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

System of Care Law
Year 4 Report

November 2020

Prepared for the NH Department of Health and Human Services and the NH Department of Education by the Behavioral Health Improvement Institute at Keene State College, with funding from the New Hampshire Endowment for Health

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Executive Summary

In 2012, the NH Department of Health and Human Services was awarded a four-year, $12 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This grant was to develop a child and family focused System of Care (SoC) throughout New Hampshire. *NH Families and Systems Together (FAST) Forward for Children and Youth* established much of the foundation on which subsequent expansions of NH's SoC have been built. FAST Forward operationalized a set of guiding principles and values that would drive NH's SoC, adopted a practice model, and began to develop the structure for delivering and funding the associated services and supports. It enrolled families in wraparound services from July 2014 through December 2016 under the grant-funded NH Department of Health and Human Services (DHHS) umbrella. In January 2017, NFI North, Inc. (NFI), a subsidiary of North American Family Institute, Inc., assumed FAST Forward operations, billing Medicaid using a Medicaid benefit established through the data and experiences accumulated during the period of grant funding, through the leadership of the Bureau of Children's Behavioral Health and the advocacy of other state leaders. DHHS continues to determine eligibility for and provide oversight of FAST Forward.

In May 2016, the New Hampshire Legislature passed, and the Governor signed, Senate Bill 534-FN that 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 the Year 3 Report , critical incremental improvements to the children's behavioral health system of care were documented. This work now contimues and is presented in this Year 4 report.

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. This Year 4 report will provide critical updates on the progress toward these goals and celebrate the immense success achieved across NH in four short years.

A System of Care (SoC) is a spectrum of effective, community-based services and supports for children, youth with or at risk for mental health challenges and their families, The SoC is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them to function better at home, school, community, and throughout life.

NH 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's core three values, and a fourth core value, trauma informed, was added in 2020. Additionally, under Section 135-F:9 ,an Advisory Committee for the System of Care was established with the purpose of:

- Promoting coordination across state agencies
- Identifying cost-savings
- Creating a more efficient and improved service array & service delivery system
- Assisting and advising the Commissioners of NH-DOE & NH-DHHS on the System of Care principles & values & implementation of RSA135-F

NH SoC Core Values

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.

Trauma Informed: Treatment and support services are delivered in a manner that is Trauma- Informed using the 6 core principles of a trauma-informed approach: Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, and Empowerment, Voice and Choice, Cultural, Historical, and Gender Issues.

Requirements and Organization of Year 4 Report

Chapter 135-F:6 of *An Act to Implement a System of Care for Children's Behavioral Health in New Hampshire* outlines incremental reporting expectations across the four years following the enactment of the statute, as shown in the table below.

System of Care for Children's Behavioral Health Required Data Elements

Year	Data Element
Year 1 (2016)	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 implementation of a system of care.
	D. Any other available information relevant to progress toward full implementation of a system of care.
Year 2 (2017)	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, and managed care and provider contracts which will be necessary to fully 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.
Year 3 (2018)	I. Projections of future demand for services in the system of care.
	J. Identification of shortfalls in workforce sufficiency affecting 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. Numbers of children and youth awaiting services in various categories.
Year 4 (2019)	M. Detailed statistical information regarding children and families serviced, along with demographic characteristics, service need and provision, involvement in service systems, service funding sources, and placement or other site of service provision.
	N. Outcomes, including but not limited to status upon exit from the system of care, measured treatment results, recidivism, and other returns to the service system.
	O. Financial information, including but not limited to measures of cost-effectiveness, comparisons with other states with regard to levels of funding from federal, state, local, and private sources, and cost savings resulting from service coordination and effectiveness.
	P. An assessment of any influences external to the department of health and human services and the department of education, including configuration of the private children's behavioral health care system, which may be affecting establishment of the system of care.

Year 4 report begins with a holistic update on the evolution of a system of care for children's behavioral health across the three years between passage of SB 534 / RSA 135-F and the current reporting period (calendar year 2019). Items M – P are addressed in the Year 4 Progress through a description and assessment of initiatives

spanning the NH Departments of Health and Human Services (DHHS) and Education (DOE). The sections of this report are as follows:

Part 1: Years 1 -3 ~ NH's System of Care for Children's Behavioral Health Initiatives

Part 2: Year 4 Progress and Initiatives

Part 3: Expenditure Data for Year 4

Part 4: Limitations

Part 1: Years 1 – 3 ~ NH System of Care for Children's Behavioral Health Initiatives

Children's Behavioral Health Collaborative (2010-2019)

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

Office of Social & Emotional Wellness (OSEW), established within the Bureau of Student Wellness in NH

Department of Education (2014- 2020)

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

Project Aware (2014-2020). Expanded the MTSS-B model to 12 additional schools and early childhood settings in NH's North Country and Lakes Region through funding, technical assistance and training.

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

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

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

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

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

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

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

Bureau of Children's Behavioral Health established within NH DHHS (2016)

Established to promote a coordinated system of care for children and families, the BCBH joined the Bureau of Mental Health Services and the Bureau of Drug and Alcohol Services in a consolidated DHHS Division for Behavioral Health. The Bureau's mission is to expand the System of Care for all children, youth and families needing and receiving publicly funded behavioral health services. The Bureau is responsible for overseeing child and youth focused Behavioral Health services delivered by 10 Community Mental Health Centers, 2 Care Management Entities, 10 Residential Treatment Facilities and any new programming that the Bureau develops to enhance the SoC in New Hampshire.

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

Unlike the previous NH 10-yr Mental Health Plan, the 2019 plan addresses the needs of children as well as adults. Recommendations include scaling up the FAST Forward wraparound model; enhancing mobile crisis capacity to serve children; community education to reduce stigma and improve access to care for at-risk youth; supporting the Infant Mental Health Plan; and creating new DHHS staff positions with expertise in early childhood mental health.

Regional System of Care Projects

The County of Cheshire, NH was awarded four years of funding to develop a SoC in the Monadnock Region (southwest NH) in October 2016 by the Substance Abuse and Mental Health Services Administration (SAMHSA). In 2019, the City of Manchester, NH was awarded a grant by SAMHSA to extend a SoC approach to the youngest (0-8 years old) and most vulnerable residents of NH's largest and most diverse city.

