 24 hours	within seven days	Avg. 20 days	N/A	No, but considering	6	6
W. Central	within 24-48 hours	?	within 1-3 days	within seven days	Yes	6	3
CLM	typically within 24-48 hours	typically within seven days	1-3 weeks	N/A	No	1	1

Riverbend		within 24-48 hours	varies	within 1-6 weeks, depending upon the level of need	N/A	No, some capacity to do same day	2	2
Community Partners								
Lakes Region			within seven days	within two weeks	N/A	No	0	0
Seacoast		within 24 hours	within seven days	1 - 12 weeks	N/A	No, but implementing	1	1
Manchester		within 1-7 days	within seven days	within 14-21 days	N/A	in Nov. (Wed.)	3	0
Monadnock		typically within 24-48 hours	within seven days	Five weeks	N/A	No	1	6
Nashua		within 24-48 hours	within seven days	within 1-3 days	within 14 days	Yes (Mon. - Thurs.)	2	1

Community MH Centers	# Open Positions: FSS	# Open Positions: Psychiatrists / APRN	Currently doing CACT?
Northern	8	2	No
W. Central	N/A	0	No
CLM	1	0	Yes
Riverbend	1	0	No, but have a family intensive team
Community Partners			
Lakes Region	0	0	No
Seacoast	0	0	No
Manchester	0	0	No, but have a family intensive team
Monadnock	2	0	No
Nashua	0	0	Yes

As a response to wait times indicated in the tables above, some Community Mental Health Centers have started to engage with a model called Open Access to Care. This model provides an approach for Behavioral Health providers to structure their staffing and work processes to allow for more timely access to services for new patients. Below is a description of the model.

OPEN ACCESS TO CARE in BEHAVIORAL HEALTH

Consultation provided through the National Council for Behavioral Health / MTM

Rationale and Summary

The longer patients must wait to get appointments, the more likely they are to go to a different provider. While a same-day appointment has a 10% chance of not being kept, almost 25% of patients with next-day appointments cancel or just do not show up. Offering same day access improves operational efficiencies, avoids revenue loss, and allows clinicians to spend more time engaging patients in treatment.

CONSULTING SERVICES IN SAME DAY ACCESS

Since 2008, the National Council has offered behavioral health organizations the opportunity to participate in various Access and Retention initiatives. These initiatives are designed to provide the tools and resources to enhance timely access to care, to address revenue losses due to no-show appointments, and to institute performance improvement measures across the board. Through our work with hundreds of community-based behavioral healthcare organizations nationwide, the National Council has proven that it is feasible to increase engagement in treatment by reducing the time it takes to enter care. We've seen that quick access to care improves continuity and more quickly engages patients.

- **Streamline documentation:** Help organizations reduce their documentation requirements by focusing on the removal of repetitively captured data elements and data elements that are not required by funding or accreditation organizations and changing the answer formats used to obtain data elements to reduce overall documentation time.
- **Concurrent collaborative documentation:** Eradicate post-session documentation time while increasing person-centered engagement of clients in their recovery by involving them in the creation of their clinical documentation.
- **Walk-in access models:** Implement a model to offer more expedient access to care and increased engagement.
- **No-show management:** Use policy changes, policy enforcement, engagement specialists, and reminder back-filling programs to help clients increase their show rates and engagement levels.
- **Employee engagement and maximization of staff productivity:** Help providers get staff to buy in to change so that they can achieve their direct service staff's productivity targets.

Organizations participating in the National Council’s Access and Retention initiatives have achieved unprecedented results:

- Average of 60% reduction in consumer wait times — with higher engagement and reduced no-shows.
- Average of 39% reduction in the cost of access to the treatment process and a 34% reduction in staff time needed per access to treatment event.
- Up to 50% reduction in the number of data elements collected.
- Average of 9 hours per week in time saved per direct care staff on documentation.
- Average 26% increase in intake capacity with no increase in the number of staff.

Greater Nashua Mental Health states: “We track access to care in three different areas: Standard requests, Urgent requests, and Emergent requests for services. Just prior to starting Open Access, we were successful in meeting our access standards in these three areas 47% of the time. Three months after implementing Open Access, we were meeting those standards 94% of the time. A pretty remarkable difference.”

References

- Bitsko, Rebecca H., Joseph R. Holbrook, Reem M. Ghandour, Stephen J. Blumberg, Susanna N. Visser, Ruth Perou, and John T. Walkup. 2018. "Epidemiology and Impact of Health Care Provider-Diagnosed Anxiety and Depression Among US Children." *Journal of Developmental & Behavioral Pediatrics* 39(5): 395-403.
- CDCa. 2018. "Children's Mental Health Data and Statistics." Accessed November 7, 2018, from <https://www.cdc.gov/childrensmentalhealth/data.html>
- CDCb. 2016. "QuickStats: Suicide Rates for Teens Aged 15–19 Years, by Sex — the United States, 1975–2015." 2017. *MMWR Morbidity & Mortality Weekly Report* 66(30): 816.
- Child Mind Institute. 2018. "2017 Children's Mental Health Report." Accessed November 7, 2018, from <https://childmind.org/report/2017-childrens-mental-health-report/>
- NSDUH, 2016. "The NSDUH Report: Trends in Adolescent Substance Use and Perception of Risk from Substance Use." SAMHSA, US DHHS. <https://www.samhsa.gov/data/report/nsduh-report-trends-adolescent-substance-use-and-perception-risk-substance-use>
- Olfson, M., Druss B.G., and Marcus, S.C., 2015. "Trends in Mental Health Care among Children and Adolescents." *New England Journal of Medicine*, 372: 2029-2038
- Perou, Ruth, Rebecca H. Bitski, Stephen J. Blumberg, Patricia Pastor, Reem M. Ghandour, Joseph C. Gfroerer, Sarra L. Hedden, Alex E. Crosby, Susanna N. Visser, Laura A. Schieve, Sharyn E. Parks, Jeffrey E. Hall, Debra Brody, Catherine M. Simile, William W. Thompson, Jon Baio, Shelli Avenevoli, Michael D. Kogan, Larke N. Huang. 2013. "Mental Health Surveillance Among Children—United States, 2005-2011." *MMWR Morbidity & Mortality Weekly Report* 62(02): 1-35.
- Torio, Celeste Marie, William Encinosa, Terceira Berdahl, Marie C. McCormick, Lisa A. Simpson. 2015. "Annual Report on Health Care for Children and Youth in the United States: National Estimates of Cost, Utilization and Expenditures for Children with Mental Health Conditions." *Academic Pediatrics*, 15:1(19-35)
- U.S. DOE. 2016-2017. "IDEA Section 618 Data Products: Static Tables. Accessed November 7, 2018, from <https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html>