New Hampshire

UNIFORM APPLICATION
FY 2024/2025 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 06/19/2024 12.53.09 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID LA2HR1U97VC6

I. State Agency to be the Grantee for the Block Grant

Agency Name Bureau of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address 105 Pleasant Street

City Concord

Zip Code 03301

II. Contact Person for the Grantee of the Block Grant

First Name Julianne

Last Name Carbin

Agency Name Bureau of Mental Health Services, Division of Behavioral Health, NH DHHS

Mailing Address 105 Pleasant Street

City Concord

Zip Code 03301

Telephone 6032715007

Fax

Email Address Kerri.R.Swenson@dhhs.nh.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/1/2023 11:48:19 PM

Revision Date 6/19/2024 12:52:21 PM

VI. Contact Person Responsible for Application Submission

First Name Kerri

Last Name Swenson

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Email Address Kerri.R.Swenson@dhhs.nh.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

BSCA Funding Plan 10.24.2023

The following narrative and budget outline serves as a response to the Substance Abuse and Mental Health Services Administration (SAMHSA) Notice of Award for the Bipartisan Safer Communities Act. The New Hampshire Department of Health and Human Services (DHHS), Bureau of Mental Health Services (BMHS) serves as the State Mental Health Authority (SMHA) and therefore will be the applicant for this grant opportunity.

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Funding for Trainings

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Mental Health Block Grant – Bipartisan Safer Communities Act Award October 17, 2022 - September 30, 2024 **Total allocation $261,905.00**		
Budget item	**Proposed Allocation FY 23**	**Proposed Allocation FY 24**
Mental Health First Aid Training & Travel		$10,000
Critical Incident Stress Management Training		$120,000
Venue costs		$26.774
room rental and travel		$30,000.02
FEP Set-Aside (10%) NAMI-NH & HOPE Trainings, Travel, & Staff Stipends		$26,190.50
Administrative Set-Aside (5%)		$12,940.48
CISM-De-escalation Training		**$24,000**
Total Expenditure		**$261,905**

BSCA Funding Plan 10.24.2023 (updated 2.28.24)

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Budget item	**Proposed Allocation FY 24**	**Proposed Allocation FY 25**
Mental Health First Aid Training & Travel	10,000	$10,000
Critical Incident Stress Management Training	108,905	$108,905
Venue costs	26,774	$26.774
room rental and travel	30,000.02	$30,000.02
FEP Set-Aside (10%) NAMI-NH & HOPE	26190.50	$26,190.50
Administrative Set-Aside (5%)	12940.48	$12,940.48
Crisis (5%) Set aside	$13,095	$13,095
CISM-De-escalation Training	**24000**	**$24,000**
Total Expenditure	**$261,905**	**$261,905**

BSCA Funding Plan 10.24.2023 (updated 4.15.24)

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Updated on 4/15/2024

The above CISM training information will remain the same with a few exceptions. We will be offering two "CISM with children" trainings as the interest in this training was more than anticipated in round one of the BSCA funding.

New Hampshire is also working to set up a training hub to provide support with set up and organization of all trainings for the second round. This hub will coordinate with vendors, ICISF and MHFA staff as well as the SAMSHA MHBG Program Planner. By contracting with a vendor, we will be able to increase training attendance without systematic barriers. In round 2 of the CISM trainings, New Hampshire will be offering the training to first responders, law enforcement, DCYF staff and any mental health providers interested who were unable to attend in round one.

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Mental Health First Aid Training	$5,000	$5,000
Critical Incident Stress Management Training	$50,000	$50,000
Training hub (hotel, venue, food and set up)	$47,904	$50,000
FEP Set-Aside (10%) NAMI-NH & HOPE	$13,905.25	$13,905.25
Administrative Set-Aside (5%)	$6547.63	$6547.62
Crisis (5%) Set aside	$6547.63	$6547.62
Total Expenditure	$129,904.51	**$132,000.49**

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
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    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: ______________________

Signature of CEO or Designee[1]: ______________________

Title: ______________________ Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Julianne Carbin is still acting as the Director of Bureau of Mental Health Services as that position is vacant and Julianne was promoted to Deputy Director.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
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d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: JULIANNE CARBIN

Signature of CEO or Designee[1]:

Title: Deputy Director, DBH Date Signed: 08/29/23
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: JULIANNE CARBIN

Signature of CEO or Designee[1]:

Title: DEPUTY DIRECTOR, DBH

Date Signed: 08/29/23
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

August 28, 2017

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Formal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Mental Health Block Grant (MHBG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services (NH DHHS), which will serve as the State Mental Health Authority (SMHA). I authorize the NH DHHS Director of the Bureau of Mental Health Services, or anyone officially acting in this role in the instance of a vacancy, to administer transactions required for the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.governor.nh.gov/ • Email: governorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Julianne Carbin

Title

Deputy Director Division of Behavioral Health

Organization

NH DHHS

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

III: B. Planning Step 1:
Assessing the strengths and needs of the service system to address the specific populations.

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Further, in support of the Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, SAMHSA is committed to advancing equity for all, including people of color and others historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths is a need of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."*

System Overview

In State Fiscal Year (SFY) 2021, 3.5 % of New Hampshire's 2021 estimated population of 1,388,992 people: 49,091 individuals, including adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), were engaged in the public mental health system. This indicates an increase of 8.1% (n= 45, 424) of the served population from SFY18 (Source: U.S. Census and SAMHSA URS tables).

The New Hampshire Department of Health and Human Services (DHHS) is the largest agency in the New Hampshire State Government. It is responsible for the health, safety, and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families, and seniors and administers programs and services such as mental health, developmental disability, substance abuse, and public health.

New Hampshire, in compliance with the Social Security Act Title XIX §1900, has established a system of care for individuals with mental illness in a comprehensive system of care. The New

Hampshire Department of Health and Human Services (DHHS) is the agent for various Departments, Divisions, and Bureaus that ensure these functions.

As the State of New Hampshire Mental Health Authority (SMHA), the Bureau of Mental Health Services (BMHS) and Bureau for Children's Behavioral Health (BCBH) responsibilities include planning, coordinating services, contracting, regulating, and monitoring New Hampshire's system of public mental health services for eligible adults with a serious, or a serious and persistent, mental illness (SMI/SPMI) and children with a serious emotional disturbance (SED). These are the statutory populations the State MH system is required to assist. BMHS and BCBH oversee new program development and provide training and technical assistance to the community mental health system and their New Hampshire service system partners. This governance ensures the comprehensive, effective, and efficient system of services for persons with mental illness intended to reduce the occurrence, severity, and duration of mental, emotional, and behavioral disabilities and prevent mentally ill persons from harming themselves or others.

BMHS provides oversight, guidance, technical assistance, training, and monitoring for mental health providers statewide to ensure the entire continuum of recovery-oriented mental health services are available to State-eligible adults who experience a mental illness and/or a co-occurring mental illness and substance use disorder(s) and ensure that services are high quality, comprehensive and evidence-based.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care (SOC), provided with federal, state, and other public and private resources, to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community-Based Mental Health Services

The state is divided into ten designated community mental health regions. Each of the ten regions has a BMHS-contracted Community Mental Health Center (CMHC). CMHCs are private, non-profit providers contracting with BMHS to deliver designated behavioral health services in their specific geographic regions. All ten regions also have Peer Support Agencies (PSAs) providing community-based services and other community-benefit organizations.

Per New Hampshire's Administrative Rules and State Medicaid Plan, CMHCs are required to provide the following services, either directly or through a contractual relationship:

►Intake assessment

►Medication services, including psychiatric and nursing assessment

►Case management

►Individual service plan development and monitoring

►Discrete employment services for adults with mental illness, including evidence-based supported employment and Assertive Community Treatment (ACT)

►Mobile Crisis Services

►Protection of consumers' rights

►Mobile psychiatric emergency services

►Planning, coordination, and implementation of a regional mental health disaster response plan, which shall specify responsibilities and procedures

►Outreach to persons with mental illness who are homeless to engage such persons in the service system and provide non-office-based diagnostic and treatment services

►Services to emergency shelters and providers of services to homeless persons

►Collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options

► Individual, group, and family psychotherapy

►Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support

►Evidence-based illness management and recovery services, including those services provided in community settings

► NH Hospital (NHH) census management services, including a staff liaison who has NHH privileges and participates in NHH treatment and discharge planning meetings regularly

► Peer Support Services, including Crisis Respite beds,

►Specialized treatment services to eligible persons with mental illness and a concomitant alcohol and/or substance use disorder,

►Medication prescription and monitoring, oral and intravenous administration, and education

Crisis Services

The New Hampshire 10-Year Mental Health Plan (2019) called for transforming New Hampshire's crisis system. In 2019, New Hampshire began intensive planning to expand and integrate crisis

services across mental health and substance use disorder services and ensure all levels of crisis care were available to children, youth, adults, and families statewide.

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

The NHRRAP provides individuals in New Hampshire with immediate access to mental health and/or substance use crisis support via telephone, text, and chat services. The NHRRAP is the centralized crisis contact (call, text, chat) center designed as the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services twenty-four hours a day, seven days a week. NHRRAP also can deploy the closest available mobile crisis team promptly. Before the transformation, at least 20 numbers existed for someone in crisis. The goal of the NHRRAP was to have one number, regardless of the time of day and/or location of the caller, to call for behavioral health crisis support in New Hampshire.

The State contracted with Carelon (formerly Beacon Health Options) to provide the NHRRAP crisis contact center. Most calls (80%) are resolved at the "call" level. The NHRRAP number is 1-833-710-6477. 988 became the National Suicide Prevention Lifeline (NSPL) number on July 16, 2022 (with the former 1-800-273-TALK still in place). The main goal of 988 is to have a manageable number to remember, akin to 911. Headrest has been the contracted NSPL call center provider in New Hampshire for many years. Headrest continues as the primary call center for 988. A Memorandum of Understanding between Headrest and Carelon was also established to do a warm hand-off if necessary and provide backup. Headrest answers the calls that come into 988, and Carelon responds to texts and chats. There has been extensive work with the New Hampshire Department of Safety wherein protocols have been developed to identify and facilitate call transfers to the 988 system based on mutually developed level of care measures. The NHRRAP can also schedule "Same day/Next day" appointments for callers whose crisis does not meet a level of deployment and/or requests to be seen later (as long as a credible safety plan is in place). These appointments take place at the CMHCs.

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

remain stable and receive the necessary assistance within their community. NHRR teams are deployed via the NHRRAP using a virtual platform. Deployments are to the closest available team, expecting teams to arrive in person within one hour. If the closest team is busy with another deployment (or isn't fully staffed with two responders), the next closest team is deployed. If the caller requests telehealth, the closest team with telehealth capability is given the dispatch. A dispatch level is part of the deployment that indicates to the NHRR team if there are issues to consider before deploying. Levels three and four are recommended to include law enforcement as the primary responder or with the mobile crisis teams.

Four crisis apartment beds are available in the Nashua, Manchester, and Concord regions. Crisis Apartments serve individuals aged 18 years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to 7 days per episode and sometimes longer when necessary. The BMHS is working with contracted vendors to establish two Crisis Stabilization Centers in the state fiscal year 2024. One center will be located in Plymouth, New Hampshire. The other will be located in the southern part of the State. The Crisis Centers are for no more than 23 hours of stay and are designed for stabilizing symptoms, safety planning, initial linkage to services, and follow-up telehealth appointments.

Carelon Behavioral Health operates the NHRRAP on behalf of the New Hampshire DHHS and in partnership with the New Hampshire Community Behavioral Health Association. The NHRRAP provides individuals in New Hampshire with immediate, 24/7 access to mental health and/or substance use crisis support via telephone, text, and chat services.

In its first year of operation, from January 1, 2022, to April 2023, New Hampshire Rapid Response has:

- Answered more than 41,000 calls, texts, and chats from people in crisis
- Deployed to the community more than 9,650 times
- Fulfilled over 6,500 same/next day appointments

Inpatient Care

Inpatient services are currently provided at state-operated New Hampshire Hospital (NHH) and Hampstead Hospital facilities, through twelve general hospitals with voluntary inpatient psychiatric capacity, one community-based Acute Psychiatric Residential Treatment Program (APRTP), and six designated Receiving Facilities (DRFs) which are treatment facilities designated by the New Hampshire DHHS Commissioner to accept for care, custody, and treatment adults and youth involuntarily admitted to the state mental health services system.

- New Hampshire Hospital (NHH) is a fully accredited public state-operated acute-care psychiatric facility. It is operated independently of BMHS and has up to 160 inpatient beds. NHH is currently the only freestanding adult psychiatric facility in the State. It is managed in a clinical partnership with Dartmouth Health.
- Hampstead Hospital & Residential Treatment Facility provides up to 40 beds for child and adolescent inpatient and specialty residential services for treating serious psychiatric and behavioral disorders.
- In addition to NHH and Hampstead Hospital, the following are also approved as Designated Receiving Facilities for New Hampshire involuntary admissions:
    - Concord Hospital – Franklin in Franklin (10 beds)
    - Cypress Center in Manchester (16 beds)
    - Dartmouth Health in Lebanon (5 beds)
    - Elliot Hospital in Manchester (16 beds)
    - Parkland Hospital in Derry (4 beds)
    - Portsmouth Regional Hospital in Portsmouth (16 beds)
- A new 24-bed forensic psychiatric hospital has been funded by the legislature, with construction beginning as of August 2023 on the grounds adjacent to NHH and with completion slated for SFY 2026.
- A New Hampshire-based Solution Health and Acadia Healthcare Co, Inc. consortium has also announced plans for another new psychiatric hospital. This joint venture promises to build a 120-bed behavioral health hospital in southeast New Hampshire as part of a joint venture. It would comprise four adult psychiatric care units, each with 24 beds: a 24-bed child and adolescent care unit, a geriatric behavioral health unit, a courtyard, and a therapeutic outdoor space. Services will include mood disorders, trauma, thought disorders, and dual diagnoses that include substance misuse. Partial hospital programs and intensive outpatient services will be offered onsite. It is slated to open in 2025.

All these inpatient programs aim to reintegrate all persons into the community, and new protocols are being structured to strengthen the discharge transition planning process.

Case Management Services for Individuals Admitted to a Hospital

Managing the cases of SMI and SED individuals who have had psychiatric hospital admissions requires coordinated case management. CMHCs are responsible for case coordination, including coordination of client evaluation, treatment planning, discharge, and linkage with appropriate community services for those individuals who are existing CMHC clients. CMHCs follow the individual during their hospital stay, ensuring that services and support are established and maintained within the community.

Case managers maintain contact with community agencies and individuals to develop community resources other than those offered through the state mental health system and to encourage community support to the individual to foster a smooth transition to the community after discharge.

Case management throughout the CMHC system assures linkage with all necessary services and people involved in the recipients' care, coordinated service planning, and monitoring progress toward goals.

Long-Term Care Rehabilitative Services

The Glencliff Home serves Adults with SMI 60 years of age or older who meet the requirements for long-term care, which identifies the Glencliff Home as the least restrictive environment and provides the level of medical care the person requires.

The Glencliff Home consistently has a list of individuals waiting for admission. Staff and CMHCs also work with current residents to facilitate a successful transition back into the community for individuals identified and deemed clinically appropriate to transition to a lower level of care.

Medicaid Managed Care Organizations

New Hampshire contracts with three Medicaid Managed Care Organizations (MCOs). These contracts include provisions that MCOs maintain ongoing relationships with the 10 CMHCs within New Hampshire, ensuring services are reimbursable and supported. Each MCO submits a quarterly report that identifies cases admitted to a psychiatric hospital and readmitted within 30 or 180-day days after the initial readmission. The readmission report allows analysis and identification of service patterns that indicate a need for system wide improvement. Ongoing work is being conducted to update the report design to improve data integrity and better inform the presenting system opportunities, such as service gaps, how to respond to co-morbidities, and what service makeup is needed to support an individual within a community setting fully.

State Eligibility for Community-Based Services

New Hampshire’s current statutes and administrative rules detail BMHS’s authority. Through its provider network, BMHS maintains responsibility for the determination and redetermination of the eligibility of individuals for community-based mental health therapeutic and rehabilitative services, which are covered under New Hampshire's Medicaid State Plan Rehabilitation Option and Targeted Care Management Option. Eligibility determinations are conducted on behalf of the State by the designated CMHCs.

Employment Services

Public and Private Employment Services

New Hampshire’s Medicaid for Employed Adults with Disabilities (MEAD) program and the Supplemental Security Income (SSI) Plan to Achieve Self Support (PASS) program allows adults with disabilities, including mental illness, to work without losing their Medicaid eligibility.

The state has several employment services available through the New Hampshire Department of Employment Security (DES) and NH Works. Additional services are available through the Division of Vocational Rehabilitation (DVR) of the New Hampshire Department of Education (DOE).

Vocational Rehabilitation is a joint State/Federal program that empowers people to make informed choices, build viable careers, and live more independently in the community.

Work Incentive Coordinators at Granite State Independent Living (GSIL), a statewide private non-profit and New Hampshire's only Center for Independent Living assist individuals with disabilities who are interested in working while retaining their Medicaid eligibility. More than 51% of board members and staff at GSIL identify as individuals with disabilities.

Among adults served in New Hampshire's community mental health system in 2021, 55% of those aged 18–20 and 72.9% of those aged 21–64 participated in the labor force. The increased implementation of Evidence-Based Supported Employment in New Hampshire's CMHCs and New Hampshire PSAs and Clubhouse programs promotes recovery through employment.

Supported Employment

For nearly 20 years, all CMHCs have provided evidence-based Individual Placement and Support Supported Employment (IPS-SE) based on the Dartmouth model. The Olmstead Community Mental Health Settlement Agreement (CMHA) called for the State to expand its delivery of supported employment services, which includes providing individualized assistance in identifying, obtaining, and maintaining integrated, paid, competitive employment: The CMHA called for the State to increase its penetration rate of individuals with SMI receiving IPS-SE services to 18.6 percent of eligible individuals with SMI by June 30, 2017. As of March 2019, the statewide penetration rate was 21.6%; as of September 2022, the statewide penetration rate had increased to 26.4%, including 4410 individuals receiving supported employment out of 16,684 eligible individuals. (Source: New Hampshire Community Mental Health Agreement Quarterly Data Report: July-September 2022)

Supported Employment is emphasized in the CMHA as an integral part of the Assertive Community Treatment (ACT) program. It is embedded in the requirement for improved discharge and transition planning from Glencliff Home and New Hampshire Hospital.

Housing Services

One of the most significant challenges individuals with mental illness face is the inability to secure and maintain safe, affordable housing. Limits on income and transportation are two common barriers to finding housing in safe, accessible neighborhoods. Everyone's needs are different; therefore, various housing options need to exist to meet the support needs and housing preferences of diverse individuals with mental illness. Stable housing is an integral part of recovery. Although

it may take some time to find the right home, New Hampshire has several programs described here to help people access the housing opportunities appropriate to the level of care they need.

Residential Treatment and Supported Housing
BMHS partners with the ten CMHCs to deliver residential services and support to adults, providing 1010 supported housing beds. (Source: New Hampshire Community Mental Health Agreement Quarterly Data Report: January-March 2023)

The Housing Bridge Subsidy Program (HBSP) is a supportive housing program currently funded to serve up to 500 individuals across New Hampshire. HBSP services include Housing Specialists assigned to each individual in the program. The Housing Specialist will assist the individual in finding an appropriate unit, sign and understand their lease, and ensure they are connected to any community supports and services the individual requests or requires. Individuals on HBSP are expected to transition onto a Housing Choice Voucher through HUD within 2 to 3 years of entering HBSP. The Housing Specialist will assist them with the transition to vouchers and remain available to the individual should they require further housing assistance.

BMHS has partnered with the New Hampshire Housing Finance Authority to manage the Project Rental Assistance Section 811 Program (PRA811). This is a permanent housing program, and recipients can access the complete support services the CMHCs provide. PRA811 provides the individual with a safe, affordable place to live and the availability of support services in the community to keep them safely housed and connected with their healthcare providers

Transitional Housing Programs (THP)
New Hampshire DHHS, directly and through a contracted provider (NFI North, Inc.), offers THP to serve the clinical, medical, vocational, and residential needs of adult men and women with mental health issues. The goal is to help individuals successfully transition from New Hampshire Hospital into the community and maintain their independence in the least restrictive environment possible. There are 95 transitional housing beds throughout New Hampshire, located in areas such as Concord, Manchester, Bethlehem, and Bradford, New Hampshire. Natural and community support systems are engaged to increase community integration and connectedness for individuals.

The New Hampshire Transitional Housing Programs provide:

- Services designed to be responsive to the individual's unique needs and to engage natural effectively and community services support systems so that community integration is wholly obtainable.
- Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational and day treatment services.

- Support for community connectedness and family involvement.
- Open communication with families and individuals.
- A comprehensive approach to service delivery driven by consumer involvement.
- Evidence-based practice approaches that include Illness Management and Recovery and IPS/Supported Employment.

HUD-funded Continuum of Care (COC)

The HUD CoC Program interim rule consolidated the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) program, and the Section 8 Moderate Rehabilitation SRO program into a single program called the Continuum of Care (CoC) Program. To accomplish CoC Program goals, funds include permanent supportive housing (PSH), rapid re-housing (RRH), transitional housing (TH), and supportive services only (SSO).

Permanent housing (PH) is community-based housing without a designated length of stay in which individuals and families formerly experiencing homelessness live as independently as possible. The CoC Program may fund two types of permanent housing:

(1) permanent supportive housing (PSH), which is permanent housing with indefinite leasing or rental assistance paired with services to help persons with disabilities experiencing homelessness achieve housing stability

(2) rapid re-housing (RRH), a model that emphasizes housing search and relocation services and short- and medium-term rental assistance to move homeless people as rapidly as possible into permanent housing.

The transitional housing (TH) project component may cover the costs of up to 24 months of housing with accompanying support services, providing stability to enable homeless people to transition successfully to and maintain permanent housing within 24 months of the program entry. SSO recipients and sub recipients may use the funds to conduct outreach to sheltered and unsheltered homeless persons, link clients with housing or other necessary services, and provide ongoing support. SSO projects may be offered in a structure or structures at one central site or multiple buildings at scattered sites where services are delivered. Projects may also be operated independently of a building (e.g., street outreach) and in a variety of community-based settings, including in homeless programs operated by other agencies. The collective goal of the programs is permanent housing placement.

Through New Hampshire's Coordinated Entry system, individuals and families are assessed using the COC's common assessment tool. This assessment tool is used to quickly assess the health and social needs of persons experiencing homelessness and match them with the most appropriate and available housing intervention. Individuals and families are prioritized for the CoC Program and other housing opportunities based on vulnerability indicated in the common assessment tool. This method matches individuals and families with the appropriate level of service based on their needs. It preserves the most intensive programs for the households with the highest vulnerabilities, such as those chronically homeless. Persons with mental illness, co-occurring disorders, Acquired Brain Disorder, and other disabling conditions. Providers include Community Action Agencies,

CMHCs, and several smaller non-profit organizations. Direct services include case management, assistance acquiring essential life skills, housing, and other supportive services to ensure their permanent housing placement.

Housing Bridge Subsidy

The Housing Bridge subsidy program provides supported housing to people with serious mental illness. The program aims to reduce institutionalization by combining mental health outreach services with a subsidy to help pay rent. The rental subsidy terminates when the individual receives a Housing Choice Voucher.

The Housing Bridge Subsidy program, administered by the BMHS, is proving to be highly successful, moving eligible persons out of the state hospital or transitional housing into safe, affordable residences in the community. This program uses New Hampshire general fund dollars to provide housing case management services and rental subsidies to adults with SMI who are homeless or at risk of becoming homeless. The CMHA commits the State to funding 450 Supported Housing units, including those under the Bridge Subsidy Program. In its latest quarterly data report, the State has committed sufficient funds to support 500 Bridge Subsidy Program units, which exceeds the CMHA target by 50 units.

Housing Bridge Subsidy Program: Clients Linked to Mental Health Care Provider Services Measure	**As of 3/31/2019**	**As of 3/31/23**
Housing Bridge Clients Linked	337/400 (84%)	383/410 (93.4%)

(Source: *New Hampshire Community Mental Health Agreement Quarterly Data Report: July-September 2022*)

Further information may be found in this Block Grant application in the Required section III.C.9. Statutory Criterion for MHBG and Requested section III.C.17. Community Living and the Implementation of Olmstead.