DCYF Adequacy and Enhancement Assessment (2018)

Citing the need for "a more preventive, integrated, and organized continuum of services and supports that are aligned to the needs of the children, youth, and families they serve" (p.33), this assessment urged "continued adoption and expansion of the SoC principles and models that NH has put into law under RSA 135-F" (p39). Described in some detail in the Year 3 report, this assessment emphasized the intention of DHHS to divert families

from DCYF intervention and out of home placement, in favor of addressing their needs through a more preventive and integrated community-based system of care.

Summary

These collective efforts have resulted in a shared vision and commitment to SoC values, along with growing capacity to implement that vision with high fidelity. NH has an emerging critical mass of qualified Wraparound coordinators and family/youth peer supports, spreading implementation of the evidence-based MTSS-B model in schools, and accumulating reach into the target population. Moreover, bipartisan support in the current legislative session for substantial investments in the 10-year Mental Health Plan attests to a collective commitment to build on these early successes. The Year 4 Progress Report that follows will offer more detail concerning recent developments related to these and other initiatives.

Part 2: Year 4 Progress and Initiatives

This section of the report provides key updates from Year 4 concerning the spread and maturation of the System of Care approach to meeting the behavioral health needs of NH's children and families.

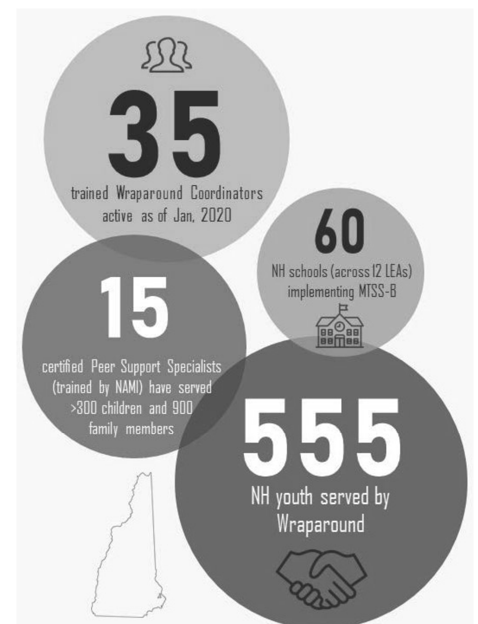
This section is organized as follows:

A) Policy/Legislature Updates

B) Enhanced access to intensive supports via Families First Prevention Services Act

C) Regional SoC Initiatives

D) Early Intervention / Prevention Initiatives



Policy / Legislature Updates

10-Year Mental Health Plan

Throughout 2018, the NH Department of Health and Human Services (DHHS) worked with Antioch University New England to facilitate the development of a comprehensive plan for addressing the mental and behavioral health needs of the state's population, including youth. The planning process described in last year's (Year 3) SoC law report resulted in the publication of a final plan just as the year was coming to a close. The plan can be accessed at https://www.dhhs.nh.gov/dcbcs/bbh/10-year-mh-plan.htm.

Just months after the release of the plan, the FY20-21 state operating budget committed substantial resources to implementing its recommendations. Specifically in relation to children, the budget calls for:

- funding an infant and early childhood mental health plan;
- expanding and relocating inpatient capacity for youth away from the state hospital;
- implementing Mobile Crisis Response Teams for children and youth;
- enhanced investments in suicide prevention training;
- expanding the scope of services eligible for reimbursement by Medicaid;

- instituting incremental increases in Medicaid reimbursement rates;
- creating new DHHS staff positions with expertise in early childhood mental health

The rapid mobilization of government and community resources in support of children's behavioral health is a testament to broad stakeholder engagement in the 10-year planning process, as well as of a growing bi-partisan consensus concerning the high priority of investing in our children's well-being. The embrace of the 10-Year Plan and the evolution of the System of Care are propelled by the same current of public urgency.

Statewide Children's System of Care Advisory Council

The System of Care Advisory Council was established within DHHS to advise on expansion and implementation of the Children's SoC and help to reduce barriers, increase awareness and assist in overall design of the Children's Behavioral Health System in NH. The Advisory Council succeeded the Children's Behavioral Health Collaborative's Steering Committee, hosting existing and new workgroups to address Policy, Workforce, School Behavioral Health, Communications and Social Marketing, Behavioral Health Equity, and Evaluation. The Council also monitors substantial federal and philanthropic funding within the scope of the SoC.

Senate Bill 14-FN: An act relative to child welfare

Adopted in June 2019, SB 14 set forth a complex set of required system components for an enhanced children's behavioral health system which included several major efforts such as: expanding the Care Management Entity requirements to establish a new system of transitional support and oversight, developing a single statewide behavioral health assessment tool, redesigning and contracting the youth residential treatment array, expanding the population for FAST Forward, establishing children's mobile crisis, a plan to address infant mental health, a parent information clearinghouse and online treatment and support locator, implementing Prevention/First Episode Psychosis (FEP), and providing Evidenced Based Practice (EBP) Technical Assistance and training support. Any one of these efforts would be a substantive undertaking; combined, they present an unprecedented opportunity and challenge for DHHS and system stakeholders and partners. *All* of the initiatives described below follow directly from or are closely aligned with SB 14. Recognizing the need for greater capacity to support these major system expansions, SB 14 also added DHHS staff. The Bureau of Children's Behavioral Health is slated to double its staff from 5 to 10 positions in summer 2020.

Enhanced Access to Intensive Supports via Families First Prevention Services Act

Residential Treatment

The FFPSA has made residential treatment options - historically available to youth in NH only through DCYF and school districts - increasingly accessible to all youth who require that level of care, without the necessity of entering the DCYF system. This work involves a large-scale transformation of NH's residential treatment system, with the goal of providing effective short-term treatment and stabilization, while diverting as many youth as possible from the trauma (and expense) of DCYF, hospital emergency departments, and psychiatric hospitalization. NH will contract with current providers to align residential treatment with the quality standards outlined in FFPSA, and shift oversight and management of this portion of the continuum of care from DCYF to the Bureau for Children's Behavioral Health. Funding has been secured to assist current treatment providers in meeting accreditation standards.

New levels of care have been developed to ensure in-state resources for children and youth with a wider range of stabilization and treatment needs. The expanded array will range from levels 1 through 5, with 1 being the least intensive, more community based and supportive living options for youth and transitional aged young adults, and 5 being the most intensive clinical need (accredited as a Psychiatric Residential Treatment Facility). As Year 4 drew to a close, BCBH was preparing a Request for Information (RFI) that would inform RFP specifications to clearly articulate the current state and desired future state of residential treatment.

A critical part of the revised residential treatment system is a standard assessment tool to ensure that all children and youth have access to the least restrictive - yet effective - treatment option. The development of the Comprehensive Assessment for Treatment (CAT) must address the model, financing, and workflow for both court/DCYF involved children and youth and those who are not involved with court/DCYF. The RFP for the developed model is expected to be issued in late 2020.

Mobile Crisis and Stabilization Teams for Children

Mobile crisis and stabilization is a nationally recognized approach to help children and youth with behavioral health needs remain in their home communities and reduce psychiatric hospitalization and residential placement. Where foster parents are involved, mobile crisis services can avoid placement disruptions for already traumatized youth. At the same time, mobile crisis and stabilization can provide parents and foster parents with opportunities for skill building.

In October 2019 a Request for Information (RFI) was issued to receive input on the efficacy and best practice standards for a fully integrated, statewide model for Mobile Crisis. This would include standards and best practices for adults, children and youth and for those with an opioid or misuse related crisis. The model development will include decisions and standards regarding a provider model, a finance model and best clinical practices for screening, assessment and triage, response and stabilization.

Expansion of the Care Management Entity Model - FAST Forward Program

High fidelity wraparound and intensive home-based services is a nationally recognized approach to serving children, youth and young adults in their homes, communities 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 through the FAST Forward program. Expanding the capacity of FAST Forward will assist DCYF in moving children and youth to less restrictive placements, and to facilitate moving kids to permanency, either reunification to home or another permanent option such as adoption. As of early 2020, the plan is to both renew the current CME contract and develop a second CME to expand capacity in 2020 and beyond.

Parent Information Clearinghouse and Treatment/Support Locator

This item is important to support families and caregivers to know where to find care and support and what type of care and support providers are offering. The vision is to have an online treatment locator for families, linked to the DHHS website. An RFP for this work is in development, possibly to be integrated with similar work happening with other Bureaus in the Division.

Evidenced-Based Practice Technical Assistance and Training

Overlapping with the parent information clearinghouse, this resource would add models and evidence-based components to the listings of providers and their associated treatments or supports. BCBH determined that because of this overlap, incorporation of this work with the parent information clearing house is most the most efficient use of resources and will achieve identified goals. The current version of the draft RFP is inclusive of both requirements.

Prevention/First Episode Psychosis

BCBH and Bureau of Mental Health Services is in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis specialty care program. The expectation is that implementation and procurement activities will begin in late 2020.

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

This initiative is funded through a Cooperative Agreement between the, NH Department of Health and Human Services (Bureau for Children's Behavioral Health), and the Adolescent and Transitional Aged Youth Treatment Implementation grant program of the federal Substance Abuse and Mental Health Services Administration

(SAMHSA). Awarded in 2017, the grant supports evidence-based SUD assessment, treatment, and recovery services for youth aged 12-25 throughout the state. The NH Bureau for Children's Behavioral Health leads the project in collaboration with family, youth, research, and content experts.

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 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.

Regional SoC Initiatives

The regional projects described below all contribute momentum, local innovation, and synergy to NH's System of Care movement.

NHSoC/FAST Forward 2020

As described in Section II, the project currently known as the NH System of Care (NHSoC) is the most direct successor to the Fast Forward project that launched NH's SoC efforts. The two primary intervention strategies of the NHSoC are 1) promotion of the Multi-tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model in schools and 2) family-driven, team-based care coordination ("Wraparound") for students/families with the most complex needs (see NHSoC logic model below). MTSS-B was designed to promote the behavioral health of NH public school students by blending research-based school mental health practices and social-emotional learning with Positive Behavioral Interventions and Supports (PBIS). MTSS-B teaches school-wide behavior expectations to all students (Tier 1), offers targeted group support for at-risk students (Tier 2), and provides individual services for the highest-need students (Tier 3). The Wraparound component of the NHSoC further addresses the needs of Tier 3 students by convening a team of service and support providers from both school and community - including the youth/family themselves - to coordinate care (see logic model on next page).

Three years into its four-year funding period in late 2019, NHSoC was making substantial progress in securing the foundations for a sustainable SoC across the seven participating school districts. The impacts of the NHSoC initiative can be summarized in three domains: policy/fiscal environment and other infrastructure; fidelity, access, and outcomes of the MTSS-B component; and fidelity, access, and outcomes of the Wraparound component.

Policy/fiscal environment and other infrastructure

Advances in the policy/fiscal arena include the aforementioned 10-year Mental Health Plan and associated state budgetary priorities, passage of SB 14 and associated SoC infrastructure, and the development of a robust Medicaid benefit for wraparound care. Collaborations among child and family serving agencies in public and private sectors have already yielded more formal inter-agency agreements to support the SoC than was anticipated for the entire 4-year project.

Efforts to enhance practice quality have shown the greatest success with training of professionals in mental health interventions; areas still in need of improvement include accountability mechanisms, and engaging and empowering youth and families to provide mental health related services and lend more voice to practice improvement feedback loops.

Fidelity, Access, and Outcomes of the MTSS-B Component

The NH DOE's Bureau of Student Wellness - Office of Social Emotional Wellness provides implementation guidance to NH districts through the MTSS-B "toolkit," which includes instruments for monitoring program fidelity. Fidelity has to do with intervention integrity – the degree to which a practice is implemented in a way that is faithful to the guiding model. Successful replication of targeted program outcomes has often been shown to depend on maintaining fidelity to critical program components, yet implementers tend to unwittingly "drift" from an intervention model in the absence of fidelity assessment. MTSS-B fidelity scores indicate that as of late 2019, about a third of implementing schools had reached fidelity benchmarks for central elements of the MTSS-B model. The challenges of achieving and sustaining implementation fidelity should not be underestimated.

School climate indicators include school staff and family member ratings of the learning environment, peer and staff relations, parent involvement, school safety, and other items. In the implementing schools, areas of strength included strong academic standards, sense of physical safety, and clear behavior expectations; areas needing improvement centered around respectful relationships, parent engagement, and fair and consistent handling of problem behaviors. Overall, school climate outcomes were making progress toward the NHSoC targets.