Educational Services

New Hampshire public schools provide an array of behavioral health services to students. Community-based mental health and other rehabilitation programs necessarily possess an educational and/or vocational aspect. Community Mental Health case management programs work closely with schools, incorporating Individual Education Plans (IEPs) or 504 plans that school Special Education programs may manage on behalf of a SED child or youth into their mental health treatment. Additionally, several communities involve collaborative partnerships between Schools, CMHCs, and Federally Qualified Health Centers to provide children, youth, and families with valuable clinical support in the school settings.

Schools throughout New Hampshire seek to support all students, particularly those who need additional resources, to access an appropriate, rigorous, and individualized education. The Department of Education supports the education of the whole child and, in doing so, recognizes

the need for evidence-based, timely, and seamless interventions. To this end, the Bureau of Integrated Programs at the Department of Education supports a balance of local participation and statewide administration. Specifically, the Title programs do not mandate how a school or district may use its funds so long as those funds meet the law's intention. Schools and districts use needs assessments to ensure the neediest students can access appropriate support. Through their needs assessments, schools identify students struggling with behavioral health issues and work with care providers, community members, parents, and, at times, students to choose the best intervention based on a student's needs. The process itself demonstrates elements of a system of care.

In New Hampshire, services and programs to assist adults with SMI in improving or attaining their educational goals have traditionally been provided by Vocational Rehabilitation. The mission of the New Hampshire Bureau of Vocational Rehabilitation is to assist eligible New Hampshire citizens with disabilities to secure suitable employment and financial and personal independence by providing rehabilitation services.

Peer Support Agencies

Peer Support Agencies (PSAs) provide services statewide through 8 contracts and 14 physical locations across the state. These peer-run agencies offer peer support, education, connectedness to the community, activities, training, and supported employment opportunities, among other services. Some of these peer agencies also provide peer respite and Orientated Step-up, Step-down beds.

BMHS and the PSAs continue to work toward expanding services and integrating services throughout the system. Four PSAs currently offer Recovery-Oriented Step-Up/Step-Down programs for short-term recovery-based transition services for adults (18 years or older) who are transitioning from inpatient or institutional settings into the community or who require more intensive support to reduce the need for admission to the inpatient setting. CMHCs have expanded their staff and service array to include peers on each Rapid Response mobile crisis team. These teams comprise multi-disciplinary staff, including clinical staff and at least one peer specialist responding to individuals in the community. Peers play a significant role in engaging individuals in crisis and following up to support individuals in connecting with their community.

Substance Use Disorder Treatment

The striking escalation of opiate use and opioid misuse over the last five years affects individuals, families, and communities throughout the state. In 2022, there were 463 confirmed drug overdose deaths, of which 395 were caused by opiates/opioids. (Source: Office of the New Hampshire Chief Medical Examiner report 3/10/23). Reducing substance use disorders and related problems is critical to the physical and mental health, safety, and overall quality of life of New Hampshire residents and the state's economy. Substance use disorders are preventable and treatable, and people do recover.

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Recognizing that substance use disorders (SUD) are complex, chronic, and life-threatening diseases; New Hampshire is striving to implement a comprehensive approach toward a continuum of care that includes prevention, early intervention, treatment, and recovery services as an integral part of every region of the state's public health and healthcare system. The State's collective response to date and the continued coordinated response move New Hampshire further toward that goal.

The Governor and Executive Council have authorized New Hampshire DHHS to enter into agreements with multiple vendors to provide prevention and early intervention services, substance use disorder treatment, and recovery support services statewide.

The importance of the ability of the state to provide SUD treatment has increased because of the New Hampshire Health Protection Program (NHHPP), the state Medicaid Expansion effort. As of January 2023, 250,027 New Hampshire residents were enrolled in full Medicaid – up from 51,000 in 2018. As Medicaid Expansion added new enrollees, previously uninsured individuals had increased access to mental health and co-occurring substance use services. [Source: NH DHHS Medicaid Enrollment Demographic Trends and Geography July 2023 dated 8/3/23]

Further information may be found in the Substance Abuse Block Grant application submitted separately by the NH-DHHS Bureau of Drug & Alcohol Services.

Targeted Services to Rural and Homeless Populations

Rural New Hampshire

Primary Care Office

The Primary Care Office (PCO) works with other agencies and stakeholders to support and improve access to comprehensive, culturally competent, quality primary health care services for underserved and vulnerable populations. This is done through three program areas:

1) Statewide Primary Care Needs Assessment,

2) Shortage Designation Coordination, and 3) Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care.

Statewide Primary Care Needs Assessment

The Primary Care Office uses geographic area and population data at county and sub-county levels to identify the lack of access to primary care services, the shortage of primary care providers, key barriers to access to health care, and the highest need for health services. The PCO also contains the Health Professions Workforce Data Center.

Shortage Designation Coordination

The Primary Care Office coordinates the Health Professional Shortage Area (HPSA) and Medically Underserved Areas/Population (MUA/P) designation process; provides technical assistance to organizations/communities about the designation process; and applies for new and updated existing designations as needed.

According to the 2020 US Census, 40% of New Hampshire's population (522,598 people) qualifies as rural, and 92.81% of the total area of New Hampshire is considered rural. All home and community-based services are available to the eligible population, regardless of location. BMHS contracts with CMHCs in all areas of the state, including providing services via satellite sites to reach the most rural parts of the state.

As of the date of this application, five New Hampshire counties have been designated as Health Professional Shortage Areas (HPSAs) (SOURCE: HRSA Data Warehouse).

The State Office of Rural Health (SORH) offers technical assistance to rural healthcare providers and organizations and provides healthcare-related information to rural healthcare stakeholders. SORH serves as a liaison between rural healthcare organizations and many DHHS programs.

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

New Hampshire's Homeless

CMHCs and PSAs are required by administrative rule to provide outreach to persons with mental illness who are homeless to engage such persons in the service system and provide non-office-based diagnostic and treatment services.

The State of New Hampshire Bureau of Homeless Services (BHS) provides an array of statewide services falling under the Homeless Prevention/Intervention Service spectrum, which, together with the emergency shelter system, act as a safety net.

The Projects for Assistance in Transition from Homelessness (PATH) program is funded through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) branch of the US Department of Health and Human Services with funds contracted to community mental health and Community Action Agencies.

The entities through which Housing and Urban Development (HUD) funds the Homeless Assistance Supportive Housing Programs are in the Continuum of Care (CoC). New Hampshire

has three distinct CoCs: Greater Nashua, Manchester, and the Balance of State. The Bureau of Housing Supports (BHS) coordinates the Balance of State Continuum of Care (BOSCOC) activities.

Further information in the Required section III.C.20. Support of State Partners may be found elsewhere within this Block Grant application.

Targeted Services to Diverse Racial, Ethnic, and Gender Minority Populations

New Hampshire has historically been composed of a homogeneous population. According to the U.S. Census Bureau, 15.8 % of New Hampshire's population are racial minorities or of Hispanic or Latino descent. 7.2% of the New Hampshire population are persons in poverty.

Services to SMI and SED minorities at Community Mental Health Centers

The data system BMHS uses is Phoenix and can report race, ethnicity, gender, sexual orientation, and age. From 2020 through 2021, BMHS worked alongside the CMHCs to ensure this data was mapped correctly in their system, and an emphasis on the importance of accurate data was placed. The quality of the data submitted has improved and continues to be watched for errors and unknowns, with active feedback occurring at the agency level.

The Office of Health Equity

The Office of Health Equity has a strategic plan to provide culturally competent mental health screening services to refugees and minorities in New Hampshire. The Office of Health Equity partners with BMHS and contracted agencies to provide various supportive services, such as language interpreters, language teaching services, and case management, to assist people with resettlement.

The CMHCs have language interpreters both onsite and available through outside agencies such as Certified Languages International and the Language Bank. All CMHCs are also contractually required to provide meaningful and effective treatment for those consumers who are deaf or hard of hearing. The Deaf Service Program ensures that CMHC staff who are fluent in American Sign Language (ASL) are available for these consumers.

CLAS Standards in New Hampshire

The National CLAS (Culturally and Linguistically Appropriate Services) Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for health and healthcare organizations to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

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In 1999, DHHS created the Office of Minority Health to help ensure that all residents of New Hampshire have access to DHHS services and to improve the health of minorities. Renamed the Office of Health Equity, this bureau has assisted in meeting the needs of minorities by instituting processes to respect the National CLAS Standards:

Since 2014, all New Hampshire DHHS Requests for Proposals (RFPs) have included a CLAS Section with an explicit statement of contractors' obligation to comply with all applicable Federal Civil Rights laws and a list of the laws. The RFP template provides the four-factor analysis bidders should use to determine the mix of language assistance services they need to provide to Limited English Proficient (LEP) clients to comply with Title VI of the Civil Rights Act of 1964.

Ensuring Equity for Diverse Minorities

Under-served/historically marginalized populations in New Hampshire (with penetration rates per 1000 population served), as shown in the most recent 2021 SAMHSA Uniform Reporting System (URS) report on New Hampshire located at NH 2021 Mental Health National Outcome Measures (NOMS) include: Black (33.1), Latino/Hispanic (36.6), Indigenous and Native American persons (36.5); Asian Americans (6.8) and Pacific Islanders (155.5) and other persons of color (11.2); members of religious minorities; Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The state average penetration rate served per 1000 population was 35.9.

New Hampshire participates in a robust refugee resettlement program. BMHS, recognizing the increasing diversity of the New Hampshire population and the corresponding diversity in CMHC clients, felt compelled to measure equality of access and other outcomes. For the 2016 Community Mental Health Consumer Survey, administered by BMHS through the application of MHBG BHSIS funds, the BMHS invited one hundred percent of minority adult clients to participate in the survey to enable comparison of satisfaction scores and behavioral outcomes by race and ethnicity. The adult survey was also translated into ten additional languages. A total of 254 minority adult clients, or 46%, completed the survey.

Overall, in the 2021 and 2022 Community Mental Health Consumer Surveys, there were no statistically significant differences in satisfaction by race (White versus non-White) or ethnicity (Hispanic versus not Hispanic).

New Hampshire's demand for mental health and substance use services is increasing among all demographics. Several factors make behavioral health transformation a priority of the State, including enacting the New Hampshire Health Protection Program (NHHPP) to cover a new adult group, in which an estimated one in six have extensive mental health or substance use care needs. New Hampshire now covers substance use disorder (SUD) services to the NHHPP population.

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New Hampshire seeks to transform its behavioral health delivery system through:

- Integrating physical and behavioral health to address better the full range of the qualified population's needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Additional efforts to advance parity include:

- Implemented outreach efforts using community health workers who were representative of under-served/historically marginalized communities
- Supported behavioral health (BH) and physical health integration through the use of the University of Washington AIMS Center integration model
- Implemented an onsite BH clinician at high-volume primary care practice (PCP) sites
- Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs
- Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care. The platform went live in February 2020
- Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention
- Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our twenty-four hour, seven days a week (24/7) nurse advice line to their entire provider network
- Passage of legislation to authorize the provision of many Medicaid-covered services to be delivered through telehealth, inclusive of pay parity, for behavioral health services with patient consent and as long as it is clinically appropriate for the service to be conducted via telehealth
- Ongoing review and updating of Medicaid rates associated with behavioral health services to support beneficiary access to services and providers (e.g., a 2022 increase to ASAM 3.7 Medically-Monitored Detoxification Treatment, a 2021 increase of residential treatment beds for individuals with a serious mental illness(e.g.)

Further information may be found elsewhere within this Block Grant application in the Required section III.C.1.HealthcareSystem-Parity-Integration.

Other Support Services

The Community Mental Health Agreement

New Hampshire's 2014 Mental Health "Olmstead" Settlement Agreement (the Community Mental Health Agreement) aimed to improve the lives of individuals with serious mental illness by reducing institutionalization at NHH Glencliff Home. There are 5 Core Components: (1)

Supported Housing, (2) IPS-SE_, (3) ACT, (4) Mobile Crisis Teams, and (5) Peer Support/Family Support.

The DHHS issues quarterly progress reports reflecting recent activity and month-over-month progress in support of the Community Mental Health Agreement. These reports are specific to achieving milestones in the agreed upon CMHA Project Plan to fulfill the core components. Where appropriate, the Report includes CMHA lifetime-to-date achievements.

Further information may be found in this Block Grant application in the Requested section *III.C.17.Community Living and the Implementation of Olmstead.*

NH CarePath
The NH CarePath was designed to be New Hampshire's "front door" that quickly connects individuals to a full range of community services and supports. CarePath educates and publicizes No Wrong Door linkage efforts and state partners, including the ServiceLink assistance program.

ServiceLink
The ServiceLink Resource Center is the New Hampshire Department of Health and Human Services web-based product. Through contracts with local agencies, ServiceLink helps seniors, adults living with disabilities, and their families' access and connect to long-term services and supports, access family caregiver information and supports, explore options, and understand and access Medicare and Medicaid.

New Hampshire Medicaid - Health Coverage for Children
New Hampshire Medicaid - Health Coverage for Children provides free health and dental coverage for children up to age 20 with a net income no higher than 196% of the federal poverty level (FPL). Expanded Children's Medicaid (Expanded CM): provides free health and dental coverage for children up to age 19 with net income higher than 196% of the FPL but no higher than 318% of the FPL.

Peer Support Center Warm Lines
Unlike hotlines, warm lines are for situations that are not considered emergencies but could escalate if left unaddressed. Peer telephone operators can offer compassion and support callers on topics such as loneliness, anxiety, and sleeplessness. When individuals use warm lines, they are encouraged to talk through their concerns with operators, and, in turn, operators may relate information about their own experiences to help the caller address their concerns. Operators can help callers who may feel isolated or "stuck," and, as a result, they may calm or reassure the callers. Operators refrain from offering advice; instead, they give a message of hope and provide resources.

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***Criterion 2: Mental Health System Data Epidemiology**: Contains an estimate of the incidence and prevalence of SMI among adults and SED among children and has quantitative targets to be achieved in implementing the system of care described under Criterion 1.*

Mental Health System Data and Epidemiology

The US Census Bureau estimates the 2022 New Hampshire population at 1.395 million. Youth under 18 are estimated at 18.1% of the population; adults at 79.9%. New Hampshire Community Mental Health Programs served 4.6% of children and 3.5% of adults.

The most recent 2021 SAMHSA Uniform Reporting System (URS) report on New Hampshire is at NH 2021 Mental Health National Outcome Measures (NOMS).

New Hampshire uses the Uniform Reporting System (URS) tables for planning and reporting. Information from the New Hampshire DHHS Phoenix client service and demographic database is sorted and analyzed to produce the URS reports as well as various other reports, including ACT program utilization, waitlist, and staffing; and IPS- program utilization, waitlist, staffing, and aggregate count reports of clients by employment status. New Hampshire DHHS also utilizes data from the New Hampshire Hospital [Avatar] electronic health record system to produce reports on admissions, daily census, readmissions, and discharge. These reports are utilized for program planning, budgeting, and target-setting for program utilization and client outcomes.

The most recent CMHA quarterly review data is in the Quarterly CMHA Report for January-March 2023.

SFY 2021 Notes on URS Table
The total served in CMHCs statewide in SFY21 was 49,091 (estimated at 3.5% of the state population).

New Hampshire submitted MH-CLD files, in addition to URS tables, for the first time in SFY21. New Hampshire has also submitted data for the Designated Receiving Facilities (DRFs) at the request of SAMHSA. These were provided with the New Hampshire State Hospital Readmission records. Attempts were made to create a methodology to link client data from the State Hospital Readmission (SHR) file to the Basic Client Information File. However, this still needs to be finalized so that duplication may exist across client identifiers within the submitted files. New Hampshire has plans to work on this methodology and perform Quality Improvement efforts to improve data for future submissions.

The Phoenix System is the state's centralized database for reporting eligible mental health clients and selected service utilization. Each Fall/Winter (September through January), the system is

enhanced to include additional data elements for reporting of additional funded programs. These updates/changes improve reporting granularity and align the data with best practices outlined by CDC and CMS. Continual Quality Improvement efforts occur monthly, quarterly, and annually for these data elements (including, but not limited to, Sexual Orientation, Gender Identity, Biological Sex, Language, Race, Ethnicity, Housing, Tobacco Use, Spoken Language, Written Language, etc.).

Of clients served SFY 21, data indicates that 42.5% of total adults served were reported eligible (SMI + SPMI) for state-supported community-based services. While adult admissions have increased, New Hampshire SMI rates for the proportion of SMI clients served have remained relatively stable and consistently below other states' reporting and the national average. This is likely due to the limited dataset used in New Hampshire: URS data consists solely of CMHC data, unlike other states, who's SMHAs are authorized to collect mental health treatment data from a broader spectrum of providers.

Of clients served, SFY21 data indicates that 80.8% of total children and youth served were reported eligible having a Severe Emotional Disturbance (SED) or Severe Emotional Disturbance with Interagency Involvement (SED-IA) for state-supported community services.

Each center monitors its caseload and costs locally; the state of New Hampshire collects case information in its Phoenix database system via monthly uploads managed jointly by the CMHCs and the DHHS data unit. The Managed Care Organizations (MCOs) manage the Medicaid program with the CMHCs through contracts negotiated annually. The data they collect on utilization and quality is shared with BMHS.

COVID-19 Pandemic: During the height of the COVID-19 Pandemic, around 50% of services were rendered through telehealth services. Although services continued to be provided to the residents of New Hampshire, there was reduced capacity at the CMHCs, Designated Receiving Facilities (DRFs), New Hampshire Hospital (NHH), and Crisis Apartments to follow social distancing and best safety practices outlined by the CDC. This could have impacted whom and where clients received services and could explain some of the reduced counts compared to the last SFY observed throughout some of these URS tables. In addition, CMHCs actively reported staffing challenges, precisely due to the pandemic, which could have also affected reported programs and services rendered.

Further information may be found elsewhere within this Block Grant application in the Required section III.C.9 Statutory Criterion For MHBG.

***Criterion 3: Children's Services**: Provides integrated services for children to receive care for their multiple needs. Services that should be integrated into a comprehensive SOC include social*

and educational services, including services provided under IDEA, juvenile justice, substance abuse, and health and mental health services.

Children's Services Children's Behavioral Health Services

The Bureau of Children's Behavioral Health (BCBH) seeks to work with the current behavioral health service delivery systems within DHHS to implement effective child, youth, and young adult approaches to enhance engagement in treatment and positive outcomes for this population. The BCBH is expanding the System of Care approach for children's behavioral health across the child-serving agencies within the DHHS and the Department of Education.

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

The BCBH focuses on children, youth, and families experiencing behavioral health issues by developing programming with an appreciation of the system of care (SOC) approach. In the past five years, New Hampshire has made significant progress in implementing a system of care approach to children's mental health with the assistance of a Children's Mental Health Initiative (CMHI) SOC grant. The following work has been done in the state to further this effort:

- Development of a program to serve high-need children and youth with a SOC and high-fidelity Wraparound model
- Expansion of that program
- Partnership with the New Hampshire Department of Education (DOE) on the use of Wraparound in schools, which is being implemented with a CMHI SOC Grant awarded to the New Hampshire Department of Education
- Partnership with a county to implement SOC and Wraparound in that specific region, with support from a CMHI System of Care grant
- Establishment of RSA 135-F SOC for Children's Behavioral Health, a state statute that mandates the Department of Health and Human Services (DHHS) and New Hampshire DOE to partner on expanding the SOC in New Hampshire.

Creation of a State Youth Treatment Plan with the assistance of SABG (Substance Abuse Block Grant) and GOEFFR (Governor's Office for Emergency Relief and Recovery) dollars to help identify strategies for youth and merge the system of care approach with the SUD treatment of youth

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In 2016, the New Hampshire Department of Education was awarded a four-year, $12 million grant from SAMHSA. The New Hampshire Families and Systems Together (FAST) Forward for Children and Youth 2020 project supports the expansion and sustainability of a state-level SOC for children, youth, and their families.

New Hampshire 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.

Three CMHCs have children's intensive wraparound teams managed by BCBH. CMHCs engage with BCBH to provide a collaborative model of Intensive Community Based Services and High Fidelity Wraparound for children and youth.

Within New Hampshire's Wraparound model, the Care Management Entities (CMEs) utilize the Child Adolescent Needs and Strengths assessment tool to help identify needs and strengths, incorporate decision-making into developing the care plans, and provide outcome measurement to manage the course of treatment more effectively. Contracted Care Management Entities (CMEs) can facilitate and coordinate access to community-based services.

In FY22, the Transformation of Residential Treatment included a voluntary pathway to episodes of residential treatment and residential levels of care. Also implemented through a vendor contract has been the comprehensive assessment of the treatment process to determine eligibility for residential care and provide a level of care recommendation. Additionally, aligning with the Family First Prevention Service Act (FFPSA), BCBH worked collaboratively with DCYF to ensure that comprehensive assessment for the treatment process supports DCYF needs and youth court-involved through DCYF seeking residential treatment.

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

Community Mental Health Centers

Per the New Hampshire Administrative Rule and State Medicaid Plan, CMHCs shall provide the following developmentally appropriate services to eligible children pursuant to the applicable rules

and prioritize children connected to the division for children, youth, and families. Services provided to eligible children shall be community-based and shall include the following:

- ►Family support and education, including designation of a family liaison
- ►Psychiatric diagnostic and medication services
- ►Case management, including appropriate interagency involvement
- ►Individual, family, and group therapy
- ►Intake and assessment; Crisis intervention
- ►Individual service plan development and monitoring
- ►Outreach support to children and their families, both in their homes and in community settings
- ►Functional support services.

The Block Grant Advisory Council in New Hampshire: The Mental Health Planning and Advisory Council plays an active role in monitoring and advocating for issues relating to Children. The Standing Committee on Children and Youth is one of the more dynamic and active standing committees, meeting monthly between quarterly meetings of the Council.

Division of Children, Youth, and Families

The New Hampshire Department of Health and Human Services Division of Children, Youth, and Families (DCYF) staff provide a wide range of family-centered services to meet the needs of parents and their children and strengthen the family system. Services are designed to support families and children in their homes and communities whenever possible.

The Bureau of Child Protection protects children from trauma, abuse, and neglect while attempting to preserve the family unit. Child Protective Service Workers help prevent further harm from intentional physical or mental injury, sexual abuse, exploitation, or neglect by a person responsible for a child's health or welfare.

Department of Education

SAMHSA-Funded Projects

The New Hampshire Department of Education, Bureau of Special Education has been awarded nearly $19 million in grants from the Substance Abuse and Mental Health Administration (SAMHSA) to implement the Safe Schools/Healthy Students initiative and Project AWARE within the state. Both projects are administered through the Office of Student Wellness. More information can be found at www.NHStudentWellness.org.

Program Goals:

- an increase in the number of children and youth who have access to behavioral health services

- a decrease in the number of students who abuse substances
- an increase in support for early childhood development
- improvements in school climate
- a reduction in the number of students who are exposed to violence.

Individuals with Disabilities Education Act (IDEA) Services

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to specific low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program.

In New Hampshire, the Department of Health and Human Services, Office of Medicaid Business and Policy (State agency), administers the Medicaid program. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P. L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act through a child's individualized education plan (IEP). The Department of Education funds the school system to provide services under the Individuals with Disabilities Education Act (IDEA) to children and youth with Individualized Education Programs (IEPs) up to age 21.

The primary State guidance for administering and operating the school-based health program is the New Hampshire Medicaid to Schools Program Manual. To be eligible for this program, a student must be (1) identified as having an educational disability in his or her IEP, (2) younger than 22 years of age, (3) eligible for Medicaid, and (4) served by an SAU that is enrolled as a Medicaid provider. Covered services under the Medicaid to Schools program include:

- medical evaluation;
- nursing services;
- Occupational and physical therapy;
- psychiatric, psychological, and mental health services;
- speech, language, and hearing services;
- rehabilitative assistance;
- vision services; and
- transportation services.

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Further information may be found elsewhere within this Block Grant application in the Required sections III.C.18.Children and Adolescents MH.SUD Services and III.C.20. Support of State Partners.

***Criterion 5: Management Systems**: States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provide for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.*

Emergency Mental Health Services

Each CMHC has staff responsible for providing 24-hour emergency or crisis services. Services are required by administrative rule to (a) be available seven days per week, 24 hours per day; (b) include clinical/psychiatric evaluation and treatment, medication services, and referral to inpatient treatment; and (c) be available at the CMHC and other community locations including hospitals, homeless shelters, police stations, and residences.