Fidelity, Access, and Outcomes of the Wraparound Component

Referral and enrollment processes were examined as indicators of both fidelity and access to the service. To date, NHSoC eligibility is determined within two weeks of referral 45 percent of the time, slightly below the interim benchmark. NHSoC's performance in this regard is promising, given the wide range of personnel, models, and processes involved in eligibility determination across districts. NH SoC quickly enrolls those families who are eligible and interested in wraparound; 86 percent of families who eventually enroll in Wraparound do so within 60 days of referral. The referral, eligibility, and enrollment process will shift as wraparound is outsourced from school districts to NFI North's FAST Forward program over the next year. NH's Department of Health and Human Services handles all FAST Forward referrals and eligibility. Shifts in NHSoC referral and enrollment patterns bears watching as the transition plays out.

Additional dimensions of Wraparound fidelity monitored by the NHSoC included standards for documentation and team meeting processes; crisis planning; and family engagement. NHSoC attained its highest fidelity scores from team member ratings of the overall wraparound process, with 67 percent of cases meeting or surpassing the fidelity threshold on this measure. The people most directly involved in NHSoC Wraparound experience it as true to its core values and principles. More granular elements of wraparound adherence to meeting and documentation standards yielded lower but still within-range fidelity scores. The lowest fidelity ratings were in youth and caregiver experience of their team meeting processes, and the lag between enrollment and holding the first full team meeting.

In the domain of family engagement, NHSoC Wraparound is very successful initiating and maintaining a personal connection with families, but less so in developing and maintaining momentum with the team-based elements of the model; getting to, conducting, and staying in team meetings has been the most challenging part of the NH wraparound model to implement with fidelity thus far.

The ultimate purpose of Wraparound is to improve the lives of youth with significant behavioral needs and their families. As of the middle of 2019, a majority of Wraparound cases experienced reliably improved caregiver stress and youth-reported well-being: most families and youth who have engaged in NHSoC wraparound for at least six months feel better about their lives than they did at baseline. A smaller proportion of cases (slightly less than half) report reliable improvements in youth symptoms and functioning, and caregiver ratings of their own well-being. It is important to note that these were *interim outcomes* - the participants were still enrolled, and thus had yet to experience a full "dose" of the Wraparound intervention.

NH Project AWARE

NH Department of Education's Project AWARE initiative shared with the NHSoC the same school-based intervention framework, bringing MTSS-B to an additional set of 12 schools (later reduced to 10 by school closings)

in three North Country Local Educational Agencies: Berlin, Franklin, and SAU 7. Funded by a 5-year grant from the federal Substance Abuse and Mental Health Services Administration, AWARE concluded in 2019 after serving more than 2500 children per year of its implementation, however an additional 4 year award was provided by to continue and expand this work. Like NHSoC, NH AWARE made significant advances in the capacity to support the social-emotional well-being of students, linking 76 organizations in formal interagency agreements, providing training to assist teachers and other school staff better understand student behavior and respond with trauma-informed strategies, and training more than 4600 school staff and community members in Youth Mental Health First Aid. Interviews with key informants from each district attested to AWARE resulting in less stigma attributed to emotional distress, less punitive discipline, and more supportive and trauma responsive interventions.

Project AWARE Implementation

Schools typically initiate MTSS-B by establishing a Tier 1 team to develop and implement school-wide positive behavioral standards and disciplinary practices that help to align staff and student expectations. Newly introduced Tier 1 practices in AWARE schools included implementation of social-emotional learning (SEL) curricula, universal SEL screening for incoming kindergartners, mindfulness-based approaches, positive disciplinary practices, and family engagement and outreach efforts. Tier 2 programming targets students who need additional social-emotional support or skills, but don't require individualized services. In NH AWARE, Tier 2 services mostly 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. Many schools implemented "Take A Break" spaces to give struggling students space to quietly reflect and self-regulate, in lieu of punitive discipline. Other districts developed afterschool programs that provided a safe, nurturing space for students in need of additional support. Tier 3 consists of individualized interventions for the most emotionally distressed students and their families, so that students receive more of the supports they need while relieving pressure from classroom teachers. Tier 3 interventions included school-based mental health, facilitated referrals to community mental health care, and Wraparound care coordination. Monitoring data revealed that fidelity steadily improved for all intervention tiers over the course of the project, yet only a minority of schools reached the fidelity targets by its conclusion. Tier 1 implementation led the way, while Tiers 2 and 3 lagged.

School and Student Outcomes Improvement

The shift from student problem behavior and punishment to underlying needs, strengths, and wellness was viewed by key informants as a major contributor to improved school climate and culture, and one of the biggest impacts of NH AWARE. As professional development and MTSS-B implementation advanced, staff came to feel more understanding and compassionate about the backgrounds and dynamics influencing student behavior, which strengthened student-staff relationships.

Interviewees reported that positive disciplinary practices created a sense of predictability and order while proactively eliciting and reinforcing prosocial student behavior. As problem behaviors decreased, instructional time in the classroom increased. 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.

Universal (Tier 1) SEL and targeted (Tiers 2 and 3) mental health services were transformative for traditionally hard-to-reach students, providing them with tools – such as mindfulness – to self-regulate in the classroom. Students also learned to better communicate their needs to teachers; in turn, as teachers better understood the motivation behind student behaviors, student-teacher relationships improved and mutual trust grew. Teachers who witnessed these changes became champions of SEL, promoting it to their peers. Even parents who were "late adopters" of the SEL mindset came around when they experienced the benefits of students bringing breathing and yoga exercises back home.

Wellness narrative undercuts stigma

The introduction and widespread dissemination of Youth Mental Health First Aid training was credited with opening up the conversation about youth mental health, cutting through the shame and silence that all too often accompanies the topic. The presence of community mental health providers as a “regular” part of the school community and culture was also viewed as reducing mental health stigma. Students openly talked with each other about seeing school-based mental health providers. NH AWARE was also credited, along with other MTSS-B and “system of care” initiatives, with contributing to a more supportive community and state policy environment. Stakeholders reported that these projects, by bringing together schools and communities via Community Management Teams and other collaborations, improved community awareness and support for SEL and children’s behavioral health. This, in turn, was viewed as supporting passage of the “System of Care” bill (RSA 135-F), which requires NHDOE and DHHS to work together to create a better, more cohesive system of care for NH youth with behavioral health needs.

School Climate Transformation Grant

The NH Department of Education, through its SEA School Climate Transformation Grant, has two primary goals: 1) to develop, enhance, and expand a statewide system to support the use of NH’s Multi-Tiered Systems of Support for Behavioral Health and Wellness (MTSS-B) model by LEAs to improve school climate and 2) to support the use of best practices to support positive school culture and climate across the state through partnerships between local communities and Office of Social & Emotional Wellness staff, especially MTSS-B consultants, and local communities. During the reporting period, considerable progress was made in advancing these goals including developing and launching the first ever train-the-trainer for NH’s MTSS-B model, recruiting and hiring state-level MTSS-B consultants, and delivering evidence-based external coaching support to numerous local school districts.

The three MTSS-B Consultants to serve the South West, South Central, and South East regions of the state within the NH Department of Education’s Bureau of Student Wellness. The consultants developed a comprehensive plan relative to the provision of technical assistance, training and ongoing coaching and support to participating LEA’s in their own comprehensive MTSS-B planning. The DOE’s BSW-OSEW plan includes short and long-term goals for regional communities of practice centered on school culture and climate, and identification of opportunities to enhance and expand the state-wide systems of support, or “systems of care” for LEAs and schools implementing the MTSS-B framework for improving behavioral outcomes and learning conditions for all students.

Launch Manchester

Coordinated by Amoskeag Health, Launch (Linking Actions for Unmet Needs in Children’s Health) promotes the well-being of children from birth-8 and their families in collaboration with multiple local child and family serving agencies. The primary strategies are improving access to high-quality early education and care; empowering families; identifying and mitigating the effects of Adverse Child Experiences; and improving access to health, behavioral health, and specialized medical services. In 2019, Launch Manchester developed an Early Learning Collaborative of 12 early childhood programs and the Manchester School District to support transitions into kindergarten, implement developmental screenings, and facilitate access to appropriate supports. The hope is that coordinating transitions will maximize the preservation and expansion of academic and developmental skills these children have attained in early childhood settings. Also in 2019, Launch laid the groundwork for a public awareness campaign through early childhood settings, primary care offices, hospitals and other public spaces.

Amoskeag Health also hosts the Adverse Childhood Experiences Response Team (ACERT), which deploys a mobile team to serve children who have been exposed to violence. Consisting of a police officer, a crisis services advocate, and a behavioral health professional, the team provides rapid assessment and referral to appropriate community supports. As of the close of 2019, Manchester’s ACERT has connected some 1100 children with services.

Project Launch joined with several other agencies in 2019 to conduct a family services needs assessment funded by the Community Collaborations to Strengthen and Preserve Families grant.

Monadnock Region System of Care

In 2016, the County of Cheshire was awarded four years of funding to implement a Monadnock Region System of Care (MRSoC), focused on the Wraparound component of the NHSoC/Fast Forward model. MRSoC began serving youth and families early in 2017, and was thus approximately three-quarters of the way through its funding period at the time of this Year 4 Report. The organization of the MRSoC maps closely onto NHSoC wraparound, aiming to improve the lives of children/youth with serious emotional disturbance and their families by 1) creating a more supportive community environment; 2) improving the behavioral health service and support array; and 3) implementing wraparound care coordination with fidelity. Successful implementation is expected to result in a more stable, sustainable SoC environment and a more cohesive and cost-effective array of services and supports. All of this hinges, among other things, on being able to hire and retain high quality MRSoC staff, access to high quality services and support in the community, integration of System of Care values (e.g., youth and family driven, culturally and linguistically competent) throughout the system, and the ability to engage Monadnock area youth and families at all levels of this work.

Policy/fiscal environment and other infrastructure

Nested within a strongly prescriptive state-level policy and fiscal matrix, regional adaptations of the NHSoC strategic framework are downstream beneficiaries of all developments that enable the “parent” initiative. All of the infrastructure achievements described for the NHSoC either directly apply at the regional level or provide models that can be re-scaled from state to local levels. Thus, the 10-Year Mental Health Plan, passage of SB 14 and associated SoC infrastructure, establishment of the Bureau of Children’s Behavioral Health within DHHS, and the introduction of a Medicaid benefit for wraparound care all created an enabling context for the launch of the MRSoC. The primary policy concern for the MRSoC in the early years of its implementation grant was the development of Governance Board bylaws, which it had achieved by the end of 2018. MRSoC made rapid early progress engaging stakeholders and developing partnerships, thanks in part to a one-year planning grant that preceeded the implementation grant, but also due to strong leadership and relationships within the region and between the county and the state.

Service and support array

Wraparound requires access to a robust array of peer supports and professional services to effectively meet the needs of youth with significant behavioral health concerns and their families. MRSoC had some notable early successes injecting new services in portions of their region: engaging and utilizing Family and Youth Peer Support Specialists and others with lived experience in their work; offering a home-based family therapy program in the Jaffrey area through partnership with the Marriage and Family Therapy program at Antioch University New England; and supporting implementation of the Youth Organized and United Towards Health (YOUTH) program to help youth with behavioral health needs engage in healthy behaviors at home and in the community. Yet the scope and reach of these programs is quite limited and youth and families continue to encounter a fragmented behavioral health system with significant practice gaps (e.g., mobile crisis, respite), and access barriers (e.g., long wait times). Changing the service array at a regional level is challenging, since it is strongly tied to state policies and reimbursement rates.

Practice Drivers

Training, coaching, leadership and organizational alignment, and performance monitoring and oversight are drivers of effective behavioral health practice. MRSoC excelled in disseminating training for service providers, and in monitoring the quality of training, coaching, and organizational support for the wraparound component of the service array.

Enrollment, engagement, fidelity, outcomes

MRSoC experienced early challenges making prompt eligibility determinations (within two weeks of receiving referrals). They were more successful in ultimately enrolling approximately half of families referred within two months. Once enrolled, most families were adequately engaged with their coordinator (2/3 had at least one meeting per month) and enrolled long enough to benefit from the process (more than 90% stayed enrolled for at least six months). Only about 1 in 5 reached the goal of meeting their full wraparound team monthly, and only 1 in 3 successfully graduated from wraparound.

MRSoC monitored the same wraparound fidelity indicators as NHSoC. Like NHSoC, MRSoC yielded its strongest fidelity scores in fulfillment of the overall wrap process; that is, the people most directly involved experienced MRSoC as true to its values. While youth/family rated their experience of MRSoC team meetings as very favorable, more granular elements of adherence to wraparound meeting and documentation procedural standards yielded lower scores. The challenge facing the MRSoC is to increase the rigor of the wraparound practice, without detracting from the experience of youth and families.