New Hampshire's CMHCs are involved in regional planning, training, and behavioral health emergency/disaster response drills. Administrative rule He-M 403 requires that Behavioral Health Disaster Response Plans provide:

- Coordination with other local and regional agencies that provide emergency management services, including relief from a disaster;
- Identification of members of the community at large who are vulnerable to behavioral health crises during times of disaster;
- Provision of onsite crisis assessment and diagnostic and counseling services; and
- Addressing the acute psychiatric treatment needs of community members and assuring the availability of community support and treatment services to consumers of the state mental health system who are vulnerable during times of disaster due to the nature of their mental illness.

The BMHS Acute Care Services Coordinator assists with and advocates for mental health training for emergency health services, participates in suicide prevention activities, and is the liaison to the Office of the Chief Medical Examiner (OCME) for the DHHS and the New Hampshire National Guard, liaison to the CMHC Emergency Services Departments, the Designated Receiving Facilities (DRF), and is on the Advisory Board of the Disaster Behavioral Health Response Team (DBHRT) as well as being a member of DBHRT.

Grant Expenditures

The majority of the MHBG award for New Hampshire supports contracts with eight PSAs at fourteen sites and two outreach programs, serving all 10 MH regions, sustaining statewide access to peer support as an alternative and/or adjunct to clinical and medical models of service provision. PSAs provide an array of recovery-oriented services.

PSAs are community-based private, not-for-profit agencies that have contracted with BMHS to provide peer-to-peer support to adults with mental illness, intended to assist adults with mental illness in their recovery.

New Hampshire has long committed to mental health peer support, starting with the establishment of the first Office of Consumer Affairs with a state mental health authority nationally and the first PSA in New Hampshire, both in the late 1980s.

The eight PSAs receive nearly 65% of the State's MHBG award. Some PSAs have been successful at accessing additional funding through such sources as private donations, the United Way, and the Community Development Block Grant.

For 2019 2023, block grant funds were used to support the First Episode Psychosis program initiation and maintenance, support of training and infrastructure for the children’s programs statewide incorporating the MATCH – ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Conduct, or Trauma Problems), professional business practice training for the regionally based PSAs, and the maintenance of the CANS and ANSA statewide system.

Outcomes report, data tables generated by the administration, and analysis of annual Consumer Satisfaction Survey results were made possible by applying federal BHSIS grant funds associated with the Mental Health Block Grant. CMHCs and the BHPAC look forward to the presentation of quality metrics provided by the vendor responsible for data collection, analysis, and presentation. CMHC-specific outcomes are incorporated into quality initiatives at the centers. The DHHS monitors year-over-year data through its CMHC reapproval processes,

The grant also supports the State Planner position and that office's activities, including serving as liaison and subject matter expert to BHPAC. The State Planner oversees the block grant, represents the BMHS at required national meetings, and provides or arranges the staff support, direct consultation, instrumental support, research materials, and financial support for the Council activities and manages all block grant-related initiatives. The Planner coordinates and collects multi-source data for the NRI National Profile and similar projects requested of the state related to BMHS.

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The State Behavioral Health Planning & Advisory Council

The State Behavioral Health Planning & Advisory Council (BHPAC) is 100% supported by the grant, which, at a minimum, provides staff, operational support, and incentives for consumers and family members who would otherwise be unable to participate in Council and BMHS activities. The Mission of the Council is to bring individuals with lived experience with mental illness and families representing children and adults throughout the life span, and other stakeholders together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of public mental health services and systems of care in New Hampshire.

The Council's purpose is to represent and advocate for adults of all ages with or at risk of Serious Mental Illness (SMI) and children under age 18 with or at risk of serious emotional disturbances (SED). The Council will, not less than once a year, review state mental health plan(s) and submit any recommendations to the State. The Council will monitor, review, and evaluate the allocation and adequacy of mental health services within the State.

The Council is charged with focusing its statutory duties in a manner that will strengthen and improve the public mental health system.

BHPAC maintains the required membership ratios following the guidelines outlined in Public Law 102-321, the currently approved By-Laws of BHPAC, and any subsequent regulations of Council membership. The number of appointed members may be as many as 35. All required state agencies are represented, along with various adult consumers, parents of children with severe emotional disturbances, and family members of both adults and youth.

There is robust advocacy representation for both adults and youth. NAMI-NH and several PSAs and Recovery Clubhouses are represented. Peers are involved in the BHPAC as active members.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

III: B. Planning Step 2:

Identify the unmet service needs and critical gaps within the current system.

Step 2: Identify the unmet service needs and critical gaps within the current system.
This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (NSSATS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS) , Youth Risk Behavior Surveillance System (YRBSS), the Uniform Reporting System (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process of primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.
This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under EO 13985. States are encouraged to refer to the IOM reports, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement and The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding36 in developing this narrative.

New Hampshire Priorities & Areas of Need

10-Year Mental Health Plan

The framework for addressing NH's unmet services needs and critical gaps within the current system is the NH 10-Year Mental Health Plan. This Plan identifies the state's long-term strategies for system-wide improvements.

In 2019, the New Hampshire Department of Health & Human Services (DHHS) submitted to the Governor, Senate President, and Speaker of the House a 10-Year Mental Health Plan that provided goals of its mental health services system spread out through the next ten years. These goals were developed by considering many stakeholders' recommendations to bolster and expand the current system to address identified gaps.

The plan includes a vision to expand the crisis continuum to include incentives to increase psychiatric bed capacity, support for those transitioning to and from higher levels of mental health care, and more peer support as people with a mental illness navigate the system of care. The 10-Year Mental Health Plan's 13 foundational recommendations highlight and reflect stakeholder input and include action steps on how the Department and stakeholders will implement those recommendations, funding benchmarks, and potential legal and regulatory changes.

Nationally, the demand for mental health services is on the rise. Luckily, New Hampshire is well poised to respond. Since the release of the State's 10-Year Mental Health Plan, significant investments were made in the area of mental health. Progress has been made on each of the thirteen foundational recommendations intended to address identified gaps as outlined in the plan. Stakeholders reconvened in 2022 to review progress and gaps and formulated new priorities for the next phase of implementation. Together with elected officials, advocates, peers, and providers,

the DHHS will continue its focus to ensure a comprehensive, welcoming, high quality, and sustainable mental health system. Overarching system priorities throughout the next year include:

- Widely publicize the state's *Strong as Granite* media campaign to promote behavioral health awareness and inform residents about how to access services and encourage help-seeking as a routine and positive action
- Further expand crisis services through the development of location-based Rapid Response Crisis Centers to create additional alternatives to emergency rooms for individuals in crisis
- Focus on workforce development by offering professional development opportunities for current staff and expand the pool of workers through the creation of new certification pipelines for peers and crisis workers
- Continue partnerships to expand independent, supported housing, and residential treatment options across the lifespan to ensure people are able to transition through levels of care that meet their clinical needs
- Expand DRF capacity and coordinate inpatient bed flow to ensure patients under the state's care are admitted into an appropriate and least restrictive inpatient psychiatric bed as quickly as possible
- Develop data reporting dashboards to increase visibility of outcomes across the system

With the assistance of Community Mental Health Block Grant (CMHBG) funding, New Hampshire has dedicated significant efforts to establish a system of care that can meet the needs of all New Hampshire citizens, one that considers the unique demographics of the state and the respective challenges those demographics present. This commitment to providing timely and appropriate services to its residents has been demonstrated throughout many of BMHS programs and initiative successes and drives forward its commitment to continue its work in expanding and growing this system and determining current priorities for improvement.

When examining New Hampshire's system through the lens of how CMHBG funding will be spent, more focused goals include:

1. Further expand crisis services through increased capacity at the state's crisis contact center
2. Increase quality improvement and data reporting dashboards to increase visibility of peer program outcomes
3. Expand availability of programs to treat early serious mental illness/ first episode psychosis
4. Increase the data reporting ability of all centers providing MATCH and continue to identify sustainability efforts

The state's current program priorities utilizing CMHBG funds over the FFY24-25 are described in the following sections:

III: B. Planning Step 2:
Identify the unmet service needs and critical gaps within the current system.

1. Increase Capacity of the States' Crisis Contact Center
Increasing access to ensure individuals get the right level of care at the right time is a priority. A core goal of the New Hampshire 10-Year Mental Health Plan has been to expand crisis intervention services statewide and improve access to care through a centralized access point. This part of the plan has been successfully implemented. A single, statewide crisis access point, the New Hampshire Rapid Response Access Point (NHRRAP), serves as a single crisis contact center and provides phone, text, and chat-based triage, intervention, and deployment of mobile crisis teams, aligned with the national 9-8-8 and Crisis Now models. Unfortunately, many people still arrive at hospital emergency rooms seeking mental health care, but a focus has been placed on further expanding the continuum and publicizing the availability of services, including the NHRRAP.

In August 2023, New Hampshire Department of Health and Human Services (DHHS) announced a new plan to eliminate "ED boarding" in New Hampshire called "Mission Zero." Mission Zero is a joint effort with providers, community, and other stakeholders and is designed to eliminate the emergency department psychiatric boarding list as soon as possible. To accomplish this, New Hampshire DHHS will work to address the three key drivers of the boarding challenge in New Hampshire:

- Front Door Issues - in which people in crisis go to the ED because they do not know where else to go or have been unable to receive timely services in the community to address their psychosocial needs and/or immediate psychological crisis;
- Inpatient Supply & Coordination Issues - in which people with acute psychiatric needs are unable to be transferred to an appropriate inpatient bed due to a shortage of system fragmentation of such beds; and
- Back Door Issues - in which people exceed medically necessary stays in inpatient psychiatric facilities due to a lack of the correct support levels needed to discharge safely.

To support these efforts, MHBG funds will be used to address the Front Door Issues. As New Hampshire develops and expands services to meet the needs of its residents, BMHS recognizes that there needs to be consistent advertising of such programs to aid residents in locating and accessing the services they need. This is partly evidenced by the large numbers of individuals who first access the mental health system through hospital emergency rooms and/or inpatient psychiatric hospitalization.

The contract for the current NHRRAP expires June 30, 2024, so the BMHS will reprocure for that service using, in part, MHBG funds. The intent is that call volume to the NHRRAP will increase with the expansion of messaging and additional outreach efforts.

III: B. Planning Step 2:
Identify the unmet service needs and critical gaps within the current system.

2. Improve Quality and Data of Peer Programs:

New Hampshire's Peer Support Agencies (PSAs) are essential throughout the System of Care, however, there is a need to continue to build on the service user experience by further developing infrastructure. The network of PSAs receives programmatic quality reviews on a bi-annual basis. A team of 2-4 program, financial and/or audit staff from the DHHS conduct on-site record reviews, remote desk audits of policies, procedures, and agency planning documents, and on-site board and participant interviews. Upon conducting the last review, it was noted that the review largely focuses on the PSA adherence to state rules and contract which excludes some program management aspects that could be valuable at informing quality improvement. Therefore, the BMHS is dedicated to developing a more comprehensive quality review tool that would benefit the PSAs and DHHS. In partnership with the Bureau of Program Quality, BMHS will explore options for the development of quality improvement and quality audit tools that incorporate service user experience and program operations.

Currently all PSAs track and report data using complex excel spreadsheets. There are limits to the quality and quantity of data these forms are able to collect. Additionally, the data is not easily analyzed or visualized at either a center or statewide level. This makes reporting on program outcomes extremely difficult. Therefore, the BMHS shall explore options for creating and/or adapting a uniform data reporting system for PSA data.

3. Expand Access to Early Serious Mental Illness Programming Statewide:

During SFY 2019-21, the State carried out a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP) treatment model using funds provided by the 10% set-aside of the MHBG**.** The initiative included two components: first, proposing a treatment model that could be scaled to provide ESMI/FEP services statewide, and second, a public awareness campaign that focuses on the importance and availability of early interventions.

New Hampshire has been working to expand FEP services statewide. In July 2021, three new Coordinated Specialty Care FEP programs were implemented in the state, bringing the total number of FEP programs to four CMHC programs. As part of the effort to best support individuals experiencing ESMI/FEP, BMHS recognizes that services must be available statewide. However, New Hampshire has a small population that makes it difficult to develop and sustain specialty FEP teams due to the low population density and intensive training requirements needed for Coordinated Specialty Care. . Continued infrastructure investments are needed, such as provider training, technical assistance for teams to start programs in line with evidence-based practices, and targeted components of the model, such as the availability of family psychoeducation statewide.

III: B. Planning Step 2:
Identify the unmet service needs and critical gaps within the current system.

In order to understand the needs and statewide readiness to expand ESMI/FEP services, evaluation is needed. The BMHS will request technical assistance from SAMHSA and engage with stakeholders and to compile an inventory of services currently available for this population, explore the needs, opportunities, and possibilities for growth of ESMI/FEP programs in New Hampshire. Once this evaluation is complete, BMHS will move forward with procuring and contracting for the expansion of services. The state will request SAMHSA approval for proposed ESMI/FEP services prior to implementing.

4. Continue to Strengthen the Implementation of MATCH:
New Hampshire promotes and supports using the Modular Approach to the Treatment of Children's Anxiety, Depression, Trauma, or Conduct Problems (MATCH) evidence-based practice for youth with ESMI at all CMHCs in the state.

For 2019 through 2021, block grant funds supported training and infrastructure for children's programs statewide incorporating the MATCH–ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Conduct, or Trauma Problems). New Hampshire intends to extend MATCH implementation throughout the CMHC system of care (SOC) and offer more training opportunities to CMHC clinicians for extended implementation of MATCH in all ten New Hampshire CMHCs.

New Hampshire provides ongoing training and implementation services to CMHCs to enable the delivery of MATCH-based treatment to children and youth suffering from anxiety, trauma, depression, and conduct disorders. MATCH has been proven effective in treatment outcomes and self-sustainability in existing CMHC treatment programs for those individuals and their families. As an element of the New Hampshire SOC for children, MATCH positively impacts the lives of children, youth, and their families throughout the state's CMHC regions. It has been especially helpful in treating youth presenting with severe clinical problems, including chronic and violent juvenile offenders, youth in psychiatric crises, and maltreated families.

The overarching goal of the MATCH treatment model is to decrease rates of antisocial behavior, improve functioning in family relations and school performance, and reduce the use of out-of-home placements (incarceration and residential treatment) by increasing the ability of severely emotionally disturbed children to remain at home with family support.

Throughout the implementation of MATCH programming, the ten CMHCs have struggled with data systems and validation. Over the next year, all ten CMHCs will work with BCBH and The Baker Center for Children and Families to improve data collection and validation efforts through the TRAC system for the MATCH program. Additionally, the MATCH Steering Committee will continue to explore sustainability models

III: B. Planning Step 2:

Identify the unmet service needs and critical gaps within the current system.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Crisis services

Priority Type: BHCS

Population(s): SMI, SED, ESMI

Goal of the priority area:

To reduce psychiatric hospitalization for adults and children by continuing to build the statewide crisis sytem, pillars one and two; "Someone to Call", "Someone to Respond"

Strategies to attain the goal:

The New Hampshire Rapid Response Access Point will resolve 70% of individual crisis calls at the caller level. If the crisis is unable to be resolved on the phone, the NHRRAP will dispatch the nearest Rapid Response Team.
New Hamphsire DHHS team will measure and montior current call volume and expencted increase in call volume post launch of the statewide campaign in promoting help seeking behavior.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls resolved at the access point triage line (contact center)

Baseline Measurement: 22,000 contacts

First-year target/outcome measurement: increase contacts by 10%

Second-year target/outcome measurement: increase contacts by addtional 10%

Data Source:

Vendor submits monthly reporting to DHHS through their own EHR and the DHHS Data Team reviews for validity

Description of Data:

number of call, text and chats received and resolved, number of adult/children served, regions in which calls originated and type of caller (self, law enforcement, hospital, etc.)

Data issues/caveats that affect outcome measures:

breakdown in technology, NSPL (988) call routing

Priority #: 2

Priority Area: Peer support

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Improvement in the quality of recovery services and data formulation, collection and validation at the Peer Support Agencies.

Strategies to attain the goal:

Enhance data collection and quality imporvement tools to improve service user experience. Explore audit tools and consumer satisfaction surveys during year 1.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improve Data and Quality Improvement Tools at Peer Support Agencies

Baseline Measurement: implement new data tool to monitor information from peer support agency

First-year target/outcome measurement: Explore 3 quality improvement and audit tools for service user experience and choose one tool to impliment

Second-year target/outcome measurement: Explore 3 data platforms for uniform use in Peer Support Agencies and choose one platform to implement

Data Source:

approved vendor will send DHHS- BMHS data as requested (to be determined) to be reviewed

Description of Data:

step up/down availability and use, data about how many peers utilize peer programs.

Data issues/caveats that affect outcome measures:

completion of implementation timely. Training, implementation and use at all peer support agencies.

Priority #: 3

Priority Area: ESMI/FEP

Priority Type: ESMI

Population(s): SMI, SED, ESMI

Goal of the priority area:

Continue to build on the current New Hampshire FEP/ESMI models and increase access to this service statewide

Strategies to attain the goal:

The New Hampshire DHHS team will complete an inventory of services and request Technical Assistance to identify options for program expansion

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improve Access to FEP/ESMI programs statewide

Baseline Measurement: complete survey to assess programs and needs of EMSI population

First-year target/outcome measurement: conduct an inventory of current services and request technical assistance working with SAMHSA to identify options for program expansion

Second-year target/outcome measurement: to set up at least one more FEP/ESMI program

Data Source:

SAMHSA TA request

Description of Data:

In order to understand the needs and statewide readiness to expand ESMI/FEP services, evaluation is needed. The BMHS will request technical assistance from SAMHSA and engage with stakeholders and to compile an inventory of services currently available for this population, explore the needs, opportunities, and possibilities for growth of ESMI/FEP programs in New Hampshire. Once this evaluation is complete, BMHS will move forward with procuring and contracting for the expansion of services after submitting for SAMSHA approval.

Data issues/caveats that affect outcome measures:

lack of responses to procurement, lack of response to survey requests.

Priority #: 4

Priority Area: MATCH

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Continue to strengthen and ensure quality of MATCH services across all centers

Strategies to attain the goal:

Continue to monitor MATCH teams through the Steering Committee for qualtiy and team training needs as well as identify sustainability plans

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Continue to monitor quality and effectiveness of MATCH

Baseline Measurement: data from sources to show engagement, and outcomes

First-year target/outcome measurement: Continue to support data collection/validation in the TRAC and Chart system at all 10 CMHCs and show an 2% increase in the total number of clients entered per center.

Second-year target/outcome measurement: Continue to support MATCH in the TRAC and Chart system transition at all 10 CMHCs and show a 2% increase in the total number of clients entered statewide.

Data Source:

The New Hampshire MATCH Steering Commitee

Description of Data:

TRAC System; client level data, status and enrollment.

Data issues/caveats that affect outcome measures:

ongoing workforce issues that make stable implementation and sustainability difficult.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

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

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$880,000.00						$291,296.00		$866,216.00	$26,191.00
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital				$36,680,230.00	$75,099,896.00		$75,693,984.00				
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$4,528,530.00	$358,032,542.00	$290,000.00	$53,917,942.00			$2,330,367.00		$1,176,113.00	$221,809.00
10. Crisis Services (5 percent set-aside)[f]		$854,000.00			$41,297,166.00			$145,648.00		$2,742,603.00	$13,905.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$329,606.00						$145,648.00		$246,543.00	
12. Total	**$0.00**	**$6,592,136.00**	**$358,032,542.00**	**$36,970,230.00**	**$170,315,004.00**	**$0.00**	**$75,693,984.00**	**$2,912,959.00**	**$0.00**	**$5,031,475.00**	**$261,905.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 10/01/2023 MHBG Planning Period End Date: 09/30/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems	$74,883.00		$150,000.00		$74,883.00		$150,000.00	
2. Infrastructure Support	$6,943.00		$250,000.00		$6,943.00		$250,000.00	
3. Partnerships, community outreach, and needs assessment	$39,262.00		$650,000.00		$39,262.00		$650,000.00	
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$43,173.00				$43,173.00			
5. Quality Assurance and Improvement	$20,828.00				$20,828.00			
6. Research and Evaluation	$20,828.00				$20,828.00			
7. Training and Education	$80,828.00		$270,829.00	$261,905.00	$80,828.00		$270,829.00	$261,905.00
8. Total	**$286,745.00**	**$0.00**	**$1,320,829.00**	**$261,905.00**	**$286,745.00**	**$0.00**	**$1,320,829.00**	**$261,905.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

All COVID funds went to crisis services and CTI programs. I do not see a category for this therefore this is why it is blank

Environmental Factors and Plan

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

Narrative Question

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

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

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

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

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

The 10-Year Mental Health Plan was adopted in 2019. It envisions and lays out a road map to achieve a statewide mental health system that aims to improve behavioral health for all individuals in New Hampshire by providing:
• Increased access to a full continuum of care, including community education and engagement,
• Prevention and early intervention services,
• Outpatient, inpatient, and crisis support and services,
• Child-focused strategies and recommendations,
• Integration of mental health and primary health care, and
• Intensified efforts to address suicide prevention

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

Since the release of the State's 10-Year Mental Health Plan in 2019, significant investments in mental health have been made. In support of the 10-Year Plan's goals, the Division for Behavioral Health (DBH) has been building system capacity, supporting innovation, and building a continuum of care that is responsive to the needs of New Hampshire residents. With strong legislative support and dedicated providers, New Hampshire has made significant gains under each of the core goals outlined in the Plan.

An annual report of accomplishments is published annually each September. The 2023 accomplishments report still needs to be finalized. Still, the 2022 report identified the below key accomplishments achieved on each of the 13 foundational recommendations:
Key Accomplishments for the Plan's 13 Recommendations through August 2022 include the following:

Recommendation 1: Increase Medicaid Rates for Mental Health Services
• Increased Medicaid rates by 3.1% in January 2020 and another 3.1% in January 2021, increasing total funds for providers by $6M
• Annually, $5M of Directed Mental Health Payments have been made since SFY 2019
• Increased the transitional housing/community residence per diem by 88%
Recommendation 2: Action Steps to Address Emergency Department Waits
• Transformed crisis services; integrated Mobile Crisis Teams and Supports; Rapid Response services available statewide
• Access Point/988 Public Outreach and Education
• Mobile Crisis Rural Implementation
• Crisis Stabilization Model Expansion
• Increased Designated Receiving Facility rates and added 34 beds since 2019, with plans to increase inpatient beds by 150 through 2025
• Established 40 new transitional housing beds
• Reallocated capacity at New Hampshire Hospital – children's unit transitioned to Hampstead
• The state acquired Hampstead Hospital and established the contract to develop the first-ever Psychiatric Residential Treatment Facility in New Hampshire.
• Amended New Hampshire's substance use disorder Institutions for Mental Disease (IMD) Medicaid waiver to include severe mental illness
Recommendation 3: Renewed & Intensified Efforts to Address Suicide Prevention
• Allocated $450K of new State funds to support suicide prevention per year since 2020
• Established New Hampshire's first suicide prevention specialist position
• New Hampshire Suicide Prevention Council revised the statewide suicide prevention plan
• Established school suicide prevention planning and training standards; CALM training provided to 33 individuals statewide
• Developed a standardized suicide screening and risk assessment tool for use in emergency departments
• Collaborative 9-8-8 planning and launch

Recommendation 4: Enhanced Regional Delivery of Mental Health Services
• Expanded services for children's system of care through Senate Bill 14
• Developed a centralized mental health Access Point
Recommendation 5: Community Services and Housing Supports
• Increased Housing Bridge subsidies by over 100 vouchers
• Established Integrated Housing Program, a housing voucher program for individuals with mental illness and criminal records
• Contracted for 60-bed supported housing expansion
• Expanded partnership with New Hampshire Housing Finance Authority and secured grant funding from the federal Department of Housing and Urban Development (HUD)
• Launched birth to 5 early childhood enhanced care coordination (EC-ECC)
• Expanded Families and Systems Together (FAST) Forward for children

Recommendation 6: Step-up/Step-down Options
• Launched a Recovery Oriented Step-up/Step-down pilot program (12 beds)
• Expanded the Transitional Residential Enhanced Care Coordination (TR-ECC) program for children
• Launched Critical Time Intervention
Recommendation 7: Integration of Peers and Natural Supports
• Expanded Access to Peer Support Centers
• Expanded training for peer leadership and workforce services
• Expanded youth peer support services
• Increased peers throughout the continuum
• Incorporate peers into ACT/Mobile Crisis Teams, EDs, and SUSD program
Recommendation 8: Establish a Commission to Address Justice-Involved Individuals
• Established the Governor's Advisory Commission on Mental Illness and the Corrections System.
• Commission partnered with the National Council of State Governments Justice Center on a high-utilizer assessment project.
Recommendation 9: Community Education
• Launched I Care NH and Onward NH, suicide prevention and early intervention campaigns
• Entered into a contract with a vendor to create a public awareness campaign encouraging positive help-seeking behavior and the reduction of stigma
Recommendation 10: Prevention & Early Intervention
• Developed the Early Childhood Prevention and Treatment for Behavioral Health Plan
• Increased availability of First Episode Psychosis intervention services
• Deployed Crisis Teams to children and families
• Developed the Infant Mental Health Plan
• Solicited proposals to study the readiness, capability, and cost-effectiveness of implementing the Certified Community Behavioral Health Clinic (CCBHC) model
Recommendation 11: Workforce Coordination
• Established the Governor’s Statewide Oversight Commission on Mental Health Workforce Development
• Invested $5M of ARPA Home and Community Based Services (HCBS) funds to support direct care staff at CMHCs
• Developed the Peer Workforce Advancement Plan
• Conducted cross-department training for criminal justice staff
• Expanded the State Loan Repayment Program (SLRP)
• Enhanced workforce training options
Recommendation 12: Quality Improvement & Monitoring/DHHS Capacity
• The DHHS established a Division of Performance Evaluation & Innovation
• Contracted with an evaluation team that would evaluate and advise on crisis system transformation and implementation
• Created four new staff positions in the Bureau for Children's Behavioral Health
Recommendation 13: Streamlining Administrative Requirements
• Streamlined administrative requirements, annual data enhancement projects, and program reviews
• Informal stakeholder engagement for State rule revisions is underway

Integration of Substance Use and Mental Health Treatment
Challenges experienced regarding gaps in service for individuals with co-occurring mental health and substance use disorders have been identified and targeted for improvement. Collaborative work is occurring across the New Hampshire Division for Behavioral Health (DBH) on care coordination, access, and program development. The DBH is comprised of the following bureaus: Mental Health Services (SMHA), Drug and Alcohol Services (SSA), Children’s Behavioral Health, and Homeless Services.
The New Hampshire DBH has been working to develop financial and programmatic procedures to address the continuum of care for these individuals. Cross-walking of Bureau rules and regulations and outlining service and access standards has begun. The goal is to streamline standards of care to ensure there is “no wrong door” and leverage innovative, sustainable treatment models.