Shifting to outcomes, approximately one year into implementation in early 2019, over half of Wraparound cases were reporting reliably improved caregiver stress and youth-reported symptoms/functioning after at least six months of participation in the program. Approximately a third reported reliable improvements in subjective well-being. In reporting these results, the program evaluators advised that only a small fraction of MRSoC families had yet been enrolled for long enough to be included in these analyses, the "reliable change" computation is a stringent standard, and like the results reported for the NHSoC, these were *interim outcomes* - the participants were still enrolled, and thus had yet to experience a full "dose" of the Wraparound intervention.

Manchester System of Care

As 2019 drew to a close, the City of Manchester Health Department was awarded a four-year grant by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to implement the NH Wraparound Practice model in NH's most populous city. The project will target children aged 0-8 with serious emotional disturbance and their families, building an infrastructure to screen for, assess, and address unmet socio-emotional, behavioral, and mental health needs. As such, the ManSoC would be aligned with the strategies developed by NHSoC/Fast Forward, with modifications for Manchester's priority population. The ManSoC was poised to begin serving families early in 2020.

Early Intervention / Prevention Initiatives

The projects described in this section are not direct successors to the NHSoC, but contribute early intervention supports that are clearly aligned with and will contribute synergies to the SoC movement in NH.

Mobile App GoodLife (2019): During the reporting period the DOE partnered with NextStep Health Tech to begin the planning and development of a GoodLife, a mobile application designed to build and strengthen student social and emotional resilience. The GoodLife's app design will ensures that all students across New Hampshire and their families have access to evidence-based resilience cultivation tools. It aligns with the System of Care values by providing a youth driven platform where adolescents are empowered to set goals, join communities of support, and share positive messages with their peers.

The app will additionally be trauma informed in accordance with the SoC values, and builds resilience skills in youth such as empowerment, support, commitment to learning, and positive identity. The app will allow students to join communities, set physical and emotional development goals, and send and receive positive feedback.The GoodLife app is built on the Search Institute's 40 Developmental Assets for Adolescents, a list of research-based, positive experiences and qualities that influence young people's development, helping them become caring, responsible, and productive adults. GoodLife anonymizes the identity of users, and does not collect any personally-identifiable information. NextStep GoodLife is available free to all NH youth and their families through Google Play and the Apple App Store.

Project GROW

More than 1 in 5 adults report a history of 3 or more adverse childhood experiences (ACEs). Nearly half of children under 17 in the U.S. experience at least one ACE; 22.6% experience two or more. Children in New Hampshire parallel national trends, with 33% having one or two ACEs and 12% with three or more. Through a Learning Community effort known as Project GROW (Generating Resilience, Outcomes, and Wellness), the NH DOE's Bureau of Student Wellness - Office of Social Emotional Wellness (OSEW) has been providing expert training, consultation, and technical assistance to school districts in MTSS-B aligned, trauma-responsive practices, including district-wide systems change, school-level adoption of new practices and procedures, classroom-level instructional and student support techniques, and individual teacher and specialist professional development. These Project GROW efforts are all designed to promote student social and emotional safety, and thus contribute to the Children's SoC ecosystem.

Beginning in 2017-18, under the leadership of the NH Department of Education's Bureau of Student Wellness, six NH school districts began implementing the Trauma-Responsive Schools (TRS) framework through Project GROW: Bethlehem, Concord, Hampton, Hopkinton, Laconia, and Merrimack. Schools participate in the project for three years, receiving training and professional development and ongoing consultation and technical assistance during that time. As of Fall 2019, GROW districts had completed two years of TRS implementation.

1. Create school districts/systems that promote optimal social, emotional, and academic outcomes for students and staff;
2. Facilitate a cross-district learning community that equips participants with the capacity and motivation to develop trauma-informed learning communities within their own site;
3. Increase staff capacity to deliver trauma-informed interventions and instruction;
4. Develop a model for implementing the TRS framework in NH schools;
5. Improve student and staff sense of safety;
6. Promote positive relationships among students, staff, families, and community;
7. Decrease discipline referrals, suspensions, critical incidents, and expulsions.

Specific aims of Project GROW

The TRS framework helps school staff understand the neuroscience and impacts of trauma and how to address student needs that underlie distressed behaviors while providing access to comprehensive, evidence-based mental health supports and services and improving school climate. Non-mental health professionals are trained to take a gentle, inquisitive, and trauma-informed approach to understanding the "why" behind challenging behaviors. Educators work collaboratively with students, caregivers, and colleagues to decipher the impacts of traumatic exposure to develop a benevolent and developmentally informed explanation for behaviors that are often misread as defiant or abnormal. Educators come to recognize the physical, emotional, and social signs of adversity, as well as the underlying negative thinking that is often instantiated by traumatic experiences, ultimately equipping them to respond to students with validation and empathy rather than defensiveness or dismissiveness.

GROW provides expert training and consultation to implement the TRS framework. This involves a trauma-responsive organizational and self-assessment, staff professional development, policy and practice transformation, and program evaluation. The TRS framework guides schools in implementing trauma-responsive practices across five domains with applications across three tiers, aligned with the MTSS-B model.

Stages of GROW implementation

GROW began with up-front training and professional development designed to support the acquisition of knowledge and skills necessary for development of a trauma-responsive stance, as well as school/district policy and practice change aligned with trauma-informed care principles. GROW districts also immediately engaged in a formative assessment phase at both individual and organizational levels, utilizing self-assessment tools that assist districts in setting goals, measuring progress, and informing decision making. Project GROW is conducted using a Learning Community (LC) format. Interdisciplinary teams from six school districts convene in in-person and virtual learning spaces to share their successes and challenges in implementing the TRS framework in their schools.

At the individual level, the process begins with a baseline assessment of trauma-informed knowledge, beliefs, and practices. In a parallel manner, formative assessment at the organizational level begins with each district inventorying TRS practices that are already in place across the five domains and three tiers of implementation. This provides districts with 15 individual areas for implementation from which they prioritize initial areas of focus through a ranking process. Once priorities have been determined, districts track their progress in detail in each area. Together, the tools used to guide this process provide necessary data to support decision making, self-reflection, and quality improvement throughout the implementation process.

GROW evaluation focuses on indicators of implementation success

To date, Project GROW evaluation has focused on the level and quality of TRS implementation across districts. Qualitative surveys of the GROW LCs during the first two years of implementation yielded the following themes concerning participant experience:

GROW inspires practice change. GROW has clearly felt transformative for the majority of participants. LC members overwhelmingly endorse the notion that GROW has led to school practice change.