One focus area related to integration for individuals with a substance use disorder and a co-occurring mental health disorder (COD) includes workforce development strategies specific to integration. The DBH has developed the capacity to cross-train those in the behavioral health system to be better equipped to identify, screen for, and respond to individuals with COD. The DBH entered into a contract with a statewide COD trainer to provide COD training, evaluation, and consultation to both SUD and MH treatment providers.

Another program area that has strategically and intentionally been integrated is New Hampshire’s crisis response system. New Hampshire is transforming its behavioral health crisis system, which includes implementing a statewide integrated (responding to both mental health and substance use crises across the age continuum) mobile crisis response model to work in tandem with the existing infrastructure, such as the Doorways (https://www.thedoorway.nh.gov/), which provide 24/7 support to individuals seeking treatment for a substance use disorder, and CMHCs.

At a policy level, all DBH Bureaus actively manage the state's Managed Care Organization (MCO) contracts to ensure effective care coordination and support services for individuals diagnosed with co-occurring disorders. Staff from each Bureau meet regularly to discuss reporting provided by the MCOs to identify policy or practice changes needed to serve individuals with co-occurring needs better. Ongoing management-level work ensures system-wide financial and programmatic discussions occur and are an ongoing focus for the coming year.

Critical Time Intervention (CTI)
Critical Time Intervention (CTI) is a model of care specially designed to support people through transitions of care. CTI is a cost-effective, evidence-based practice offering highly specialized interventions that bridge the gap and ease transitions from institutional to community-based care. When implemented correctly, CTI facilitates successful transitions during critical times of change. The ongoing services facilitate community reintegration and ensure individuals have established ties and support systems for sustained care continuity.

In New Hampshire, CTI has been implemented (starting in 2022) to enhance the quality of life of adults with serious mental illness transitioning from inpatient behavioral health settings back to the community. Once enrolled, individuals are assigned a CTI coach who provides up to 9 months of supportive services following a discharge from an inpatient psychiatric hospitalization. The goal is to improve linkages to community supports that enable recovery and help prevent readmissions. All 10 New Hampshire Community Mental Health Centers (CMHCs) have implemented and operationalized CTI to offer statewide program availability. Training, consultation, a community of practice, and technical assistance around fidelity to the model are provided through a state contract with the University of New Hampshire.

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

Suicide Prevention Initiatives
In early 2021, the Division for Behavioral Health (DBH) hired its first statewide suicide prevention coordinator, linking the Bureaus' efforts in this area. This position also leads DBH with the state's legislatively mandated Suicide Prevention Council (SPC). Because of the impact suicide has on the residents of New Hampshire, New Hampshire RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall "oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the Plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the Plan. The council shall also be a proponent for suicide prevention in New Hampshire."
The mission of the SPC is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:
• Raise public and professional awareness of suicide prevention;
• Address the mental health and substance abuse needs of all residents;
• Address the needs of those affected by suicide and
• Promote policy change

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

A substance use disorder is a known risk factor for suicide, so even when not in a life-threatening crisis, it is prevalent for individuals with a substance use disorder to have a co-occurring mental health disorder (COD). Addressing COD during treatment for a substance use disorder can improve client outcomes. As a step towards more comprehensive treatment of COD and support for individuals in recovery experiencing COD, New Hampshire DBH is providing Mental Health First Aid and Zero Suicide training to all contracted substance use disorder (SUD) treatment providers and to recovery community organizations under the umbrella of the division’s contracted facilitating organization. Training may also be made available to other treatment and recovery providers outside of those contracted with the DBH upon review of the implementation design.
Development and Coordination of Prevention Services New Hampshire's prevention efforts are primarily driven by the State's Regional Public Health Networks and Community Coalitions. These groups already provide a robust support network, but more work is underway. BDAS is providing funding to apply the Strategic Prevention Framework at both the state and local levels to support and expand existing initiatives, such as Student Assistance Programming and the I Care NH Initiative (part of the I Care Mental Health & Wellness Initiative) as well as to develop new initiatives made possible by the rollout of 988. The goal of this work is to help regions and communities identify the evidenced-based and/or promising practices that will be the most effective in their localities and assist these communities in standing up programs as well as to coordinate better the efforts of these groups in providing population, targeted, and direct prevention services across New Hampshire.

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

New Hampshire's demand for mental health and substance use services is increasing. Several factors make behavioral health transformation a priority of the State, including enacting the New Hampshire Health Protection Program (NHHPP) to cover a new adult group, in which an estimated one in six individuals have extensive mental health or substance use care needs. New

Hampshire now covers substance use disorder (SUD) services to the NHHPP population.

New Hampshire, through the NHHPP, seeks to transform its behavioral health delivery system through:
· Integrating physical and behavioral health to address better the full range of the qualified population's needs;
· Expanding provider capacity to address behavioral health needs in appropriate settings and
· Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Additional efforts to advance parity include:
· Supported behavioral health (BH) and physical health integration using the University of Washington AIMS Center integration model
· Implemented an on-site BH clinician at high-volume primary care practice (PCP) sites
· Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs
· Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care. The platform went live in February 2020
· Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention
· Provided education about appropriate Emergency Department use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our twenty-four hour, seven days a week (24/7) nurse advice line to their entire provider network
· Passage of legislation to authorize the provision of many Medicaid-covered services to be delivered through telehealth, inclusive of pay parity, for behavioral health services with patient consent and as long as it is clinically appropriate for the service to be conducted via telehealth
· Ongoing review and updating of Medicaid rates associated with behavioral health services to support beneficiary access to services and providers (e.g., a 2022 increase to ASAM 3.7 Medically-Monitored Detoxification Treatment, a 2021 increase of residential treatment beds for individuals with a severe mental illness(es)

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

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

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

c) Efforts to integrate primary care into behavioral health settings

Demonstration Project and Integrated Delivery Networks
In 2016, the Centers for Medicare and Medicaid Services (CMS) approved a New Hampshire DHHS five-year Medicaid demonstration project to improve access to and quality behavioral health services by establishing regionally-based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical healthcare delivery system. To achieve the goals of the demonstration waiver, the IDNs were charged with participating in statewide planning efforts and selecting and implementing specific evidence-supported projects. These projects comprised three enabling pathways: mental health and substance use disorder treatment capacity building, physical and behavioral care integration, and improving care transitions across settings.
The central focus of the networks is the integration of care across primary care, behavioral health, and social support services. This includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions to address more comprehensively the current challenges experienced by patients, families, and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

Specific achievements include:
· Integration of primary care and behavioral health
· Supported expanded implementation of Medications for Opioid Use Disorders (MOUD) for people with substance use disorders, in conjunction with the Doorways (points of entry for people seeking help for substance use), which have been established in New Hampshire
· Critical Time Intervention (CTI), an evidence-based practice, was used in several regions to improve transitions from emergency departments, inpatient care, residential settings, or incarceration to stable housing and community recovery (individual IDNs targeted different segments of the population)
· Established standardized protocols across multidisciplinary providers for comprehensive assessment, workflows, timely exchange of information, closed-loop referrals, and multidisciplinary care teams.
· Implemented various levels and types of co-located Primary care and Behavioral Health reverse integration clinics for people with serious mental illness/ serious emotional disturbance (SMI/SED)
· Several IDNs have designed and implemented a Collaborative Care Model (CoCM) inclusive of the development of processes and protocols.
· Integrated Care and Enhanced Care Coordination between hospitals, SUD, Federally Qualified Health Centers (FQHCs), and CMHCs
· Improved Health Information Technology (HIT) to enhance integration, improve transitions and promote quality

· Implementation of a real-time event notification system, electronic shared care plan, and statewide direct and secure messaging
· IDNs supported the expansion of telehealth during the COVID-19 public health state of emergency (funding, training, ongoing technical support)

ProHealth Program in New Hampshire
In 2018, New Hampshire received a five-year grant from SAMHSA to provide integrated behavioral and physical health care within the services of CMHCs in New Hampshire to improve health and wellness for its young people with SED and SMI.
This project, called the ProHealth NH program, has since delivered integrated medical and behavioral health care, recovery, and wellness services in 3 New Hampshire communities (Greater Manchester, Greater Nashua, and Strafford County). ProHealth NH was implemented utilizing partnerships between FQHCs and CMHCs that serve over one-third of the State. Primary care services are now co-located and integrated at the three CMHCs with this project. The other seven CMHCs in the State have also implemented or are now implementing an integrated care program.
The ProHealth NH program has enrolled over 800 youth and young adults aged 16 and older with SED or SMI, including a substantial proportion of people who identify as a cultural or linguistic minority. Across the State, over 650 individuals are enrolled in integrated care services.
Continuing evaluation, training, and consultation are provided on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through participating CMHCs and FQHC partnerships. Per SAMHSA guidance, evaluations will measure effectiveness in identifying and addressing SED, SMI, SPMI, and physical health indicators earlier and improving health outcomes for youth and young adults with mental illness.
New Hampshire DBH continues to conduct the evaluation and reporting of outcomes consistent with federal project requirements to be able to examine the resulting outcomes of integrated care. The expectation is that integration can increase access to and receipt of recommended outpatient screening and treatment for both physical and mental health conditions. Such treatment will reduce unnecessary emergency room visits and hospital stays. The team also expects that service recipients' physical and mental health will stabilize and improve with treatment and that satisfaction will be high.
CCBHC Introductory Efforts
On 3/15/23, SAMHSA awarded New Hampshire DBH a grant of $1 million to fund planning activities for implementing CCBHCs in New Hampshire.
There are three project goals in this CCBHC Planning grant to help the State build efficiencies and increase the quality of integrated community-based mental health and substance use services through potentially implementing the CCBHC model in New Hampshire:
1. Develop and implement a certification system for CCBHCs in New Hampshire,
2. Establish Prospective Payment Systems (PPS) for Medicaid reimbursable services, and
3. Prepare an application to participate in a four-year CCBHC Demonstration program

These three goals are vital to the potential establishment of a CCBHC model of service – integrating physical health care with behavioral health care and substance use treatment – across New Hampshire's current Community Mental Health and Substance Use Disorder treatment systems.
Support for integration through MCOs
New Hampshire contracts with three Managed Care Organizations (MCOs) supporting integration with physical health services. The MCOs have worked to promote the values of whole-person care and foster a coordinated continuum of care. To that end, they have focused on building collaborative relationships across providers. Specific MCO accomplishments include:
· Developed provider resource packets distributed in March 2020 to the entire provider network. Included in the resource packet was a PCP toolkit providing tools to screen for the most common behavioral health diagnoses and social determinants. Packets also included referral information and behavioral health resources.
· Supported behavioral health (BH) and physical health integration using the University of Washington AIMS Center integration model
· Implemented an on-site BH clinician at high-volume PCP sites
· Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs
· Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care
· Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention
· Provided IDN partners with comprehensive care gap reports, Healthcare Effectiveness Data and Information Set (HEDIS) rates, and under/over-utilization reports
· Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our 24/7 nurse advice line to their entire provider network
· Supported expanded implementation of Medications for Opioid Use Disorder (MOUD) for people with substance use disorders in conjunction with the Doorways established in New Hampshire. Doorways are points of entry for people seeking help for substance use.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

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

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

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

The state continues to offer Assertive Community Treatment programs in all 10 CMHCS, funded by General Funds and Medicaid reimbursement. These programs offer intensive care coordination and treatment for individuals with severe mental illness and often co-occurring substance use. Additional, NH has continued with implementation of a CTI (Critical Time Intervention) model in all CMHCs across the state. This evidenced based model provides short term intensive care coordination for 9 months to help address all areas of need after a transition from psychiatric hospitalization. This program is funded by General Funds and SAMSHA COVID supplemental funds. For children/youth with SED NH has implemented FAST Forward Program which is the Bureau of Children's' services in our WRAP Around program. This program is in place at our two Care Management Entities, has supported over 1,000 families and youth with care coordination needs for behavioral health conditions. The majority of the funding is billable through Medicaid through a 1915i SPA which was developed and accepted back in July 2018. Additionally, NH has started the requirement of care coordination by including language in the SFY 24/25 contract for every CMHC to engage in Care Coordination

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

Within Departmental contracts with providers, including the community mental health centers and three Managed Care Organizations, the Department includes provisions to assess individual needs, inclusive of mental health and substance use disorders, and to provide the needed services or refer individuals to applicable providers, as well as to work together on collaborative care approaches, etc. This becomes a more consistent and supported focus for Medicaid beneficiaries who need targeted case management services.
A children's system of care framework has been developed and implemented to provide a continuum of care across the system that assesses/identifies needs, provides early intervention and community-based services, intensive community-based supports, episodes of residential treatment, and acute and crisis care. The system of care includes care coordination roles across the continuum. For youth with complex needs, including Severe Emotional Disturbance, in addition to the above approaches, coordinated individualized care plans can be developed to address a youth and family's needs. Contracted Care Management Entities (CMEs) can facilitate and coordinate access to a full array of community-based services, utilizing the evidence-based practice of High-Fidelity Wraparound. Within New Hampshire's Wraparound model, the CMEs utilize the Child Adolescent Needs and Strengths assessment tool to help identify needs and strengths, incorporate decision-making into the development of the care plans, and provide outcome measurement to manage the course of treatment more effectively.

The Department was awarded a 1-year Planning Grant from SAMHSA on March 15, 2023, to look at the Certified Community Behavioral Health Clinic (CCBHC) model for New Hampshire. This model supports further integrating services and support for individuals with co-occurring mental and substance use disorders. Three CMHCs in New Hampshire are developing CCBHC models in their programs based on SAMHSA grants they have engaged in independently. The Department's grant work has included work internally among Departmental sub-units to analyze systemic capacities, explore opportunities from a whole-system perspective, and work with stakeholders to explore the CCBHC model to evolve the behavioral health system in New Hampshire. The Department is currently reviewing its readiness assessment and planning for implementation to more efficiently and effectively meet the needs of individuals with co-occurring disorders through integrated treatment and care coordination as key components of the CCBHC model.

The state's crisis response system is an integrated model responding to mental health and substance use crises. To that end, all crisis response staff are specialty trained to screen for and address both substance use disorders and mental disorders.

The state has also initiated a targeted, two-year program to provide training and technical assistance to improve knowledge and skills among staff in CMHCs and substance use disorder treatment facilities. Participants will learn skills for co-occurring disorders treatment.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

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

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ◉ Yes ○ No

e) Gender identity ◉ Yes ○ No

f) Age ◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ◉ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ◉ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ○ Yes ◉ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ◉ No

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

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

1. The data system used by the Bureau of Mental Health Services (BMHS) and Bureau for Children's Behavioral Health (BCBH), Phoenix, can report and disaggregate data by race, ethnicity, gender, and age. Starting in the fall of 2020 through early 2021, the system was updated to allow for reporting of sexual orientation and gender identity. The quality of that data depends on the accuracy of data entry by the Community Mental Health Centers (CMHCs). It supports the CMHCs to ensure that the data points are updated and captured as clinically necessary.

2. The BMHS will continue to provide technical assistance to the CMHCs to ensure standardized responses and accuracy of information.

3. The Office of Health Equity (OHE) within the New Hampshire Department of Health and Human Services (DHHS) assures equitable access to effective, quality programs and services across all populations, explicitly focusing on racial, ethnic, language, gender, sexual minorities, and individuals with disabilities. OHE provides coaching and TA to DHHS program areas and external organizations to improve systems and practices for organizations to serve all people with high-quality care and services. These include effective strategies for communication access, cultural competence, data collection to identify disparities, community engagement, Culturally and Linguistically Appropriate Services (CLAS) Standards implementation, gender identity 101, immigrant/refugee integration, and more.

4. The State Refugee Program in the OHE partners with the BMHS as well as with contracted agencies to provide service provider training as well as health case management, health education and orientation, and other supportive services to newly arriving and vulnerable New Hampshire refugees to build capacity to address identified health needs within refugee communities and to reduce barriers to achieving wellness.

5. The CMHCs are aware of their responsibility to provide qualified and meaningful communication access for consumers who require communication assistance. The CMHCs can access spoken and signed language interpreters on-site and available through agencies such as Certified Languages International and the Language Bank. All CMHCs have the additional capacity to provide culturally tailored effective treatment by CMHC staff who are fluent in American Sign Language for consumers who are deaf or hard of hearing through the Deaf and Hard of Hearing Services Program, which operates statewide out of the Greater Nashua Mental Health Center.

6. The ProHealth NH teams deployed community health workers who identify as members of underserved and minority populations. They conduct outreach to engage members of these populations and help them utilize and stay connected with services. These approaches have helped reduce disparities in service access and utilization in our integrated care program. Regarding racial and ethnic minority status, participation in mental health treatment was somewhat lower for individuals who identified as Black and another racial minority (53/60; 88.3%) than those who identified as White (384/387; 99.2%). Participation in

integrated physical health appointments was somewhat higher: (53/60; 88.3%) vs. (316/387; 81.7%). Among people who identified as Latino/a, participation in mental health treatment was similar (40/40; 100%) compared to individuals who identified as non-Latino/a (397/407; 97.5%). Participation in physical health appointments also was similar: (30/40; 75%) vs. (339/407; 83.3%). Regarding those who identified as a sexual preference or gender identification minority, participation in mental health treatment was similar (118/120; 98.3%) compared to heteronormative (319/327; 97.6%). Participation in physical health appointments was similar: (102/120; 85%) vs. (267/327; 81.7%).

7.. One goal of the Certified Community Behavioral Health Clinic (CCBHC) development is to continue and expand this approach to address the disparities in behavioral health treatment in New Hampshire. Should the state move forward with CCBHC implementation, CCBHCs will deploy community health workers who identify as members of underserved and minority populations. They will work to conduct outreach to engage members of these populations and help them utilize and stay connected with services. In addition, CCBHCs will have an improved capacity to track service utilization by disparity groups, enabling continuous quality improvement to serve disparity populations.

For the 2022 Community Mental Health Consumer Survey, administered by JSI Research & Training Institute through the application of MHBG Behavioral Health Services Information System (BHSIS) funds, 1,694 adult clients were invited to participate in the Adult Survey, and 1,167 Family members of children receiving services were invited to participate in the Family Member Survey to enable assessment of satisfaction scores and behavioral outcomes. 622 or 40% of the selected adult clients and 432 or 39% of the selected family members responded to the survey. The Surveys were provided in English and Spanish when indicated. They included a babble sheet with translations into 20 languages and contact information for interpretation services. The initial mail surveys also included a $5 upfront incentive. Phone follow-up was provided to non-respondents, and a web-based survey option was provided.

• Generally, at least 70% of clients responded positively in four of the nine satisfaction domains. The highest scores were in the domains of quality and appropriateness (81%), access to services (77%), general satisfaction (79%), and self-determination (75%). Seventy-one percent of clients were satisfied with their participation in treatment planning. The health and wellness (69%), social connectedness (61%), functioning (56%), and treatment outcomes (50%) domains were lower.
• From 2020 to 2022, there was a statistically significant difference in the health and wellness domain, which increased from 59% in 2021 to 69% in 2022; however, this is likely due to three items and questions being revised in 2022.
• Domain scores were compared across the last three years. Overall, there were no statistically significant differences in satisfaction scores between male and female clients.
• There were statistically significant differences in the three domains by age group. Respondents aged 25-44 had lower satisfaction in the access, general satisfaction, and self-determination domains. Respondents aged 65+ had higher satisfaction in health and wellness, and 70% of clients aged 65+ were satisfied with access, general satisfaction, and self-determination.
• Clients receiving services for one year or more had statistically significantly higher satisfaction with participation in treatment planning (73%) than those who received services for less than a year (57%).
• Currently employed clients had similar satisfaction scores to those unemployed in all nine domains. There were no statistically significant differences in the domain.
• Among family members of children receiving services, satisfaction scores were at least 80% or higher in four domains. The highest was in the area of cultural sensitivity of services (94%), followed by participation in treatment planning (85%), social connectedness (80%), access to services (83%), and General Satisfaction (72%).
• Domain scores were compared across the last three years (2020-2022) to determine whether there were any changes in satisfaction over time. There were no statistically significant differences when comparing 2022 domain scores to 2020 or 2021.
• There was no statistically significant difference in family members' satisfaction with children receiving services between male and female children or age groups.
• There were significant differences in the participation in the treatment planning domain by the length of time receiving services. Those who received services for one year or more had significantly higher satisfaction with participation in treatment planning (73%) than those who received services for less than a year (57%).

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

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

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

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

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

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

Per Member Per Month Models
The State continues contracting with three Managed Care Organizations (MCOs), including a Per Member Per Month (PMPM) rate required for all ten regionally-based Community Mental Health Centers (CMHCs). These rates are based on the CMHC eligibility status of the Medicaid beneficiary according to acuity levels (e.g., degree of impairment caused by the member's serious mental illness) to ensure a rate consistent with meeting their anticipated CMH service utilization needs. Through this model, CMHCs receive one monthly payment encompassing most Managed Care Program covered services provided to beneficiaries at one rate. The remaining balance of the Managed Care Program covered services must be reimbursed as a directed payment from the MCOs to the CMHCs at a minimum fee schedule equivalent to the Department's fee-for-service schedule to ensure CMHCs are reimbursed for the total cost of care.

Integration Services
Additionally, the three MCOs have supported the integration of physical health services by promoting the values of whole-person care and fostering a coordinated continuum of care. The New Hampshire SAMHSA grant-funded project, ProHealth NH, aims to improve health and wellness for young people with serious emotional disturbance (SED) and serious mental illness (SMI). ProHealth NH was implemented utilizing partnerships between Federally Qualified Health Centers (FQHCs) and CMHCs that serve over one-third of the State. Primary care services are now co-located and integrated at three CMHCs with this project. The expectation is that integration can increase access to and receive recommended outpatient screening and treatment for physical and mental health conditions. Such treatment will reduce unnecessary emergency room visits and hospital stays.

Mental Health Medicaid Directed Payments

As authorized by the Centers for Medicare and Medicaid Services (CMS), the New Hampshire Department of Health and Human Services (DHHS), through its Medicaid Care Management agreements and contracted MCOs, has supported many directed payment models in the State since 2019. These payment models are specifically designed to improve mental health outcomes. They are adjusted each year to ensure an approach responsive to trends specific to the New Hampshire Medicaid beneficiary population's behavioral health needs.

For the past two years, the directed payment approach includes $5m allocated to:
• Support Assertive Community Treatment (ACT) teams' ability to provide ACT services with fidelity within the 10 CMHCs;
• Ensure prompt and continued access to community-based care through the same day/next day face-to-face service to individuals within 24 hours of discharge from a State Institute for Mental Disease (IMD) or designated receiving facility (DRF), and an additional payment for each subsequent, consecutive weekly (7-day period) with a face-to-face service, up to 90 days. These payments are anticipated to result in decreased readmission rates;
• Timely prescribing for new individuals determined eligible for CMHC services. This payment is attached to the individual's intake and followed by an appointment with the CMHC prescriber within 21 days. It is anticipated to reduce Emergency Department (ED) visits and readmissions for those individuals not already connected to the State's Community Mental Health (CMH) system.
• Support effective Illness, Management, and Recovery (IMR) program participation. This payment is made if a beneficiary receives at least one hour per week of IMR services for at least 10 out of 13 weeks in 13 weeks. It is anticipated to reduce ED visits and readmissions for program participation.
• Support beneficiaries who are dually diagnosed with a developmental disability (DD) and SMI who are being discharged from New Hampshire Hospital (NHH) with a need to transition to a more community-integrated living situation. This payment supports the specialty residential services they will need, including receiving coordinated care through a multidisciplinary approach that crosses the MH and DD systems.

Consolidation of Crisis Billing
To support the statewide behavioral health crisis response system transformation, the billing for acute crisis services, including mobile crisis response and stabilization services, has been consolidated and streamlined to help support a robust and sustainable crisis response system through the goals of:
• Responding to all individuals who require a face-to-face crisis intervention anywhere in the community.
• Deploying a two-person response team for the initial crisis intervention.
• Developing a reimbursement structure that supports two-person crisis response teams and instances when a one-person response is allowed.
• Providing crisis stabilization services to individuals who need extra support following a crisis episode that resulted in contact with the mobile crisis response team.

Five specific billing codes were identified to cover crisis intervention services, psychotherapy for crisis, and crisis stabilization services. Each code was priced at levels based on the credentials of the service's staff, whether it be a masters-level clinical, bachelor's level staff, or peer support specialist. Crisis codes will be billed using a specialized modifier to access enhanced rates specifically developed to support these community-based crisis services.

CMHC EBP Incentive Funding
The CMHCs receive incentive funds via contracted state general funds to assist them with achieving higher fidelity and improving the quality of EBP's required by the Community Mental Health Agreement (CMHA) and in their contracts. Each center can draw down money to achieve a score of "3" in frequency and intensity of services. A score of 3 for intensity is measured by individuals receiving 50-84 minutes of services per week by members of the ACT team. The frequency of service must occur between 2-3 times per week per individual to score a 3. Additional areas will also increase efficacy by addressing both frequency and intensity of services, such as the team approach within the ACT model. The following contract year is anticipated to increase the incentive requirement in these two areas to a score of 4 or 5, thus taking a step-wise approach to quality improvement.

Substance Use Disorder, Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access (SUD SMI SED TRA) 1115 Medicaid Demonstration
The State's 2018 Demonstration originally encompassed SUD IMDs. This demonstration gives the Department authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient settings that qualify as an IMD. It also builds on the State's existing efforts to improve models of care focused on supporting individuals in the community and at home, outside of institutions, and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

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

On June 16, 2023, the Department received approval from CMS to temporarily extend the SUD, SMI, and SED-Dentures Treatment Recovery and Access Demonstration Waiver. Within the Department's extension request, an additional component was sought to

provide Medicaid coverage to incarcerated individuals approaching release from the State's correctional system, who would otherwise be eligible for Medicaid if not for the incarceration and who have a history of SMI or SUD. This component would provide a limited Medicaid benefit to facilitate timely access to community-based mental health and SUD services upon release, such that Medicaid will be opened for a 45-day pre-release period to ensure all eligibility, assessments, and care plans could be coordinated between existing State correctional providers, the targeted new community-based providers, and the State's MCOs. The anticipated outcome of this limited benefit is to reduce ED and hospital stays, as well as correctional system recidivism, by providing continuous access to needed care for this vulnerable population. The Department's request to add this component is under review. CMS is actively working with the Department to guide development and potential approval.

Other non-fiscal strategies
In addition to financial incentives, the State has implemented the below strategies to ensure evidence-based or promising practices guide purchasing and policy decisions:
• Independent fidelity reviews for Individual Placement and Support – Supported Employment (IPS-SE) and ACT are conducted annually for all 10 CMHCs. If the CMHC scores in the highest fidelity bucket, they are incentivized by being able to "skip a QIP," meaning they do not have to develop a comprehensive quality improvement plan for that fiscal year.
• Quarterly data reports are generated using monthly validated data submissions from the CMHCs regarding service delivery and utilization. Decisions about program expansion and funding are made as a result of data reporting.
• The Department and MCO providers review quarterly data submitted by the State's MCO providers to drive policy and practice decisions.
• Hold contracts with independent experts to provide training, technical assistance, and evaluation of evidence-based programs for providers in areas such as CTI, FEP, IMR, MATCH, and crisis services.
• The annual consumer satisfaction survey informs program and practice improvement via a collaborative annual review and quality improvement plan.

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

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

Please respond to the following items:

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

Model(s)/EBP(s) for ESMI/FEP	Number of programs
NAVIGATE (Coordinated Speciialty Care)	4

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

FY2024	FY2025
440000	440001

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

All Coordinated Specialty Care (CSC) ESMI/FEP programs are operated by the State's designated Community Mental Health Centers (CMHCs). Therefore, for Medicaid-eligible individuals, the providers can bill on a per member/month basis per the terms of their contract with the MCO. Medicaid billing includes reimbursement for individual services provided through the CSC model, such as prescription services, medication monitoring, supported employment/education, therapy, functional support services, and case management. Some individual services, such as prescriber services and therapy, are billable to private insurance. There currently needs to be specialized rates or billing categories for CSC. Any services not otherwise billable through Medicaid or private insurance are supported using MHBG funds via contract.

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

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

Each of the four CMHCs bills for the individual services through the client's insurance, as applicable. For those clients who are "un" or "under" insured, the CMHCs can draw up to $60,000 of MHBG dollars each state fiscal year to meet their service needs.

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

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

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

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

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

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

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

Through a contract with the BMHS, NAMI NH developed the "Onward NH" public awareness campaign to help New Hampshire residents

recognize ESMI/FEP, connect quickly to resources and support, and understand there is hope –recovery is the expectation. Onward NH launched in May 2020 and is informed by research that spanned nationwide public awareness campaigns and features curated content for individuals, family members/friends, providers, and educators. Personal stories from each perspective are featured alongside resources to help recognize ESMI/FEP and opportunities for treatment and support throughout New Hampshire.

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

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

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

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

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

The ESMI/FEP CSC programs serve individuals aged 16 to 35. Suppose an individual outside of this age group is identified. In that case, the program may submit a request to serve the individual when clinically appropriate. Individuals who have experienced symptoms that demonstrate psychosis and/or symptoms that are highly likely to be the signs of an existing or emerging schizophrenia spectrum disorder are included. New Hampshire also includes those meeting the diagnostic criteria beyond existing or emerging Schizophrenia Spectrum Disorder (including Schizophreniform and Schizoaffective disorders) to include additional ESMI diagnoses such as Major Depressive Disorder and Mood Disorders, and others that can cause severe impairment.

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

Less than 2% of the overall population in New Hampshire.

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

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

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

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

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

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

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

New Hampshire Division for Behavioral Health (DBH) is dedicated to supporting, promoting, and requiring person-centered planning, to ensure that individuals are fully involved in making decisions about their treatment.

In the person-centered system that New Hampshire DBH strives to maintain, individual needs, goals, and values are respected and acknowledged. This approach involves a collaborative partnership between individuals and providers to ensure that each person's values, experiences, and knowledge are central to developing a personalized care plan and delivering services that focus on their strengths.

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

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

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

The Bureau of Mental Health Services (BMHS) strives to maintain a person-centered, community-based environment that promotes individuals' independence, dignity, and wellness. Person-centered planning establishes a process by which an individual support plan can be developed, directed by the participant and their representative, and intended to identify their preferences, strengths, capacities, needs, and desired outcomes or goals.

BMHS strongly advocates for and mandates person-centered planning, ensuring individuals' active involvement in their treatment decisions. The state utilizes the Child Adolescent Needs and Strengths Assessment Tool (CANS) and Adult Needs and Strengths Assessment Tool (ANSA) collaborative evaluation tools, which involve the individual and their natural supports in guiding, prioritizing, and supporting treatment choices. Through these tools, a collaborative conversation occurs between the individual, provider, and relevant natural supports to identify strengths and needs, translating into goals for the individual service plan. Ratings generated by the New Hampshire version of the CANS or ANSA assessment are utilized to develop individualized, person-centered treatment plans, ensuring the treatment approach is tailored to each individual's unique needs and preferences.

New Hampshire State Regulation requires all of New Hampshire’s Community Mental Health Centers (CMHCs) to engage

individuals in their treatment planning process. Each individual service plan focuses on the following items:
• Recovery;
• Strengths;
• Community integration and participation;
• Enhancing natural community supports and relationships, with particular emphasis on maintaining and improving family relationships;
• Employment, self-sufficiency, and other similar, socially valued roles;
• Identifying functional impairments that are a result of mental illness;
• Identifying treatment interventions to mitigate the functional impairments;
• Promoting access to generic services and resources;
• Establishing time-specific, sequentially-stated objectives for improved personal functioning;
• Establishing a crisis plan with individual strength and preferred responses to crisis; and
• Establishing an employment or educational plan, as appropriate.

These plans are reviewed with the individual or the individual and their caretakers/natural supports/or family bi-annually with the expectation that the services provided are reviewed to establish an ongoing need from both the provider and the individual's perspective.

BMHS oversight includes an Office of Consumer and Family Affairs (OCFA), which provides information, education, and support for children and youth, families, adults, and older adults who are dealing with the challenges of mental illness. The OCFA aims to facilitate individual and family input into all aspects of the state-funded mental health system and BMHS' planning and policy development. By recruiting, organizing, and empowering individuals and families, BMHS seeks to support them in establishing and maintaining strong input and mental health leadership on a local, regional, state, and national level.

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

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

For individuals in crisis, New Hampshire's No Wrong Door (NWD) System represents a collaborative effort of the U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration (VHA), to support state efforts to streamline access to Long Term Services & Support (LTSS) options for all populations and all payers. In a "No Wrong Door" entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process administered and overseen by a coordinating entity.

The New Hampshire NWD System builds on the strength of existing entities, such as State Units on Aging, Aging, Disability Resource Centers, and Centers for Independent Living, by providing a single, more coordinated system of information and access for all persons seeking long-term support. This minimizes confusion, enhancing individual choice and supporting informed decision-making. In New Hampshire, Peer Support Agencies provide a place for individuals experiencing or recovering from SMI to receive support in a dignified and purposeful way. Peer support agencies provide services by and for people with a mental illness and are designed to assist people with their recovery through supportive interactions based on shared experiences among people. The services and supports are intended to assist people to understand their potential to achieve their personal goals.

Wellness Recovery Action Planning (WRAP) is a group intervention that helps individuals plan for all the steps to achieve recovery. WRAP is delivered in a self-help group context and used in discharge planning at New Hampshire's inpatient psychiatric hospitals and PSAs to facilitate recovery. WRAP guides participants through identifying and understanding their wellness resources ("wellness tools") and helps them develop an individualized plan to use them daily to manage their mental illness. The WRAP process supports individuals in identifying the tools that keep them well and creating action plans to put them into practice in their everyday lives. All along the way, WRAP helps individuals incorporate key recovery concepts and wellness tools into their wellness plans and lives. The five key concepts of WRAP include hope, personal responsibility, education, self-advocacy, and support.

Starting in SFY23, New Hampshire implemented Critical Time Intervention (CTI) services at all 10 CMHCs to support individuals in maintaining recovery after discharge from inpatient hospitalizations. Driven by person-centered goals, CTI ensures those individuals have intensive support available during the initial nine months of discharge to improve recovery and quality of life while lowering readmission rates and costs.

Lastly, ensuring peer support specialists are part of the team that supports individuals during a crisis is a focus in New Hampshire. Through the crisis response system transformation, New Hampshire intentionally included peer support specialists as core members of the two-person mobile crisis response deployment teams. Peers respond alongside master's level clinicians to an initial crisis and remain part of the crisis stabilization team to deliver peer-oriented services once an individual's immediate crisis has stabilized. Peer support specialists are also required by contract with BMHS to be employed at all transitional housing programs to support and facilitate person-centered planning. These are examples of steps BMHS is taking to support the lived and learned experiences model, allowing for person-centered approaches to drive recovery, wellness, and treatment planning.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

At this time, NH's 10 CMHCs are providing and documenting treatment preferences, warning signs, contact individuals, skills that are helpful, which is currently titled "Relapse and wellness plan". In the future, the state will explore the possibility of having a more standardized "Psychiatric Advanced Directives" procedure.

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

At this time, no we do not have needs. If NH decides to implement this procedure, we will potentially need assistance at that time.

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Footnotes:

Please see question 5 for newly added information.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

New Hampshire understands the restrictions on using block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31. New Hampshire MHBG funds are allocated to support evidence-based, culturally competent programs and activities for adults with SMI and children with SED. All programs funded by the MHBG are subject to this requirement.

Community-Based Programs and Confidentiality
The Bureau of Mental Health Services (BMHS) ensures that recipients of mental health services can have complete confidence in the confidentiality of their medical information. All Community Mental Health Center (CMHC) clients receive notice of HIPAA privacy practices and State confidentiality protections at intake and annually after that. Members and staff of New Hampshire's Peer Support Agencies (PSAs) sign a Statement of Confidentiality detailing their rights and the obligation to protect the specific rights of their fellow members, and, in addition, PSA and CMHC staff receive client rights training at the time of hire and regularly after that. These practices are monitored, reviewed, and reported on by a BMHS team, including the MHBG State Planner.

Community Mental Health Consumer Survey
The MHBG State Planner manages the annual Community Mental Health Consumer Survey and the Behavioral Health Services Information System (BHSIS) grant that, in association with the MHBG, supports the survey's execution and data collection efforts

that inform the URS tables. The MHBG State Planner ensures that the Behavioral Health Planning and Advisory Council (BHPAC) members are informed of survey progress and are offered opportunities to inform the process. The survey vendor, by contract, is required to present the survey findings and report to the BHPAC, the public, the CMHCs, and other state agency heads. In this way, the quality findings stated in the survey report are presented as a source of suggested quality improvement efforts to be prioritized by the public and BMHS.

The recipients of mental health services who comprise the random survey sample are clients served throughout the CMHC system. The sample is derived from the New Hampshire DHHS client-level services database. Survey recipients are advised that participation in the survey is voluntary and completely confidential. The survey is administered by a third-party vendor who is held to strict information security guidelines. In addition, survey participants are informed that their individually identifiable responses are not shared with DHHS.

Peer Support Agencies
In SFY 2022, 39% of New Hampshire's MHBG funds were directed to fund contracts with eight independent, nonprofit Peer Support Agencies (PSAs) that provide services at 14 physical locations, thus assuring statewide access to standalone peer support programs for eligible adults. Insurance and/or Medicaid does not currently fund these services.

Because of the large proportion of MHBG funds allocated, BMHS assists the PSAs in adopting policies and practices that promote compliance with program requirements, including quality and safety standards, as outlined in the State Administrative Rules and other state and federal requirements. This is achieved by providing continual and accessible oversight, technical assistance, and linkages to state and national resources.

The PSAs file annual budgets, monthly financial reports, and quarterly outcomes reports to BMHS. PSAs undergo annual financial reviews conducted by outside auditors. Audit reports are submitted to the BMHS Financial Management Department and are reviewed and reconciled by the DHHS Bureau of Program Integrity.

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

During 2018 – 2019, BMHS conducted quality reviews of PSAs for contractual and administrative rule compliance. The review team consisted of several BMHS members and two Bureau of Program Integrity staff members. PSAs were notified of the review in a detailed letter describing the review process and requesting initial programmatic, policy, and financial information. Post-review, program, and financial findings were detailed in formal reports. The review team evaluated and approved the PSA's corrective action responses. Follow-up visits were conducted to verify corrective actions and other improvements recommended by BMHS. Upon completion of all corrective actions, final reports are approved and distributed. The process will be repeated on a biannual basis.

As a result of this review, BMHS contracted with the New Hampshire Center for Nonprofits in SFY 2020, 2022, and 2023 to provide individualized consultation services, training, and support, focusing on improving agency governance, fiduciary oversight, and programmatic enhancement. 100% of federal funds have funded these contracts.

In 2022, BMHS conducted quality reviews of the 4 Recovery Orientated Step-Up Step-Down (SUSD) program contracts held by the PSAs. The review team consisted of several members of BMHS and two to four staff members from the Bureau of Program Integrity. PSAs were notified of the SUSD review in a detailed letter describing the review process and requesting initial programmatic, policy, and financial information. These reviews concluded in SFY 2022, and post-review, program and financial findings are being written in formal reports to be distributed in the first quarter of SFY 2023.

Other Programs Supported and Monitored by the BMHS:

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

MHBG funds allocated to support the BHPAC are budgeted as a set dollar amount on a State Fiscal Year basis. Each expenditure request is correctly invoiced, drawn down, and recorded by the BMHS Finance Department. The MHBG State Planner reviews each invoice for approval before its being paid. Both BMHS and DHHS Finance departments conduct further reviews before being paid.

BHPAC membership is unpaid; only peers (recipients of mental health services) and family members not participating in the council as part of their paid employment are eligible for mileage reimbursement. The BHPAC Chair and Subcommittee Chairs receive a small, token stipend for the extra time and assistance they provide to the support and well-being of the BHPAC. All funds are

disbursed through a cost-effective and compliant process. Other reimbursements or stipends to BHPAC members for participation in stakeholder capacities provide the dual advantage of encouraging participation and rewarding labor and time. For example, members are asked to assist with MHBG application research and participate in Steering Committees associated with BG-funded initiatives. Care is taken to follow and document DHHS protocol prohibiting conflicts of interest.

MATCH

Another CMHC program funded by the MHBG and subject to program integrity review includes training on the Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) treatment protocol statewide. MATCH is a treatment program developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and MATCH trainer certification are provided via a contract with Judge Baker Children's Center (affiliated with Harvard Medical School). Once the training is completed, the CMHCs can continue utilizing the EBP by training peers at their agency and maintaining their certifications. MHBG funds are expended to assist each CMHC in training new clinicians, maintaining new and renewed certifications, and utilizing the TRAC-JBCC online platform. Approximately 60 trained clinicians in New Hampshire maintain their certification, and over 75 staff have been trained.

CANS & ANSA in the New Hampshire System

The Child Adolescent Needs and Strengths Assessment Tool (CANS) and Adult Needs and Strengths Assessment Tool (ANSA) project is wide-ranging in scope and goals. These two instruments are used to assess, direct, and monitor person-centered treatment for SED in children and youth via the CANS and SMI in adults via the ANSA. The goal is to utilize these instruments as a standard assessment tool statewide throughout the youth and adult systems of care. Progress toward this goal is a BMHS and the Bureau for Children's Behavioral Health (BCBH) priority. As of SFY24, 9 out of the 10 CMHCs are currently using the ANSA for screening and ongoing treatment planning. All 10 CMHCs utilize the CANS for assessment and ongoing treatment planning.

Since 2013, New Hampshire has provided technical assistance in the form of CANS and ANSA online training and support for the certification of clinical staff employed by the CMHCs and by statewide partners throughout the children and youth System of Care, including participants in FAST FORWARD (a Wraparound program), and other community-based partnerships. Annual CANS or ANSA certification from the Praed Foundation is required to preserve item rating reliability, and New Hampshire covers this cost for CMHC staff. Program supervisory staff are encouraged to seek Trainer certification to provide CANS/ANSA guidance consistently with BMHS and Praed Foundation expectations.

The MHBG State Planner approves general MHBG oversight allocations, program encumbrances, and expenditures, and the BMHS Finance Department manages the accounting of the funds. Status and balance reports are provided to the MHBG State Planner and BMHS leadership quarterly. The MHBG State Planner meets with the Finance Department frequently on an informal basis to track payments, vendor compliance, and fund balances. The MHBG State Planner oversees vendor compliance by managing project work plans that align program deliverables and invoices with costs, as budgeted and referenced in their contracts.

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

N/A

2. What specific concerns were raised during the consultation session(s) noted above?

N/A

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

N/A

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

New Hampshire does not have any Federal or State recognized Tribes; there are no tribal governments or lands within its boundaries. However, this does not eliminate the possibility of the presence of American Indians and/or Alaska Natives within our state or supports specific to their needs.

In SFY 2021, there were 107 persons served in the NH public mental health system via the Community Mental Health Centers (CMHCs) who report being Native Indian or Alaskan Native. (SOURCE: FY21 URS Table 14A).

New Hampshire Intertribal Native American Council

The mission of the New Hampshire Intertribal Native American Council is to create a culturally integrated organization to identify, unify, support, and service the cultural and non-cultural needs of the various Native American Indian people, their descendants, and organizations residing within New Hampshire. The New Hampshire Intertribal Native American Council does not represent any one Native American Nation; but are made up of many Nations, Tribes, Clans, and People who reside in and around New

Hampshire.

One of the Council's stated purposes is to “provide services and resources to assist all Native American Peoples that have been assimilated into the general population of NH, so that they may live without hunger, be clothed, have proper housing, and experience the spiritual and cultural awareness that is part of the Native American Heritage.”

Members of the BHPAC have identified the Council as a potential source of BHPAC members. In SFY 2024 a more detailed focus will be applied to council and subcommittee membership with more of a guiding force from the BMHS.

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Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Bureau of Mental Health Services (BMHS) seeks to promote respect, recovery, and full community inclusion for adults, including older adults, who experience a mental illness. The BMHS provides oversight, guidance, technical assistance, training, and monitoring for mental health providers statewide to ensure high-quality services are comprehensive and evidence-based.

Community Mental Health Centers
The State is divided into ten designated community mental health regions. Each of the ten regions has a BMHS-contracted Community Mental Health Center (CMHC), and all ten of New Hampshire's Regions have Peer Support Agencies (PSAs) providing community-based services.

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

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

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

Administrative Rules for CMHCs detail the community-based psycho-rehabilitative services available in New Hampshire that are provided with BMHS oversight. The purpose of these services is to support and promote the ability of individuals to function in the community outside of inpatient or residential institutions. The New Hampshire administrative rules governing community mental health program structure, services, and treatment programs may be found at He-M 401-421 (state.nh.us)
https://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html

New Hampshire contracts with three Medicaid Managed Care Organizations (MCOs). These contracts include provisions that MCOs maintain ongoing relationships with the 10 CMHCs within New Hampshire, ensuring services are reimbursable and supported. Each MCO submits a quarterly report identifying individuals admitted to a psychiatric hospital and readmitted within 30 or 180 days after the initial readmission. The readmission report allows the MCO and BMHS to continuously improve services or lack thereof. Ongoing work is being conducted to present these reports to the CMHCs and utilize them for continuous quality improvement.

New Hampshire has created a Children's System of Care (SOC) to organize services into five tiers or levels based on what services our children, youth, and families need: from lower levels of care (Tier 1) to the highest intensity, which is hospital care and psychiatric residential treatment (Tier 5). Assessments are provided at each Tier to ensure that a child or youth is matched to the best service, support, or treatment given their needs. Tier 1 services are for youth and families trying to determine their needs. Tier 2, includes outpatient behavioral healthcare, treatment, services, and short-term care coordination. Tier 3 includes services and support for children and youth with complex mental health or substance use concerns but remain in the community with intensive in-home support. Tier 4 is out-of-home residential treatment, which provides care for children and youth who need short-term treatment for a serious mental or behavioral health concern. A Comprehensive Assessment for Treatment (CAT) is required to enter

Tier 4 care. Residential Treatment Providers or New Hampshire's Psychiatric Residential Treatment Facility (PRTF) provide this level of care. In contrast, Transitional Enhanced Care Coordinators provide care coordination. Tier 5 services are inpatient psychiatric treatment provided in a hospital setting, including short-term hospitalization and intensive residential treatment.