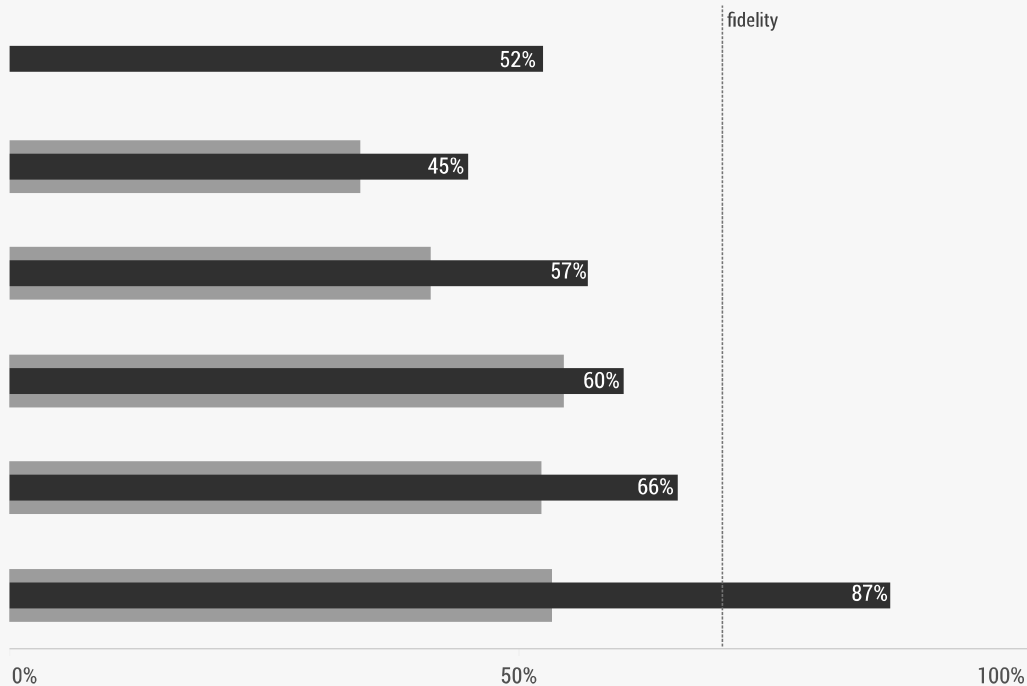
GROW inspires systemic change in NH schools. LC participants report major shifts in their attitudes and beliefs, especially in terms of a new understanding of what has been traditionally characterized as “problem” behavior. In turn, this LC-inspired mindset has helped participants approach students in new and different – and far more trauma responsive – ways. Increased commitment, cross-fertilization between districts/schools, creative thinking, and understanding students “beyond the surface” were all hallmarks of this shift.

LC member input improves GROW. Recently, many LC members have called for a greater emphasis on train-the-trainer initiatives to support on-the-ground implementation and sustainability of trauma-responsive school practices. Helping them maintain momentum, develop more internal capacity and expertise, and a sense of self-sufficiency were major suggestions for the year ahead.

The GROW evaluator, the Behavioral Health Improvement Institute at Keene State College, developed the Trauma-Responsive Schools (TRS) Fidelity Tool for districts to self-assess their progress adopting the TRS framework. Each district GROW team completes the TRS Fidelity Tool as a group, discussing and coming to consensus on scoring of each item. Participating districts conducted a baseline assessment using the TRS Fidelity Tool in 2017-18 and reassess fidelity annually to determine areas in need of continued development.

Each item is scored based on degree of implementation (0 = not implemented, 1 = partially implemented, 2 = fully implemented). The percentage of total points possible is used to summarize level of implementation at the domain and total score levels. A score of 70% or above at the domain, tier, and/or overall level is considered high-fidelity TRS implementation.

The chart below shows overall fidelity to the TRS framework by district over the past two years of GROW implementation, with the exception of the Hampton School District, which only completed the full fidelity tool in the most recent year (2018-19). Clearly, districts have increased their overall fidelity to the TRS framework in the first two years of GROW.



Preschool Development Grant - Birth through 5

In 2019, the University of NH and the NH Departments of Education (NHDOE) and Health and Human Services (NHDHHS) secured a one-year planning grant from the United States DHHS to develop a strategic plan to create a comprehensive and coordinated early childhood care and education system. Near the end of 2019, NH was notified that their application for a follow-up implementation grant was successful, providing $26.8 million over three years (2020-2022) to bring the strategic plan to life. This implementation grant application outlined six plan activities:

During the reporting period plans were well underway to conduct a Statewide Needs Assessment to inform the development of the Statewide Strategic Plan that will guide the work of the Preschool Development Grant. The feedback from this survey will be disseminated in early 2021. There are several goals of this collaborative initiative including Maximizing Parent and Family Knowledge, Choice, and Engagement in Their Child's Early Learning and Development; Sharing Best Practices and Monitoring, Evaluation and Data Use for Continuous Improvement

An integral part of this initiative is the collaborative efforts between the NH Department of Education and NH Department of Health and Human Services in the creation of NH's Early Childhood Integration Teams (ECITs) in each agency. These ECITs will work to inform the work of the Council for Thriving Children.

Established by Executive Order 2020-03, the Council for Thriving Children, is New Hampshire's advisory council on early childhood care and education and is co-led by the Departments of Health and Human Services and Education. The Council is responsible for advising, making recommendations, and undertaking the following:

- Strengthen New Hampshire's early childhood infrastructure in all environments, including, home, childcare, schools and community settings.

- Build the capacity of families, professional and non-professional caregivers and educators throughout the state to meet the important health and educational needs of our children
- Ensure an integrated and coordinated early childhood governance structure across state government and connected to local communities by ensuring ongoing needs assessment and strategic planning
- Enhance the interoperability of data systems within and across government agencies to inform and monitor program and service access, equity, and quality
- Promote parent knowledge and choice through sustained family and community engagement, support, resources and feedback
- Ensure the sharing of best practice by establishing and sustaining a Center for Excellence and local/regional forums that support parents, professional caregivers, educators, and community members
- Expand access and equity, and improve transitions for children and their families across the span of early childhood supports, services, and educational environments.