Peer Support Agencies

Peer Support Agencies (PSA) provide an alternative to traditional clinical treatment delivered by individuals with lived experience of mental illness and/or substance use disorders. These individuals, often called "peer support specialists", "peer recovery specialists" or "peer counselors," have gone through their recovery journey and are trained to provide support and guidance to others facing similar challenges.

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

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

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

Recover Orientated Step Up/Step Down

In December 2020, New Hampshire first entered into a contract with four PSAs, each to operate a three-3-bed Recovery-Oriented Step-Up/Step-down (SUSD) Program. Start-up program locations were located in Nashua, Manchester, Keene, and Northwood. Additionally, in 2022, Keene expanded to hold two SUSD contracts totaling six beds. These programs offer a new level of crisis care in New Hampshire. The SUSD Programs provide short-term recovery-based transition services for adults (18 years or older) transitioning from inpatient or institutional settings into the community or requiring more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer support with access to peer staff 24 hours a day, seven days a week. Staff focus on recovery-oriented peer support services that also work to coordinate and engage with outpatient community-based clinical treatment providers. Programs are operated per the SAMHSA Core Competencies for Peer Support Workers in the behavioral health system and accept referrals from many community-based treatment providers. Each program has operated at over 80% capacity since opening, and most continue to have waiting lists. In 2022, the Department increased stay limits to 120 days per episode to allow more time for stabilization and transition back into the community.

Peer Respite

New Hampshire has two long-standing contractors within the peer support agency vendors, who provide two peer respite beds per agency, totaling four beds statewide. These programs provide non-clinical peer support with access to peer staff twenty-four hours a day, seven days per week. Staff focus on recovery-oriented peer support services and enhancing community connection to support individuals maintaining recovery in their community. Historically, these programs have a seven-stay limit; in 2022, the Department increased stay limits to 10 days per episode to allow more time for stabilization and transitional steps back into the community.

Transitional Housing Residential Services

The New Hampshire BMHS, through contracted providers, offers an array of supported housing programs to allow individuals to remain in the community. These programs include but are not limited to, Transitional Housing Programs (THP), the Housing Bridge Subsidy Program (HBSP), Project Rental Assistance, Section 811 (PRA811), and licensed community residences. The THP is designed to serve the clinical, medical, vocational, and residential needs of adult men and women with mental health issues. The recovery model is to help individuals maintain their independence in the least restrictive environment possible so they may successfully transition from inpatient hospitalizations back into the community, where they can manage their needs with the help of a CMHC. This way, support is titrated from intensive treatment to independence, preventing frequent hospital readmissions. Natural and community support systems are engaged to increase community integration and connectedness for individuals. Transitional Housing offers the following services designed to be responsive to the unique needs of the individual, including:

• Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational, and day treatment services
• Support for community connectedness and family involvement
• Open communication with families and individuals
• A comprehensive approach to service delivery driven by consumer involvement
• Evidence-based practice approaches include IMR and IPS-SE

The THP provides a solid foundation to move individuals into more independent housing, such as full community integration through the HBSP and PRA811, as well as moving individuals into community residences and specialty housing, where they are provided community integration coupled with daily staffed support. A supportive housing continuum that provides resources and education needed at each step is integral to empowering individuals to remain in community-based settings.

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

• The New Hampshire Rapid Response Access Point (NHRRAP) is the centralized crisis contact (call, text, chat) center designed to provide the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services. NHRRAP also can deploy the closest available mobile crisis team promptly. Individuals in New Hampshire have immediate, around-the-clock access to mental health and substance use crisis support through NHRRAP via various communication channels, including telephone, text, chat, and telehealth services.
• Statewide NHRR Mobile Crisis Response Teams (NHRR): These teams operate 24 hours a day, seven days a week, providing mobile crisis intervention services. Comprising two specially trained crisis responders, NHRR teams can respond to requests for crisis assessments and interventions within one hour of receiving calls. Once engaged with a case, the responding team can offer services and support for up to 30 days after the crisis, ensuring individuals remain stable and receive the necessary assistance within their community.
• Crisis Apartment Beds: Available in the Nashua, Manchester, and Concord regions, Crisis Apartments serve individuals aged eighteen years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to seven days per episode and sometimes longer when necessary.
• Currently in the process of implementing two location-based crisis centers. These crisis centers will offer short-term (23-hour) observation and crisis stabilization services, accommodating all referrals in a homelike, non-hospital environment. One location may offer a seven day stay for individuals and families.

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

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

		Yes	No
a)	Physical Health	●	○
b)	Mental Health	●	○
c)	Rehabilitation services	●	○
d)	Employment services	●	○
e)	Housing services	●	○
f)	Educational Services	●	○
g)	Substance misuse prevention and SUD treatment services	●	○
h)	Medical and dental services	●	○
i)	Support services	●	○
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	●	○
k)	Services for persons with co-occuring M/SUDs	●	○

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The BMHS works closely with the Bureau for Children's Behavioral Health (BCBH) and the Bureau of Drug and Alcohol Services (BDAS); both agencies serve the New Hampshire DHHS under the umbrella of the Division for Behavioral Health (DBH). DBH leadership reinforces coordinating Behavioral Health treatment and care services for SUD, Mental Illness, Developmental Disorders, and Co-Occurring disorders.

Comprehensive psycho-rehabilitative services (inclusive of education, employment, housing, peer support, and physical health services) for individuals with mental illness and services for persons with co-occurring disorders are provided by all ten CMHCs. Several CMHCs additionally offer specialized SUD treatment services directly. Still, all refer to close partners in SUD treatment based on identified needs. Gaps in services for those individuals with co-occurring mental health and substance use disorders have been identified. Current and future work has started and will continue to increase collaboration across New Hampshire DHHS DBH. Detailed financial and programmatic strategies require ongoing development to address the continuum of care. Crosswalking of both DBH rules and regulations, outlining service standards and access, has been a topic of discussion. Once completed, standards of care will be established with best practices to ensure No Wrong Door access. The bureaus within DBH work together to oversee the behavioral health components of the MCO contracts to ensure contract terms, performance metrics, and quality improvement efforts meet the expectations and needs of all individuals with behavioral health needs.

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

3. Describe your state's case management services

Community Mental Health Case Management
The philosophy of case management stems from the concept of wellness. When an individual reaches their optimum level of wellness and functional capability, everyone benefits the individual being served, their support system, the health care delivery system, and the various reimbursement sources. Case management aims to meet the needs of an individual and address their social determinants of health. This is achieved through a collaborative assessment, planning, facilitation, care coordination, evaluation, and advocacy.

The foundation of the community mental health system in New Hampshire is built on case management. The Administrative Rules set the standard for New Hampshire community mental health programs. These Rules outline case management, and case managers act as core treatment constituents throughout service delivery while providing person-centered services. CMHC programs may serve as the sole case management entity for individuals with SMI or SED, or the CMHCs may serve as the linkage point for mental health services for clients whose needs are coordinated by another entity, including schools, developmental services agencies, or nursing homes.

The Targeted Case Management (TCM) requirement limiting case management billing to one entity per client encourages communication across the service spectrum and a client-centered experience. Individuals involved across the system can select the agency to manage their case.

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

Supporting individuals diagnosed with SED and SMI to help them integrate into their community of choice is a crucial case management activity. An annual case management assessment and care plan, pursuant to He-M 426, includes documentation of the following:

• Information gathered from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual
• An assessment of the individual’s strengths
• Identification of the consumer's case management needs
• The individual’s preferences for needs to be addressed

All assessment needs, including referrals, linkage, and monitoring activities, are documented in an individual's care plan. Needs are reviewed on a mutually agreed-upon frequency (at least bi-annually) with an annual review and revisions to the assessment on an as-needed basis.

The development and periodic revision of a specific and comprehensive care plan relates to information collected through the assessment or reassessment that indicates goals for medical, social, educational, and other needs.

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

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

Among the most effective community-based services supported by the BMHS (through contractual arrangements) are Functional Support Services (FSS), ACT, IPS-SE, Supported Housing, CTI, NHRR Teams, First Episode Psychosis early intervention (FEP), Case Management, Peer Support Center services, including day programs, SUSD, and Crisis Respite. These services play a critical role in promoting the overall well-being of individuals and supporting their mental health needs.

Functional Support Services (FSS)

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

Assertive Community Treatment (ACT)

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

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

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

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

Comprehensive Crisis Transformation Efforts
New Hampshire is actively expanding and transforming its crisis services to create a comprehensive and integrated crisis response system for individuals of all ages experiencing mental health and/or substance use crises. This initiative is aligned with the national Crisis Now model and has been gradually implemented over the past two years. It now encompasses a full continuum of care, including:
1. The New Hampshire Rapid Response Access Point (NHRRAP) is the statewide centralized crisis contact (call, text, chat) center.
• The BMHS implemented the NHRRAP system on January 1, 2022. Before that date, there were more than 20 different numbers to call for access to crisis services. The goal of NHRRAP was to have one number, regardless of the time of day and/or caller's location, to call for behavioral health crisis support in New Hampshire. The State contracted with Carelon (formerly Beacon Health Options) to provide the NHRRAP service. The AP answers calls 24 hours a day, seven days a week. Most calls (80%) are resolved at the access point level. The NHRRAP number is 1-833-710-6477.
• 988 became the National Suicide Prevention Lifeline (NSPL) number on July 16, 2022 (with the former 1-800-273-TALK still in place). The main goal of 988 is to have an easy number to remember, akin to 911. Headrest has been the NSPL call center provider in New Hampshire for many years. Headrest continues to answer the calls that come in via 988. 988 is integrated with the NHRRAP through shared protocols
2. Mobile Crisis Response Teams deploy twenty-four hours, seven days a week to support children, youth, adults, or families experiencing a mental health or substance use crisis.
• Mobile crisis response teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals in their homes and other community-based settings outside a traditional clinical office. Crisis intervention teams work to intervene with an individual/family in crisis and safely direct them to treatment appropriate for their condition, thus reducing the arrest rate, incarceration, or unnecessary emergency room visits. Since the statewide launch of mobile crisis in January 2022, teams have deployed more than 9,000 times.
3. Crisis apartments provide crisis stabilization for up to seven days.
• Three mobile crisis teams located in the population centers of Nashua, Manchester, and Concord each operate four crisis apartments.
4. Although walk-in location-based crisis intervention services are available on a limited basis in all regions, New Hampshire is in the process of implementing two 23-hour location-based crisis centers. Expansion of these crisis centers is expected in late 2023 with the support of Technical Assistance provided by SAMHSA.

Supportive Housing and Housing Supports
The availability of safe and affordable housing is often a core social determinant of health for those diagnosed with severe mental illness. The cascading effects of mental illness can strain the individual's ability to acquire and maintain housing. Having a safe and secure place to live is critical to stabilization and recovery, along with access to services that enable those with mental health conditions to live independently after hospitalization. There are currently several successful housing programs managed by the BMHS to assist individuals experiencing homelessness due to disabling symptoms of mental illness.

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

The Housing Bridge Subsidy Program (HBSP) is a supportive housing program currently funded to serve up to 500 individuals across New Hampshire. HBSP services include Housing Specialists assigned to each individual in the program. The Housing Specialist will assist the individual in finding an appropriate unit, sign and understand their lease, and ensure they are connected to any community supports and services the individual requests or requires. Individuals on HBSP are expected to transition onto a

Housing Choice Voucher through HUD within two to three years of entering HBSP. The Housing Specialist will assist them with the transition to vouchers and remain available to the individual should they require further housing assistance.

The BMHS has partnered with the New Hampshire Housing Finance Authority (NHHFA) to manage the Project Rental Assistance Section 811 Program (PRA811). This is a permanent housing program, and recipients can access the complete support services the CMHCs provide. PRA811 provides individuals with a safe, affordable place to live and the availability of support services in the community to keep them safely housed and connected with their healthcare providers.

Supported Housing Subsidy Summary for data ending in March 2023.
Total Supported Housing subsidies by the end of the quarter: 1010
Housing Bridge Subsidy: 392
Section 8 Voucher
(NHHFA): Transitioned from Housing Bridge* 310
811 Units: PRA* 164
Mainstream* 75
Other Permanent Housing Vouchers (HUD, Public Housing, VA)* 32

Peer Support Agencies (PSA)
Peer Support Agencies provide an alternative to traditional clinical treatment. Among PSA programming, individuals can receive support from individuals with lived experience with mental illness. PSAs offer support groups, resources, warm line services, community connection, on-site activities, educational events, recovery orientated SUSD, and Peer Respite. Peer Respite and SUSD provide an alternative to psychiatric ED or inpatient hospitalization. In response to an anonymous survey, 143 out of 195 peer program participants reported that day support programs for peers provided by Peer Support Agencies, helped to keep them out of the hospital. (Source: NH Peer Support Outcomes Survey 2021).
In SFY2023, PSAs have served 2331 total members and see an average of 161 daily visits.

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

Each year, the 15-bed recovery oriented SUSD program serves approximately 72 people, 17 individuals stepping down from inpatient care and 40 individuals seeking an alternative to inpatient care.

PSAs also maintain warm lines, “a direct service delivered via telephone by a peer that provides a person in distress with a confidential venue to discuss their current status and needs.”

First Episode Psychosis (FEP)
In the last two years, New Hampshire has operated the HOPE (Helping Overcome Psychosis Early) Program/FEP treatment teams at four CMHCs. These centers have been and continue to utilize the NAVIGATE Coordinated Specialty Care (CSC) model. One of the CMHCs, Greater Nashua Mental Health, was part of the RAISE-ETP study and witnessed the positive impact on the lives of young adults and their families.

The CSC teams are composed of a Program Director, Family Education (FE) Clinician, Prescriber, Individual Resiliency Trainer (IRT), and Supported Employment and Education (SEE) Specialist. Additionally, case management and functional support services are offered.
Block Grant funds will continue to support the HOPE program with implementation costs and reimbursement for uncompensated HOPE program services.

New Hampshire has expanded efforts to increase awareness and reduce stigma related to mental illness in young people and first -episode psychosis specifically. The State has implemented learning and education models such as Mental Health First Aid statewide. These programs have planted the seeds of awareness about mental illness and how to recognize early signs. Stigma reduction, we have found, plays a large part in the ability of the general public to recognize early symptoms, refer to appropriate services, and engage in treatment. As part of New Hampshire’s 10-Year Mental Health Plan, early treatment models, including FEP, were highlighted and identified by stakeholders as foundational recommendations.

During SFY 2021-23, the State carried out a stakeholder engagement process to identify, propose, and begin an implementation strategy for a statewide ESMI or FEP treatment model using funds provided by the block grant 10% set-aside. The initiative included two components: proposing a treatment model that we can scale to provide ESMI/FEP services statewide and a public awareness campaign focusing on the importance and availability of early interventions. New Hampshire continues to work on the expansion of FEP services statewide.

Critical Time Intervention (CTI)
In July of 2022, the BMHS launched Critical Time Intervention an intensive care transition program to support individuals preparing for discharge from psychiatric inpatient settings. CTI aims to connect these individuals with services and support in their home communities. CTI is vital in ensuring patients leaving hospital settings can access the necessary support and services to

improve their quality of life and prevent unnecessary readmissions. The program is a partnership among Designated Receiving Facilities (DRF), New Hampshire Hospital (NHH), and ten CMHCs. It supports individuals in transitioning between inpatient and outpatient services effectively.

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

N/A

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.4% (59,261)	5.4% (59,261)
2.Children with SED	3.4% (8,691)	3.4% (8,691)

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

New Hampshire utilizes the Uniform Reporting System (URS) tables for planning and reporting. Information from the NH-DHHS Phoenix client service and demographic database is sorted and analyzed to produce the URS reports as well as various other reports, including ACT program utilization, waitlists, and staffing; and IPS-SE program utilization, waitlist, staffing, and aggregate count reports of clients by employment status.

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

These reports are utilized for program planning, budgeting, and target setting for program utilization and client outcomes.

New Hampshire Hospital: Adult Census Summary for reporting ending in March of 2021.

January-March 2021 October-December 2020
Admissions 165 187
Mean Daily Census 173 173
Median LOS for D/C 35 32
Discharges 173 191
Deaths 2 0

In the summer of 2023, the New Hampshire Department of Public Health hired the State's first behavioral health epidemiologist. This person will work in partnership with the DBH to further use prevalence and incidence data for planning purposes.

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

N/A

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

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

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

N/A

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

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

All ten CMHCs must care for individuals in rural settings within their regions. Specific regions with high rural settings include Northern Human Services, West Central Behavioral Health, and Monadnock Family Services. Within these regions, CMHCs work to provide care via telehealth platforms, within the community or clients' living location, and provide support in transportation where needed. The local PSAs often provide transportation services for individuals to attend appointments and receive support. The Department further supports the following services through rural care venues.

Targeted Services to Rural and Homeless Populations and to Older Adults Rural Populations
The New Hampshire DHHS, Division of Public Health Services, Bureau of Community Health Services Rural Health and Primary Care section includes the Primary Care Office, the State Office of Rural Health, and Workforce Development. The mission and function of the Rural Health and Primary Care section are to support communities and stakeholders that provide innovative and effective access to quality healthcare services with a focus on the low-income, uninsured, and Medicaid populations of New Hampshire.

Primary Care
The Primary Care Office (PCO) works with other New Hampshire partners statewide to improve access to quality healthcare services, especially for uninsured residents. The PCO is the location of the New Hampshire Health Professions Data Center. It is responsible for federal healthcare shortage designations. The PCO also provides technical assistance for National Health Service Corps sites.

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

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

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

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

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Four of the ten CMHCs provide Street Outreach and Supportive Services Only through SAMHSA's Projects for Assistance in Transition from Homelessness (PATH). These PATH programs comply with the Federal Public Health Services Act, Section 522(b) (10), Part C, to individuals experiencing homelessness or at imminent risk of becoming homeless and believed to have SMI, or SMI, and a co-occurring substance use disorder. The CMHCs provide outreach, screening, diagnostic treatment, and case management services. Services are targeted to assisting eligible homeless individuals with obtaining and coordinating services, including referrals for primary health care. The designated PATH workers assess the individual immediacy of needs and continue to focus and work with the individual to enhance treatment and housing readiness.

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

(SUD) or co-occurring disorders (COD).

All PATH and GBHI providers coordinate and actively participate in the three New Hampshire Continuums of Care for local community organizations and housing resource connections.
Homelessness
The US Department of Housing and Urban Development (HUD) defines someone who is experiencing homelessness as "an individual or family who lacks a fixed, regular, and adequate nighttime residence," meaning the individual:

1. Has a primary nighttime residence that is a public or private place not meant for human habitation;
2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional Housing, and hotels and motels paid for by charitable organizations or by federal, State, and local government programs); or
3. Is exiting an institution where the individual has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
4.
During the 2022 HUD Point in Time Count in New Hampshire, 1,605 persons were identified as experiencing homelessness on a single night in January. Of those:
• 331 individuals were experiencing unsheltered homelessness
• 478 individuals had mental health diagnoses that were expected to be of long, continued, and indefinite duration and that substantially impaired the person's ability to live independently
• 337 individuals had chronic substance use disorders, defined by HUD as alcohol misuse, illicit drug misuse, or both, that are expected to be of long-continued and indefinite duration and that substantially impair the person's ability to live independently
• According to The State of Homelessness in NH, by the New Hampshire Coalition to End Homelessness, while overall yearly data showed a nominal decrease in the total homeless population, the variance in the subpopulation data year to year was considerable. Individuals experiencing unsheltered homelessness more than doubled from 2020 to 2021- with 411 individuals in 2020 to 1,082 individuals in 2021.
• The unsheltered increase represents the extreme impact that COVID-19 had on individuals experiencing homelessness. With emergency shelters pivoting to adjust for pandemic safety measures and an extremely low housing vacancy rate, many people experiencing homelessness in 2021 stayed in places not meant for human habitation as their only solution to survival. Regions across the State responded with increased homeless outreach services to bridge this population to available services. However, many emergency shelters remained at capacity, and housing options were limited.
• In 2021, there was also an increase in chronic homelessness, which describes those experiencing homelessness while struggling with a serious mental illness, substance use disorder, or physical disability. Eight hundred and eighty-nine individuals were identified as chronically homeless in New Hampshire. These individuals comprise 19% of New Hampshire's sheltered and unsheltered homeless population.
• Black and Hispanic individuals are overrepresented in the homeless population. They are more likely to experience homelessness than White people in New Hampshire. Six percent of people experiencing homelessness identified as Black in 2021 despite making up only 1.46% of the population in the State. Similarly, people who identified as Hispanic were 9% of the homeless population but only 4% of the population in New Hampshire. Black and Hispanic populations in New Hampshire have less income on average, making these groups susceptible to increased housing instability.
• Reports from the New Hampshire Housing Finance Authority also show that the housing market across the State remains exceedingly tight, with a high demand for rental units, a low vacancy rate, and ongoing pressure on the affordability of rental units. To afford the statewide median cost of a typical two-bedroom apartment with utilities, a New Hampshire renter must earn 137% of the estimated statewide median renter income, or over $70,600 a year.
• The 2023 New Hampshire Housing Finance Authority Residential Rental Cost Survey Report found that:
o Statewide monthly median gross rent (including utilities) of $1,764 for two-bedroom units has increased by 11.4% since 2022.
o Rents statewide continued their steady 10-year climb.
o Increasing rents are both a cause and a result of inflation in the broader economy. They generally occur when leases are renewed or when rental properties are sold.
o Average monthly utility costs increased substantially over the last year due to a spike in energy prices, contributing to the survey's reported 11.4% increase in monthly median gross rent for two-bedroom units.
o With a vacancy rate of 0.8% for all rentals, finding an affordable apartment takes much work. (A vacancy rate of 5% is considered a balanced market).
o Based on the State's estimated population growth, a total of 23,670 additional housing units is needed today to meet New Hampshire's current housing shortage
o A lack of affordable Housing is the primary precipitating factor leading to homelessness in New Hampshire. However, an often-overlooked factor leading to homelessness for single individuals is having a disability. Disabilities can include physical, behavioral, and/or intellectual disorders. Acknowledging disabilities as a precipitating factor in homelessness is critical as it recognizes the need to design responsive programming for this specialized population.
o While many factors influence health, stable housing is a crucial "social determinant of health" that directly impacts health outcomes. Just as untreated behavioral health diagnoses can precipitate homelessness, homelessness is a significant risk for poor mental health. While some need only short-term assistance to regain health- including behavioral health- and reconnect to employment and housing independently, others may be seriously ill and/or disabled and need longer-term support services to maintain housing. Other health outcomes improve by increasing access to safe, affordable housing and improving housing stability.
• The Bureau of Housing Supports (BHS) provides various statewide services, which act as a safety net for some of New Hampshire's most vulnerable citizens. Projects include priorities for identified vulnerable populations, such as new Supplemental COC funding supporting Supportive Services for unsheltered individuals and COC Permanent Supportive Housing for chronically homeless individuals. Services are provided through five Community Action Agencies and other non-profit service providers across the State. These agencies provide service and financial interventions targeted at ending the homelessness experience and improving ongoing housing stability. Various program types make up a Continuum of Care- from Street Outreach through Permanent Supportive Housing- all based on preventing the homelessness experience, or

for those already homeless, quickly connecting to permanent housing solutions. Examples of services provided include:
o Assisting people experiencing housing instability or homelessness with urgent needs to access Housing, shelter, and/ or other services to achieve or maintain housing stability and independence.
o Providing short and medium-term rental assistance through Rapid Rehousing and Permanent Supportive Housing to individuals, youth, and/ or families, along with supportive services to maintain housing stability.
o Providing outreach services to those considered "hard to reach," such as chronically homeless residing on the streets or other places not meant for human habitation in rural regions to increase their transitions to housing stability.
o Provide intensive case management services to connect individuals and families to appropriate services, including medical and behavioral health care, TANF/SNAP benefits, SSI/SSDI, and other necessary services.
o Services provided through the Bureau of Housing Supports follow the Housing First approach. Housing First is a homeless assistance approach guided by the belief that housing is a basic need for people that should be met as quickly as possible, without any prerequisites or conditions beyond those of a typical renter. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and participating in supportive services and that exercising that choice is likely to make a client more successful in remaining housed and improving their life. Traditional homelessness programs have been based upon the assumption that people should not be placed into housing until they have resolved personal issues, such as diagnosis and treatment of a disability or training in independent living skills. Conversely, a Housing First approach assumes people should start with stable, permanent housing. They may then choose to address other life issues contributing to their homelessness experience to maintain their ongoing housing stability. Supportive services (such as recovery resources or mental health treatment) are offered to support people with housing stability and individual well-being. Still, participation is optional, as services are more effective when a person chooses to engage.
o A Housing First approach's flexible and responsive nature allows it to be tailored to help anyone based on their choice. Individuals using a Housing First model have been shown to access Housing faster. They are more likely to remain stably housed.
o Additionally, all programs must participate in the statewide Coordinated Entry process to ensure people with the longest histories of homelessness and with the most severe service needs are given priority and expedient access to available permanent supportive housing. Case management services also include connecting individuals with housing based on their needs, including housing opportunities outside of COC resources such as Housing Choice Vouchers, low-income Housing, affordable housing, or other solutions. Through this, individuals and families experiencing homelessness are assessed and linked to housing navigators who can help the individual/ family navigate housing services and supportive services such as mental healthcare, employment/benefit supports, and mainstream services that help keep households housed.
o Each individualized POC will use the above approach to create a strengths-based, individualized, community-based, culturally and linguistically informed action plan to obtain or retain housing, including through:
i. State Funded Emergency and Transitional Shelters
ii. HUD Continuum of Care funding
iii. HUD Emergency Solutions Grant Funding
iv. SAMHSA's Projects for Assistance in Transition from Homelessness

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

New Hampshire is Aging
As of 2019, New Hampshire’s population over 65 increased by 2.7%. A need exists for services and programs targeted to our aging population, which is 2.2% greater than the rate of increase in the US. (SOURCE: US Census)

New Hampshire Referral, Education, Assistance, & Prevention Program (REAP)
The New Hampshire Referral, Education, Assistance, & Prevention Program is a partnership between the BMHS, BDAS, the Bureau of Elderly and Adult Services, and the CMHCs. The program is available to all older adults, 60 years or older, residents of New Hampshire Senior Housing, caregivers, or family members of an older adult in New Hampshire. The program is designed to assist those adults in taking control of their lives and living a happy, healthy, and independent lifestyle. REAP counselors are available to provide support, education, information, and resources on how to deal with life changes and encounters. REAP also ensures that individuals can improve their quality of life and maintain their independence.

Community-Based Care
The Bureau of Elderly and Adult Services (BEAS) and supports are intended to assist people to live as independently as possible, safely, and with dignity. Services range from home care, Meals on Wheels, care management, transportation assistance, and assisted living to nursing home care.

The Service Link Resource Centers and the New Hampshire DHHS District Offices can access various social and long-term services and supports. Services and supports are intended to assist people to live as independently as possible, safely, and with dignity. Examples include:
• Home care
• Meals on wheels
• Transportation assistance
• Long Term Care-Nursing home and community-based care
• Information and assistance regarding Medicare and Medicaid
• Information about volunteer opportunities
• Investigation of reports of abuse, neglect, or exploitation of incapacitated adults

Long-Term Care Rehabilitative Services
The Glencliff Home (GH) serves Adults with SMI 60 years of age or older who meet the requirements for Long-Term Care that identifies GH as the least restrictive environment and provides the level of medical care the person requires.

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

N/A

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

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

Criterion 5

a. Describe your state's management systems.

Adults: PEER SUPPORT AGENCIES – STAFFING, TRAINING, and OVERSIGHT

In New Hampshire, the most extensive recovery support services are through our network of PSAs that the MHBG and State general funds subsidize. To maintain professionalism, expand implementation, support individuals with mental illness, and in compliance with contract provisions of services, the PSA system in New Hampshire remains heavily reliant on ongoing training and leadership development.

New Hampshire has fourteen PSAs that employ individuals who identify with having lived experience with mental illness. They are peer-led, peer-driven in programming (e.g., community meetings, team-building meetings, support groups, educational events) and agency policy-making through mutuality and consensus of members.

Some PSAs also offer Peer Respite. Peer Respite provides a short-term place to stay with twenty-four hour seven days a week, peer support available on-site in a homelike environment, intending to divert an individual entering a higher level of care.

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

All Warm Line staff also receive Warm Line Training to create expertise in this vital use of Peer Support.

The MHBG FFY 2019-2021 supplemental award, granted in September 2019, supported over ten trainings for PSAs designed to strengthen governance, management, technical and leadership skills, and non-profit best practices, including the customized board of directors training for each agency in "Deepening Community Awareness and Fundraising," "Board Recruitment and Retention," and "Non-profit Financials," among others.

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

Preparation of the Advancement Plan included stakeholder input at three public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the BMHS, National Alliance on Mental Illness of New Hampshire (NAMI-NH), and Eduardo Vega, Humannovations. Participating stakeholders included individuals representing PSAs, CMHCs, community and system advocates, and many individuals with lived experience.

On-site monitoring visits occurred in SFY 20-21 at all PSAs. Interviews and file reviews based on a customized review tool gave the

BMHS a clear impression of needs and strengths to guide PSA oversight. Corrective Action Plans were requested approved, and monitoring continues.
Improvements in the contracting process ensure that funds and programs are operating efficiently and in accordance with best practices.

Mental health training for criminal justice staff was made available through SAMHSA's supplemental training and technical assistance mental health block grant funds. In FY2021, grant funds supported New Hampshire's workforce development goals to increase mental health training for individuals working in the criminal justice system. Through a partnership with the New Hampshire Department of Corrections (DOC), training sessions for personnel working with individuals with mental illness who are involved with the justice system have occurred. Attendees included more than 275 staff from the New Hampshire DOC, the court system, and law enforcement personnel. The series of trainings included Building Trauma-Responsive Correctional Settings, Mental Health First Aid/Awareness Training, Suicide Prevention Training, Responding to People with Mental Illness, and Crisis Intervention Training. The trainings were targeted to directly address recommendations within New Hampshire's 10-Year Mental Health Plan.

Children: MATCH
The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, or Conduct Problems (MATCH) is a treatment program developed over the past decade to address these concerns. The MATCH program combines treatment procedures from common EBPs for anxiety, depression, trauma, and conduct problems for children and adolescents with SED.

Statewide training and trainer certification was provided via a contract with Judge Baker Children's Center (affil. Harvard Medical School); the Judge Baker Children's Center (JBCC) employs the Learning Collaborative model and includes rigorous implementation strategies for evidence-based practices, including conducting continuous quality improvement review and assessment, and developing and implementing data systems to collect, analyze, and report outcomes and implementation data. Over sixty CMHC clinicians were trained in the MATCH protocol by JBCC, and over 130 additional staff have been trained by CMHC MATCH-certified trainers. A rigorous reporting structure and an online clinical component provide the CMHCs and the BMHS with management reports that provide guarantees of program integrity.

Clinical Staff Participants by Cohort

Learning Collaborative Cohorts CMHC Participation and Clinical Staff Training

Training Cohort 1 Planned:
• 4 CMHCs with 5-8 clinical staff each for up to 32 clinical staff.
• (At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families.)
Training Cohort 2 Planned:
• 6 CMHCs with 5-8 clinical staff each for up to 48 clinical staff.
• (At least one clinician identified for MATCH training must serve in a supervisory role within the CMHC and simultaneously carry an active caseload of at least two CMHC families)

The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projects have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract. Actual and projected SFY costs are as follows: The MHBG will be the 100% sole source of funds for the MATCH training – Judge Baker contract. All deliverables and projects have been listed on a timeline as part of a work plan. The vendor invoices contain references to the Work Plan and the contract.

First Episode Psychosis
PROGRAM SUPPORT AND STAFF TRAINING COSTS
Each year since the inception of the requirement for 10% of the block grant required to set aside for First Episode Psychosis (FEP) programming, these MHBG funds have been used for continued training and support in the NAVIGATE CSC model to the HOPE FEP program team at Greater Nashua Mental Health.

In July of 2021, the CMHC contracts were updated to include start-up training funds of $51,000 each to four CMHCs beginning to implement FEP/ESMI programs to cover initial costs associated with training and consultation in the NAVIGATE model. Funds also include $60,000 each to four CMHCs to support non-billable programming costs and staff time.

The State entered into a contract with Dartmouth Health to operate the PEARLS (Psychosis Early Action, Resource and Learning Services) team,

PEARLS provides services that include:
• Offering virtual training twice a year and certification in core components of the CSC model using Adobe Connect Software allows individuals to work in large and small groups, participate in polling activities, and access web links and documents
• Facilitating a monthly learning collaborative for ongoing education and shared learning
• Providing consultation services that include medication management and family engagement consistent with the CSC model
• Connecting and engaging service providers and care teams at CMHCs with an Implementation and Clinical Support team

• Engaging community organizations in building a statewide community-based peer and social support system for individuals experiencing early psychosis and their families

PEARLS also provides training and consultation services for CSC minimum service requirements that include:
• Developing a Department-approved screening process at intake
• Identifying case management criteria such as
• Developing coping skills with individuals
• Managing medications
• Navigating treatment options
• Providing family psychoeducation
• Providing psychiatric support and/or specialty tele-psychiatric consultation services
• Providing education on the importance of managing symptoms with medications and providing assistance with securing the best, lowest dosage medications
• Utilizing Peer Support Services

PEARLS also provides technical assistance for outcome-supported and evidence-informed CSC services that:
• Increase knowledge, skills, and abilities of the Community Mental Health Program Service system and its practitioners
• Increase the Community Mental Health Program service systems' capacity to improve health outcomes within communities statewide
• Support implementation of the CSC program, policies, and practices that reduce psychotic symptoms across the lifespan
• Increase and support integration efforts with primary and mental healthcare across the statewide service system
• Support the existing collaboration efforts with community-based groups of diverse stakeholders
• Ensure program fidelity while meeting state and federal grant requirements, including, but not limited to, the MHBG

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

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

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

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

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

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

N/A

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ● No

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

The New Hampshire (NH) Department of Health and Human Services (DHHS) Bureau of Mental Health Services (BMHS) Quality Improvement efforts include a collaboration between BMHS and the DHHS Bureau of Program Quality (BPQ) in conducting annual Quality Service Reviews (QSRs) for each Community Mental Health Center (CMHC). Through the QSR process, DHHS collects and analyzes data from clinical records reviews, client interviews, and staff interviews to identify strengths and areas for improvement at individual, provider, and system-wide levels. The QSRs result in quality improvement plans jointly monitored by BPQ and BMHS.

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

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

The BMHS continues to be responsible for the Peer Support Agencies (PSAs) program reviews. Review tools were further refined over the last two years based on administrative rules He-M 402 Peer Support Agencies, He-M 315 Rights of Persons Receiving Peer Support Services, BMHS contract compliance, and state nonprofit regulations. In SFY19, monitoring was completed on SFY18; in SFY20, follow-up was done on those findings. PSA quality reviews include site visits, a member interview, a staff interview, an Executive Director interview, an interview with the Board of Directors, and a program, policy, and financial review. Individual agency reports include findings, implementation timeframes, corrective action plans, and ongoing monitoring of corrective action plans as part of the review process.

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

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

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

The survey serves several valuable purposes that contribute to improving mental health services and meeting the needs of clients and their families:
• Gathering Client Feedback: The survey allows mental health centers to receive direct feedback from clients and their families regarding their experiences with the services provided. This input is crucial in understanding the strengths and weaknesses of the mental health system, identifying areas for improvement, and tailoring services to meet clients' needs better.
• Identifying Service Gaps: Through the survey, mental health centers can identify potential gaps in services or areas where clients may not receive adequate support. This information enables the centers to address those gaps and enhance the overall quality of care provided.
• Informing Service Enhancements: The survey data helps mental health centers make informed decisions about service enhancements and improvements. By knowing what clients and families value most and what aspects of care may need refinement, mental health centers can focus on areas that will significantly impact client satisfaction and well-being.
• Meeting SAMHSA Grant Requirements: The survey data fulfills the reporting requirements of the SAMHSA MHBG. This ensures compliance with grant regulations and facilitates the continued funding and support of mental health services.
• Facilitating Accountability: CMHCs are committed to accountability and transparency by regularly conducting client satisfaction surveys. The survey results hold centers accountable for the quality of care provided to clients and help them track progress over time.

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

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

	Question	Response
1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	● Yes ○ No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	● Yes ○ No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	● Yes ○ No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	● Yes ○ No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	● Yes ○ No
6.	Does the state use an evidence-based intervention to treat trauma?	● Yes ○ No

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

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

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

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

In 2022, the State of New Hampshire enhanced crisis services by implementing New Hampshire Rapid Response (NHRR), which includes the New Hampshire Rapid Response Access Point (NHRRAP) and statewide Rapid Response mobile crisis teams. NHRRAP provides immediate, twenty-four hour, seven day a week access to mental health and/or substance use crisis support through telephone, text, and chat services. CMHCs, through their mobile rapid response teams, provide crisis intervention and stabilization services to individuals experiencing psychiatric and/or substance use-related crises using short-term, trauma-informed approaches.

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

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

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

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

N/A

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Footnotes:

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

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

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

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

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

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

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

Please respond to the following items

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

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [ ] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [ ] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [ ] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [ ] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

( ) Yes (•) No

N/A

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

(•) Yes ( ) No

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

The Governor's Advisory Commission on Mental Illness and the Corrections System was established through an Executive Order in 2019. The Commission's mission is to examine and make recommendations on issues facing individuals with mental illnesses in the corrections system, including but not limited to the following:
• steps that can be taken to reduce incarceration and improve mental health services for incarcerated individuals who suffer from mental illnesses
• the use of restraints during transports to and from either mental health or corrections facilities
• methods for improving transitions between county and state institutions
• reforms to support individuals with a mental illness who are transitioning from incarceration back into the community and
• any other issues which the Commission deems relevant to its charge

In 2022, state leaders in New Hampshire launched a Justice Reinvestment Initiative effort to address the high and persistent utilization of public health and county jail resources by people with mental illnesses and substance use disorders (behavioral health conditions). For the project, CSG Justice Center staff conducted extensive analysis of case-level data from county jails and Medicaid claims data from the Department of Health and Human Services (DHHS). Examining these data revealed local trends in jail populations, including identification of behavioral health (BH) needs, participation in treatment and services within jails, and services accessed by people before and after incarceration. The project resulted in a comprehensive report of key challenges and findings and five overarching policy recommendations.
mh-jail-utilizer-project-april-2023-csg.pdf (nh.gov)
The Commission submitted annual reports in 2019, 2021, and the 2022 report, the CSG report of key findings.

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

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

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

The New Hampshire 10-Year Mental Health Plan called for the transformation of New Hampshire's crisis system. Therefore, in 2019, New Hampshire began planning to expand and integrate crisis services across mental health and substance use disorder and ensure all levels of crisis care were available to children, youth, adults, and families statewide.
The transformation of crisis services is aligned with the national Crisis Now model. It has been gradually implemented over the past two years.
The New Hampshire Rapid Response (NHRR) crisis system launched on January 1, 2022. This system includes the New Hampshire Rapid Response Access Point (NHRRAP), a twenty-four-hour, seven-day-a-week crisis contact center, statewide integrated mobile crisis response teams (NHRR), and soon-to-be-established crisis centers.
The NHRRAP is the centralized crisis contact (call, text, chat) center designed as the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services 24 hours a day, seven days a week. NHRRAP also can deploy the closest available mobile crisis team promptly. Before the transformation, at least 20 numbers existed for someone in crisis. The goal of the NHRRAP was to have one number, regardless of the time of day and/or location of the caller, to call for behavioral health crisis support in New Hampshire. The State contracted with Carelon (formerly Beacon Health Options) to provide the crisis contact center. Most calls (80%) are resolved at the "call" level. The NHRRAP number

is 1-833-710-6477.
On July 16, 2022, the National Suicide Prevention Lifeline (NSPL) transitioned from a 10-digit number to the easy-to-remember number 9-8-8 (with the former 1-800-273-TALK still in place). Headrest has been the NSPL call center provider in New Hampshire for many years. Headrest continues as the primary call center for 988. A Memorandum of Understanding between Headrest and Carelon was also established to do a warm hand-off if necessary and provide backup. Headrest is primary on calls, texts, and chats, and Carelon is the secondary Lifeline call center for New Hampshire.
There has been extensive work with the New Hampshire Department of Safety wherein protocols have been developed to identify and facilitate call transfers to the 988 system from 911 based on mutually developed level of care measures. Over 200 calls have been transferred from 911 to date.
The NHRRAP can also schedule "Same day/Next day" appointments for callers whose crisis does not meet a level of deployment and/or requests to be seen later (if a credible safety plan is in place). These appointments take place at the Community Mental Health Centers (CMHCs).
Mobile response teams are available statewide when the NHRRAP cannot resolve the crisis on the phone (or the caller requests an in-person response). The NHRR teams are staffed by each of the State's 10 CMHCs. These teams operate twenty-four hours, seven days a week, providing mobile crisis intervention services. Comprising two specially trained crisis responders, NHRR teams can respond to requests for crisis assessments and interventions within one hour of receiving calls. Once engaged with an individual, NHRR teams can offer services and support for up to 30 days after the crisis, ensuring individuals remain stable and receive the necessary assistance within their community.
NHRR teams are deployed via the NHRRAP, using a virtual platform. Deployments are to the closest available team, expecting teams to arrive in person within one hour. Suppose the closest team is busy with another deployment (or is not fully staffed with two responders). In that case, the next closest team is deployed. If the caller requests telehealth, the closest team with telehealth capability is given the dispatch.
A dispatch level is part of the deployment that indicates to the NHRR team if there are issues to consider before deploying. Levels 3 and 4 are recommended to include law enforcement as the primary responder or in conjunction with law enforcement.
Four crisis apartment beds are available in the Nashua, Manchester, and Concord regions. Crisis Apartments serve individuals aged eighteen years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to seven days per episode and sometimes longer when necessary.
The BMHS is working with contracted vendors to establish two Crisis Stabilization Centers (CSCs) in the state fiscal year 2024. One Center will be in Plymouth, New Hampshire. The other will be in the southern part of the State. The Crisis Centers are for up to 23 hours of stay. They are designed for stabilizing symptoms, safety planning, initial linkage to services, and follow-up telehealth appointments.
In addition, the BMHS applied for and received – training and technical assistance through SAMHSA to assist in the planning and development of the Crisis Stabilization Centers and support for and facilitation of implementation with our two CMHCs who will be the vendors for this project. An initial fact-finding meeting with BMHS and Advocates for Human Potential, Inc. (AHP) was held on Thursday, August 17. AHP is working on an initial proposal for BMHS on potential options for crisis stabilization centers in New Hampshire.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

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

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment

Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: The NHRRAP has twenty-four-hour coverage, seven days a week, for caller/text/chat. There is an incident log for questions/concerns for ongoing quality assurance. Additionally, BMHS has contracted with Dartmouth Health to evaluate the entire Crisis Response system and issue recommendations to New Hampshire DHHS for improvement in the NHRRAP and NHRR mobile teams. This work includes working with the NHRRAP and the State's Crisis & Suicide Prevention Lifeline to align the caller experience at 988 and the RRAP.
Someone to respond: While each CMHC has a mobile crisis response team, not all are fully staffed twenty-four hours a day, seven days a week. The CMHC in the northern part of the State uses a unique model of having two Peer Support Specialists respond and having a Master's level Clinician be part of the team via telehealth. This model was proposed to address the rural nature of the area, the longer commutes, and the smaller population of staff who can work in these teams.
Somewhere to go: New Hampshire is in the early stages of implementing Crisis Stabilization Centers with two of the 10 CMHCs.

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

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

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

It is expected that the NHRRAP will use part of the 5% set aside, and the proposed two Crisis Stabilization Centers may use, in part, the 5% set aside.

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

The State of New Hampshire has applied for technical assistance from SAMHSA to guide the implementation of the Crisis Stabilization Centers. An initial fact-finding meeting was held with BMHS and Advocates for Human Potential, Inc (AHP), designated by SAMHSA, on Thursday, August 17. AHP is working on an initial proposal for BMHS on potential options for crisis stabilization centers in New Hampshire.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

   b) Required peer accreditation or certification? (●) Yes ( ) No

   c) Use Block grant funding of recovery support services? (●) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Peer Support Agencies (PSAs) provide peer-based mental health services statewide through eight contracts and fourteen physical locations across New Hampshire. These peer-run agencies offer mental health peer support, education, connectedness to the community, activities, training, and supported employment opportunities, among other services. Some of these peer agencies also provide Peer Respite and Recovery Orientated Step-up/Step-down (SUSD) programs.

The Bureau for Children's Behavioral Health (BCBH) also contracts with two Care Management Entities that provide Family and Youth Peer Support. Both roles provide a unique service foundationally implemented to engage youth and their families, empower family voices, and share lived experiences. Family Peer Supports are provided to all families enrolled in the FAST Forward program (High Fidelity Wraparound), which has seen a significant increase in enrolled families since 2016. Youth Peer Support is provided to youth thirteen and older within FAST Forward and has also seen a significant increase in enrolled youth being provided this critical component.

Many regions have made great strides in delivering peer support services over the past few years despite the pandemic and its challenges. The PSAs quickly set up virtual support groups and services. They increased their phone outreach to members while on-site activities were halted. This technology enhancement allowed the agencies to continue offering virtual and hybrid support beyond the pandemic. This ability has continued to increase access for those seeking peer support services who may have various challenges preventing on-site attendance.

Over the past year, each PSA has worked with a consultant contracted through the NH Center for Nonprofits to enhance its leadership, board governance, and fiduciary infrastructure. In FY2022, each agency developed priorities through a work plan; in FY2023, agencies worked on implementing these work plans.

Peer support has been proven successful and has been shown to divert individuals from psychiatric hospitalizations, increase the likelihood of employment, reduce suicidality, and lead to a better quality of life. Certified Peer Support Specialists (CPSS) are a crucial component of New Hampshire’s mental health delivery systems that foster supportive interactions based on shared experiences and assist people to rediscover their potential. CPSS are employed throughout New Hampshire's mental health system and, in many instances, are required by state rules and/or contracts. CPSS are integrated into various programs offered by the State's ten community mental health centers and community mental health providers, including supported housing, transitional housing programs, ACT teams, IPS-SE teams, and mobile crisis response teams.

BMHS and the PSAs continue to work toward expansion of services and integration of peer support services throughout the system. In December 2020, New Hampshire first entered into contract with four PSAs, each to operate a three-bed SUSD program. Initial program locations were in Nashua, Manchester, Keene, and Northwood. In 2022, Keene expanded to hold two SUSD contracts totaling six beds. These programs offer a new level of crisis care in New Hampshire.

These SUSD programs provide short-term recovery-based transition services for adults (18 years or older) transitioning from inpatient or institutional settings into the community or requiring more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer support with access to peer staff twenty-four hours a day, seven days per week. Staff focus on recovery-oriented peer support services that also work to coordinate and engage with outpatient community-based clinical treatment providers.

SUSD programs are operated per the SAMHSA Core Competencies for Peer Support Workers in Behavioral Health Services and accept referrals from many community-based treatment providers. Most programs have kept bed occupancy rates over 80% since opening, and most have waiting lists. In 2022, the department increased SUSD stay limits from 90 to 120 days per episode of need to allow more time for stabilization and transitional steps back into the community. The department completed Quality Assurance reviews of each SUSD program within the last few months; results are being reviewed, and reports will be issued identifying strengths and areas for improvement.

For over ten years, the BMHS has contracted with the National Alliance on Mental Illness, New Hampshire (NAMI NH) to provide

family mutual support programming to individuals statewide. In 2021, a family mutual support programming contract was competitively procured and awarded to NAMI NH to provide family and peer-run support groups, education classes, training, and advocacy opportunities for approximately 11,000 individuals and families affected by mental illness throughout the State. Over the past two years, NAMI NH has also started supporting the work of the Olmstead Settlement Agreement by providing the Glencliff Liaison position to help support individual transition to the community from Glencliff Home, the State's specialized psychiatric nursing home. More recently, NAMI NH entered a contract to support the advisory work and stakeholder feedback for the CCBHC model assessment project.

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

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

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

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

Peers on Mobile Crisis Teams
New Hampshire Community Mental Health Centers (CMHCs) have expanded their staff and service array to offer Rapid Response Mobile Crisis Services. The New Hampshire Rapid Response (NHRR) teams comprise multi-disciplinary staff, including clinical staff and at least one peer specialist responding to individuals in the community. This shift in our system has grown New Hampshire's peer workforce tremendously. The teams can screen, assess, and connect with individuals to provide support and refer to additional services as needed. Peers play a significant role in engaging individuals in crisis and following up to support individuals in connecting with their community. In the rural northern part of the state, Peers lead the mobile response and only reach out to a clinician when necessary. Over 70% of dispatches statewide are resolved with individuals remaining in the community.