Infant Mental Health Plan

In accordance with both RSA 135-F, which established the SOC, and RSA 132:13, which supports services for maternal and infant needs, NH DHHS and stakeholders participated in an Infant and Early childhood finance strategy TA group through the Zero to Three national policy organization. This work included a work plan on how NH would address and finance this work. The goals are to develop a comprehensive Medicaid benefit to address the needs of infants and young children who have been identified as at risk and who require treatment and support for themselves and their primary caregiver. The program focuses on:

- Parent/child relationships;
- Address any early mental health challenges;
- Provide support to families with young children with identified Mental Health challenges;
- Provide support and education to the parent/caregiver to prevent future abuse and neglect;
- Allow for dyadic assessment and eligibility for at-risk infant/children and families to permit broader access;
- Allow for increase units to support the dyadic assessment/eligibility;
- Train providers and allow the use of the DC 0-5 diagnostic manual for eligibility and access to services for infants and young children;
- Allow for Z codes in the absence of a more appropriate diagnostic code for treatment services;
- Allow for an enhanced rate to support the dyadic treatment of child and caregiver using models such as CPP;
- Re-establish broader access to home visiting services with prior established treatment codes and refreshed rates;
- Increase the number of infants/young children receiving treatment and supportive services.

Part 3: Expenditure Data for Year 4

Previous reports under RSA135-F have presented costs for children’s behavioral health services in the form of (1) DHHS and DOE expenditures attributable to meeting children’s behavioral health needs; and (2) a survey of local schools concerning personnel and contracts associated with creating a system of care, providing behavioral health services and supports to students, and professional development undertaken by educators to meet system of care

aspirations. The school survey was not administered in 2019, so we are unable to update estimates associated with that survey, which summed to approximately $6M in Year 3. DHHS and DOE expenditures are summarized below. The DHHS and DOE expenditures combined, total more than 127 million dollars compared to year 3 total of just over 126 million dollars.

DHHS Expenditures

Expenditures are reported for four areas of DHHS: Division of Children, Youth, and Families (DCYF), Division of Behavioral Health (DBH), and Bureau of Developmental Services (BDS) and Medicaid. Using State Fiscal Year 2018 data, the expenditures are as follows:

Division for Children, Youth, and Families

DCYF Non-Medicaid dollars	
Age 13-18	$3,573,992
community-based service	$122,432
General Funds	$87,135
Title IV-A	$35,297
out of home service	$3,451,560
General Funds	$1,505,822
Title IV-B	$7060
Title IV-A	$833,785
Title IV-E	$1,104,893
Age 6-12	$905,840
community-based service	$42,121
General Funds	$11,776
Title IV-A	$30,345
out of home service	$863,719
General Funds	$334,523
Title IV-B	$2,683
Title IV-A	$221,091
Title IV-E	$305,422
Grand Total	$4,479,832

DCYF Medicaid Dollars	
Ages 13-18	
Community-based service	
out of home service	$17,522,182
Ages 6-12	
Community-based service	
out of home service	$12,903,098
Ages birth-5	
Community-based service	
out of home service	$696,966
Grand Total	$31,122,246

Mental Health Services for youth at SYSC	$16,656

Division for Behavioral Health/Medicaid

Estimated NH Medicaid Provider Payments for Children's Behavioral Health Services- SFY 2018				
Age of Children	Community Based	Non-Community Based	Pharmacy	Total
0 to 5	$5,934,724	$55,855	183,703	$6,174,282
6 to 12	$26,362,472	$2,480,639	7,668,135	$36,511,247
13 to 18	$20,513,453	$4,793,341	6,515,192	$31,821,986
19 to 20	$2,875,479	$1,324,020	1,088,683	$5,288,182
Total	$55,686,128	$8,653,855	$15,455,714	$79,795,697
Notes				
Data Source: NH MMIS & NH PAP as of 11/30/19				
Community Based Includes Non-Residential Professional Services				
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 non BH use)				
New methods have been used to produce this data that may make some components not directly comparable to prior reports				

Medicaid Home and Community Based waiver services and DCYF services are excluded

Expenditures funded by the Bureau of Drug and Alcohol Services using the federal block grant

Substance Use Disorder Prevention Programming		Drug and Alcohol Block Grant expenditures for treatment services		
Age of children	Amount	Age of Children	Community-Based amount	Non Community-Based amount
6-12	$964,548	Birth-5		
13-18	$2,408,994	6-12		
Total	$3,373,542	13-18	$1,100	
		19-21	$37,220	
		Total	$38,320.00	

DOE Expenditures

DOE expenditures are presented for selected federal title programs, and for federal competitive grant programs led by the Office of Social & Emotional Wellness. It must be acknowledged that these categories of funding represent but a thin slice of expenditures on children's behavioral health. The priority accorded to local control in NH's educational system presents challenges to compiling cost estimates beyond the scope of state-level agencies. Local property tax dollars, federal grant funds received by local communities, private foundation funds, and philanthropic donations are not aggregated or monitored by any single entity. The data presented here, then, represents a narrow set of readily quantifiable funding sources.

Federal Entitlement Programs	
Title II	$180,000
Title IVa	$1,240,000
Title IVb	$5,300,000
IDEA	$355,000
Total	$7,075,000

Federal Competitive Grants	
Project Aware	$1,798,531
System of Care Sustainability and Expansion	$3,000,000
School Climate Transformation	$699,414
Total	$5,497,945

Part 5: Limitations

As has been the case throughout all four years of reporting under the System of Care Act, the greatest challenge has been approximating estimates of the “costs” of children’s behavioral health services in the state, when the true costs are distributed beyond our capacity to monitor. As in other years, we have again interpreted “cost” narrowly, defining it as the sum of state expenditures that have a primary focus on the promotion of children’s behavioral health. Specifically, we estimate fiscal year expenditures, and note that this might not capture more periodic investments.

Additionally, these expenditures illustrate only what was spent, not what the actual costs of services would be if made fully available. Perhaps more importantly, such a definition of “cost” does not entail those human and societal costs that result from unmet behavioral needs. Ultimately, such an inquiry is beyond the scope of this report.

Additionally, the detailed expenditures presented in this report reflect state and federal funding exclusively, as these are the only levels at which such fiscal data are readily available. School districts and communities do receive funding from other sources, such as local taxes, grants, and contributions from local businesses and philanthropic organizations. The total spending on child behavioral health services from these local sources is assumed to be substantial, but ultimately cannot be included here.