Peer Workforce Advancement Plan
In 2021, the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) was developed. The Advancement Plan identifies thirteen actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector.
The Advancement plan results from the New Hampshire 10-Year Mental Health Plan's Recommendation #7, which seeks to expand the availability of peers in practice settings and integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas: training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies. At the same time, other factors are specific to the roles, challenges, and opportunities of people with lived experience as Peer Support Specialists. In 2023, a procurement was posted for implementing the Advancement Plan, and the department is finalizing that procurement.

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

Peer Training
The department has been enhancing training availability and access for individuals statewide. The department has fully funded all CPSS training requirement components within the past two years. Work is underway to refine the New Hampshire CPSS certification curriculum to be more comprehensive and expand access to the curriculum available through the New Hampshire Community College network or an established training hub.

In 2022, the BMHS worked with Dartmouth Health to deliver a Peer Supervision ECHO series over six months. The statewide ECHO series provided monthly educational opportunities and open discussions with panel experts and attendees regarding various topics related to peer supervision, such as boundaries, ethics, helping versus co-learning, and self-disclosure. Attendees were from various agencies and backgrounds; however, most attendees were peer specialists and supervisors.

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

The department would benefit from technical assistance in the following areas: creating guest file documentation templates for all Recovery Orientated Step-up Step-down contracted programs, identifying and training on a data platform for Peer Support Agencies reporting as well as assistance in the review and revision of the state peer certification and training infrastructure

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(●) Yes ( ) No
Home and community-based services	(●) Yes ( ) No
Peer support services	(●) Yes ( ) No
Employment services.	(●) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (●) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

In the State of New Hampshire's needs assessment "A Strategy for Restoration," crafted in 2008, claims of over-utilization of institutions and prolonged wait times resulted in a class action suit, Amanda D. v. Hassan; United States v. New Hampshire, No. 1:12-cv-53-SM, filed in 2013, alleging "New Hampshire's administration of its mental health system violates the rights of individuals with SMI."

The settlement agreement, hereafter referred to as the Community Mental Health Agreement (CMHA), finalized in February 2014, mandates the State develop and implement certain services, including an expanded crisis system, expanded Assertive Community Treatment (ACT), Supported Housing (SH), and Supported Employment (SE) programs. Under the Agreement, these services may be provided directly by the State or through contracts with Community Mental Health Programs (CMHPs) (also referred to herein as Community Mental Health Centers CMHCs).

Priority populations specified in the CMHA include adults (18+) who have a serious mental illness (SMI) or a severe and persistent mental illness (SPMI) who are patients at New Hampshire Hospital (NHH), residents at Glencliff Home (GH), and who may have been "unnecessarily institutionalized."

The core areas of the agreement include:

Crisis Services
The CMHA requires that the State develop a twenty-four-hour, seven-day-a-week crisis system that provides timely access and

services to individuals experiencing a mental health crisis via the development of mobile crisis teams and crisis apartments in three state regions.
• New Hampshire has far exceeded these requirements by establishing mobile crisis teams and apartments in the three designated regions and expanding the service statewide and population to children and adults.

Assertive Community Treatment (ACT)
The CMHA requires that the State develop and implement Assertive Community Treatment (ACT) teams in alignment with evidence-based practice. The CMHA also requires statewide access to ACT services and the capacity to serve at least 1,500 individuals at any time.
• New Hampshire has established multi-disciplinary ACT teams in all 10 CMHC-designated regions. All ACT programs undergo annual fidelity reviews by an external reviewer. Expert consultants provide the ACT teams with training, consultation, and technical assistance.

Housing Services
The CMHA requires that New Hampshire expand supported housing options by creating 600 additional supported housing units that meet CMHA standards and can serve 16 individuals in the community with SMI and complex health care needs that currently reside in the Glencliff Home (GH).
• New Hampshire has exceeded these requirements through various efforts to meet the targeted population's needs under the CMHA. The total additional supported housing units exceeds 1,000 through the following programs:

o The primary program, the Housing Bridge Subsidy Program (HBSP), has established subsidized housing for up to 500 individuals at any time under the CMHA. The HBSP prioritizes individuals ready for discharge from NHH, GH, and NFI's Transition Housing Services Program. Additional prioritized individuals include those served by ACT teams in the community who are homeless and individuals currently in community residences ready to transition into the community. HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, ongoing housing supports, and connections to mental health services (if desired and requested by the individual). At least 400 individuals receive a state subsidy at any one time that, combined with the individual's contribution toward rent, fulfill monthly rent payments and maintain the individual's access to the apartment.

The HBSP also assists the individual with remaining on a waiting list for traditional HUD-funded programs, other municipally administered programs or until the individual's income exceeds the HBSP's financial eligibility guidelines. So far, more than 300 people who transitioned off HBSP to another Section 8 subsidy are being supported under the terms of the CMHA.

o The State has created the Integrative Housing Voucher Program for individuals who do not meet the criteria for the HBSP due to criminal history. This program is funded to serve up to 50 people and provides housing support services and a housing rental voucher, which aligns with the HBSP.

o The State supports individuals needing more intensive support and services to return to the community post-psychiatric hospitalization through NFI's transitional housing programs (THP). These programs (76 beds statewide) combine residential, therapeutic, vocational, and other services and supports to prepare individuals for independent living.

o New Hampshire also provides individuals within the target population who need ongoing housing support to maintain access to HUD-funded Section 811 units. This includes assisting with the application process, locating available units, and working with property owners to secure housing successfully. Units accessed under these programs are permanent expansions to New Hampshire's affordable housing inventory – created specifically for this population under two separate grants with the New Hampshire Housing Finance Authority (NHHFA). The Mainstream 811 program currently serves 75 individuals and 169 through the PRA811 program.

o BMHS has recently entered a contract to establish four 5-bed specialty residential programs (20 beds total) for individuals transitioning out of GH or those at NHH waiting for GH.

Employment Services
The State agreed to deliver evidence-based Individual Placement and Support-Supported Employment (IPS-SE) services per the Dartmouth Psychiatric Research Center evidence-based model. (Please note this model had a national name change to Individual Placement and Support-Supportive Employment IPS-SE from EBSE). These services help individuals obtain and maintain competitive employment in integrated community settings. The CMHA requires the statewide penetration rate of individuals with SMI receiving IPS-SE to be 18.6% of the eligible individuals (adults with SMI or SPMI).
• New Hampshire has far exceeded the penetration requirements with over 24% penetration rate in IPS-SE statewide.
• New Hampshire has established multi-disciplinary IPS-SE teams in all 10 CMHC-designated regions. All IPS-SE programs undergo annual fidelity reviews by an external reviewer. Expert consultants provide training, consultation, and technical assistance to the IPS-SE teams.

Family & Peer Support
The CMHA requires the State to ensure effective family and peer support programs throughout New Hampshire to help individuals manage and cope with their mental illness. Peer support services offered through peer support agencies were

required to be open at least eight hours per day, five-and-a-half days per week, or the hourly equivalent for individuals to receive support and services.
• New Hampshire has maintained a contract to provide family mutual support services with NAMI NH.
• New Hampshire has established a network of peer support programs through 8 vendor contracts offering 14 physical locations statewide. Programs are open to a minimum of 44 hours/week.

Transition Process
The CMHA requires that the State provide each individual in NHH and GH with an effective and written transition plan. To address this provision, New Hampshire has:
• Developed standard transition planning processes and protocols, which include "visioning" with individuals to help them explore the idea and imagine life in an alternative community setting.
• Established a multi-disciplinary Central Team to assist in addressing and overcoming any barriers to discharge identified during transition planning and/or outlined in the transition plans.
• Designed and implemented a system for in-reach activities, including coordination with the community mental health centers and hiring of an In-Reach Liaison employed through NAMI NH to work with individuals, guardians, staff, and community providers to support transition planning and successful transitions.

Quality Assurance and Performance Improvement
The CMHA requires that the State develop and implement a quality assurance and performance improvement system, emphasizing the use of client-level outcome tools and measures, to ensure that existing community-based services described in the Agreement are offered per the CMHA.
• New Hampshire established a Quality Service Review (QSR) tool and process to conduct in-depth annual reviews of the CMHC network to ensure services are delivered in line with the terms of the CMHA. The review, which takes place at each CMHC over six days by a team of 8-12 DHHS staff, includes interviews with clients, staff, and leadership, along with chart and data reviews.

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

New Hampshire is in the process of seeking a new expert reviewer for the state’s Olmstead settlement agreement. Any recommendations from SAMHSA would be welcomed.
Seeking Applicants for Expert Reviewer for the State’s Community Mental Health Agreement (CMHA) | New Hampshire Department of Health and Human Services (nh.gov)

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

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

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

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

a) The recovery of children and youth with SED?	◉ Yes	○ No
b) The resilience of children and youth with SED?	◉ Yes	○ No
c) The recovery of children and youth with SUD?	◉ Yes	○ No
d) The resilience of children and youth with SUD?	◉ Yes	○ No

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

a) Child welfare?	◉ Yes	○ No
b) Health care?	◉ Yes	○ No
c) Juvenile justice?	◉ Yes	○ No
d) Education?	◉ Yes	○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	◉ Yes	○ No
b) Costs?	◉ Yes	○ No
c) Outcomes for children and youth services?	◉ Yes	○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	◉ Yes	○ No
b) Mental health treatment and recovery services for children/adolescents and their families?	◉ Yes	○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	○ Yes	◉ No
b) for youth in foster care?	◉ Yes	○ No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	◉ Yes	○ No
d) Does the state have an established FEP program?	◉ Yes	○ No
Does the state have an established CHRP program?	◉ Yes	○ No
e) Is the state providing trauma informed care?	◉ Yes	○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The New Hampshire System of Care
In the past five years, New Hampshire has made significant progress in implementing a system of care approach to children's mental health, with the assistance of a Children's Mental Health Initiative (CMHI) System of Care (SOC) grant. The following work has been done in the state to further this effort:
· Development of a program to serve high-need children and youth with a SOC and high-fidelity Wraparound model
· Expansion of that program
· Partnership with the New Hampshire Department of Education (DOE) on the use of Wraparound in schools, which is being implemented with a CMHI SOC Grant awarded to the New Hampshire Department of Education
· Partnership with a county to implement SOC and Wraparound in that specific region, with support from a CMHI System of Care grant
· Establishment of RSA 135-F SOC for Children's Behavioral Health, a state statute that mandates the Department of Health and Human Services (DHHS) and New Hampshire DOE to partner on expanding the SOC in New Hampshire.
· Creation of a State Youth Treatment Plan with the assistance of SABG (Substance Abuse Block Grant) & GOEFFR (Governor's Office for Emergency Relief and Recovery) dollars to help identify strategies for youth and merge the system of care approach with the SUD treatment of youth.

System of Care Sustainability and Expansion
In 2016, the New Hampshire Department of Education was awarded a four-year, $12 million grant from SAMHSA. The New Hampshire Families and Systems Together (FAST) Forward for Children and Youth 2020 project supports the expansion and sustainability of a state-level SOC for children, youth, and their families.

New Hampshire 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. Develop, enhance, and expand a statewide system to support the use of New Hampshire's Multi-Tiered System of Support for Behavioral Health and Wellness Model (MTSS-B) by Local Education Agencies (LEAS) and local communities to expand and sustain New Hampshire's SOC
2. Enhance and expand the ability of the DHHS in partnership with the Community Mental Health Centers (CMHCs) and its providers to collaborate with and respond to the needs of LEAS and New Hampshire Students.
3. Ensure that New Hampshire's statewide SOC is culturally and linguistically appropriate for all residents to develop, enhance, and sustain MTSS-B within participating LEAs
4. Strengthen partnerships between participating CMHCs and LEAS to leverage resources, create a shared understanding, and increase access to high-quality mental health services and support for New Hampshire students and their families
LEAs specific strategies:
• Culture and linguistically competent
• Increase the percentage of children entering Kindergarten and first grade who possess the necessary skills to be successful in schools
• Improve the mental, emotional, and behavioral health functioning of all students by facilitating access to relevant mental health services at every tier along the continuum
• Develop and utilize a facilitated referral process with the participating CMHCs
• Increase connectedness among families, schools, and communities through knowledge building and family and youth engagement
• Develop a strategy to support improvements in youth and family serving systems through the coordination and integration of funding streams to support protective factors and resiliency.
• Increase safety and protective factors, reduce risk factors, and improve the measure of positive climate in culture in participating schools
• MTSS-B ties it to the identification of needs of the student population, current efforts to address the needs, prevention, comprehensive school mental health, family and youth engagement, school culture and climate

During the third year of the SOC expansion New Hampshire DOE 2020-2024 grant, progress has continued in building cross-agency collaboration among partners and in the building of systems. All work has been conducted through the lens of sustainability.

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

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

State statute RSA 135-F System Care for Children's Behavioral Health mandates that New Hampshire DHHS and the New Hampshire

Department of Education partner and collaborate on the expansion of the SOC in New Hampshire to provide:
· Residential services (such as therapeutic foster care, crisis stabilization services, and inpatient medical detoxification)
· Residential Treatment Services for SUD youth

The Bureau for Children's Behavioral Health (BCBH) focuses on children, youth, and families experiencing behavioral health issues by developing programming with an appreciation of the system care approach. Recent expansions of the program include:
· Three CMHCs have developed children's Intensive Community Based Services teams managed by the BCBH.
· One CMHC has engaged with BCBH to pilot and provide a collaborative model of High-Fidelity Wraparound for children and youth.
· BCBH is developing other pilot programs to provide a collaborative model of Intensive Community Based Services and High-Fidelity Wraparound for children and youth.

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

N/A

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The State's 10-year Mental Health Plan includes goals and strategies to reduce the incidence of suicide in New Hampshire. One recommendation in the plan was to renew and intensify efforts to address suicide prevention. In early 2021, the Division for Behavioral Health (DBH) hired its first statewide suicide prevention coordinator, linking the Bureaus' efforts in this area. This position also leads DBH with the State's legislatively mandated Suicide Prevention Council (SPC). Because of the impact suicide has on the residents of New Hampshire, New Hampshire RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall "oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the plan. The council shall also be a proponent for suicide prevention in New Hampshire."

The mission of the SPC is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:
• Raise public and professional awareness of suicide prevention
• Address the mental health and substance abuse needs of all residents
• Address the needs of those affected by suicide
• Promote policy change

The SPC published the New Hampshire Suicide Prevention Plan, which has two overarching goals:
1. Promote awareness that suicide in New Hampshire is a public health problem that is generally preventable
2. Reduce stigma associated with obtaining mental health, substance misuse, and suicide prevention services

The activities associated with these goals include, but are not limited to:
• Support data collection, analysis, and visualization on suicide rates and prevention efforts
• Fund, organize, and/or promote suicide prevention training
• Engage with legislators, policymakers, educators, and providers to inform public policy and education
• Identify, recruit, and retain diverse stakeholders for the New Hampshire Suicide Prevention Council who represent various regions, racial/ethnic diversity, and high-risk populations
• Develop and/or promote campaigns to raise awareness of best practice suicide prevention strategies
• Conduct an Asset and Gaps analysis to inform where there are greatest needs in the State

Further, New Hampshire liaises with the Office of Chief Medical Examiner (OCME). The liaison serves to connect notifications and confirmations of suicide deaths in New Hampshire and inform the local Community Mental Health Center (CMHC). The purpose is to have timely information about the deaths to address postvention activities proactively. School districts are contacted when a student dies and offered SAMHSA toolkits. Workplaces that experience a suicide death on site are likewise contacted and offered The Manager's Guide to Postvention Supports. Survivor of Suicide Loss packets are mailed to the Next of Kin of the deceased by the liaison. The packets provide information about a variety of SOSL supports. Statistically, knowing someone who dies by suicide increases the risk of suicide in that individual. The packets are one way to attempt to lessen this negative outcome.

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

providers outside of those contracted with the DBH upon review of the implementation design.

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

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

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

Participants in the CTI program receive intensive support at the beginning of the 9-month program, which gradually decreases as they grow more comfortable working with the connections created within their communities. CIT coaches are employed at all ten of New Hampshire's CMHCs.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

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

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

Currently, the participating organizations are engaged in the community of practice, which allows the participants to refine their zero-suicide strategies and receive real-time feedback on adherence/fidelity to the framework. Each participating organization will receive a one-on-one consultation with Zero Suicide Institute to offer customized facilitation on priority areas identified thus far.

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

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

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ◉ Yes ○ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ◉ Yes ○ No

   If yes, with whom?

   As part of the Bipartisan Safer Communities Act, SAMHSA awarded the BMHS over $260,000 in funding to prepare communities to respond to adverse events involving youth, such as school shootings. The plan is to use the funds to sponsor a variety of trainings with a variety of stakeholders.
   One training program to be delivered is Mental Health First Aid for Youth, which focuses on identifying, understanding, and responding to signs of mental illness and/or substance use disorders in youth. This training provides the skills needed to reach out and support children and adolescents developing mental health or substance use problems. The goal is to help to connect them to appropriate care. The 9-hour course will be offered primarily to New Hampshire's Disaster Behavioral Health Response Team (DBHRT) members. DBHRT has over 700 volunteers who support communities following "disasters" of any kind, such as unanticipated deaths, suicide deaths, crimes, and natural disasters. There are 5 DBHRT regions covering the State, and current explorations are underway to host training in each DBHRT region. Training sites, trainers, and dates are currently being researched; BMHS aims for late fall 2023 for at least one training.

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

Since the last planning period, the System of Care (SOC) statute has been enacted, ensuring cooperation between state partners around providing children and youth behavioral health and special educational services. The passage of SB 534 indicates that there is widespread support for rethinking and improving aspects of the State's systems. Furthermore, through smaller-scale, grant-funded projects, efforts have been underway for over ten years to move New Hampshire toward a SOC model. These efforts focus on acute care and intervention, prevention, and healthy socio-emotional development for all children. A more comprehensive, integrated, and efficient child behavioral health services system can emerge in New Hampshire with continued focus on these matters.

Criminal Justice System
The Governor's Advisory Commission on Mental Illness and the Corrections System was established through an Executive Order in 2019. The Commission's mission is to examine and make recommendations on issues facing individuals with mental illnesses in the corrections system, including but not limited to the following:

- steps that can be taken to reduce incarceration and improve mental health services for incarcerated individuals who suffer from mental illnesses;
- the use of restraints during transports to and from either mental health or corrections facilities;
- methods for improving transitions between county and state institutions;
- reforms to support individuals with a mental illness who are transitioning from incarceration back into the community and
- any other issues which the Commission deems relevant to its charge

Through the Commission, in 2022, state leaders in New Hampshire launched a Justice Reinvestment Initiative effort to address the high and persistent utilization of public health and county jail resources by people with mental illnesses and substance use disorders (behavioral health conditions). For the project, CSG Justice Center staff conducted extensive analysis of case-level data from county jails and Medicaid claims data from the Department of Health and Human Services (DHHS). Examining data from the State Medicaid Authority for individuals served in the behavioral health system and local jails revealed local trends in jail populations, including identification of behavioral health (BH) needs, participation in treatment and services within jails, and services accessed by people before and after incarceration. The project resulted in a comprehensive report of key challenges and findings and five overarching policy recommendations.
mh-jail-utilizer-project-april-2023-csg.pdf (nh.gov)

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

The Commission submitted annual reports of key findings in 2019, 2021, and 2022 of the CSG report.

Department of Safety and Law Enforcement
In preparation for the launch of the National Suicide and Crisis Lifeline, 9-8-8, extensive work with the New Hampshire Department of Safety took place wherein protocols were developed to identify and facilitate call transfers to the 988 system from 911 based on mutually developed level of care measures. Over 200 calls have been transferred from 911 to date.
With statewide mobile crisis response expansion, the BMHS partnered with the mobile crisis response teams, the State's Lifeline centers, and law enforcement to create uniform dispatch criteria. A dispatch level (scale of 1-4) informs who (law enforcement, a mobile response team, or both) deploys and how. Levels 3 and 4 are recommended to include law enforcement.
Level 3 dispatch protocol: Mobile Crisis Team Leads with law enforcement in the background or following behind and on the scene.
Level 4 dispatch protocol: Emergency Services/Law Enforcement Leads with Mobile Crisis Team accompanying or following behind. The mobile team must heed police instructions and respond as the scene is deemed safe for entry.

NH Housing Finance Authority

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

NH Center for Nonprofits
The BMHS partnered with the New Hampshire Center for Nonprofits to provide governance and management training to Peer Support Agencies (PSAs) throughout New Hampshire. The Center for Nonprofits is a statewide nonprofit association dedicated to strengthening and giving a voice to the State's nonprofit sector. Its programs are designed to advance the capacity of nonprofits by providing board and staff leaders with the information, resources, and tools they need to manage and govern effectively. The Center has a successful record of working collaboratively with the BMHS through contracts over the past several years. The Center has delivered leadership and governance training for New Hampshire's Peer Support Agencies through a sole source contract with BMHS since 2019. This contract with the New Hampshire Center for Nonprofits is 100% federal funds. This training series will build upon prior training to strengthen governance, management, and fiscal oversight at the PSAs. Customized agency consultation services were available through the SFY2022 contract with the New Hampshire Center for Nonprofits.

Department of Education, Vocational Rehabilitation
Since June 2021, CMHCs have employed a Work Incentive Counselor. These positions were made available through a partnership with the New Hampshire Department of Education, Vocational Rehabilitation. The counselor's responsibilities include:
1. Assisting individuals in connecting, applying, and transitioning to Vocational Rehabilitation services.
2. Engaging individuals in Individual Placement and Support-Supported Employment (IPS-SE) services or increased employment through work incentives, counseling, and planning.
3. Developing comprehensive plans for individuals, considering the impact of different income levels on existing benefits, and identifying specific work incentive options to increase financial independence and accept pay raises.
4. Documenting all existing disability benefits programs, such as SSA disability programs, SSI income programs, Medicaid, Medicare, Housing Programs, and food stamps and food subsidy programs.
5. Collecting data to create quarterly reports on employment outcomes and work incentives counseling benefits.
6. Collaborating with Vocational Rehabilitation providers to develop a partnership and promote cooperation between Employment Specialists and Vocational Rehab.

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

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

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

Public Health
The New Hampshire DHHS, Division of Public Health Services, Bureau of Community Health Services Rural Health and Primary Care section includes the Primary Care Office, the State Office of Rural Health, and Workforce Development. The mission and function of the Rural Health and Primary Care section are to support communities and stakeholders that provide innovative and effective access to quality healthcare services with a focus on the low-income, uninsured, and Medicaid populations of New Hampshire.

In the summer of 2023, the Department hired its first behavioral health epidemiologist. The position sits within public health and will work closely with the division for behavioral health to evaluate population health indicators and advise on policy and practice improvements.

CCBHC Partnerships
BMHS has been awarded a planning grant from SAMHSA, effective April 1, 2023, through March 31, 2024, to explore and implement a Certified Community Behavioral Health Clinic (CCBHC) Model. BMHS engaged Brandeis University in completing a readiness assessment for the State to help define the current and prospective partnerships needed to align with the CCBHC model. Through this assessment, BMHS identified collaborative opportunities to expand and build. BMHS is presently partnered with the State Medicaid Authority, the Bureau for Children's Behavioral Health, and the Bureau of Drug and Alcohol Services (State Substance Use Authority) to explore the application of the model to the New Hampshire behavioral health system based on the readiness assessment. This exploration has supported increased collaborations with Community Mental Health Programs in reviewing the scope and utility of their collaborations. The system is exploring increased use of data metrics and interfacing

between health information technology platforms and the program's use of care coordination, expanding their partnerships. The CCBHC model requires partnerships between the program's specific regional services, supports, and providers, including local educational agencies, child welfare agencies, juvenile/criminal justice agencies, and other human services in their communities. BMHS, through partnership with the New Hampshire National Alliance on Mental Illness New Hampshire (NAMI NH), is currently soliciting input from these regional services, supports, and providers to inform the building of partnerships for the CCBHC model. The use of community needs assessments in the regions that will be piloting the CCBHC model through the grant is also helping to define the partnerships that need to be built to meet population-specific needs better. Three programs are currently preparing their applications with copies of their written agreements with their local partners to meet behavioral health consumers' needs in their regions.

DOE and DCYF
New Hampshire's Bureau for Children's Behavioral Health children's system of care efforts continues to focus on improving the clinical outcomes and functioning in the home, school, and community for New Hampshire's children and youth with serious emotional disturbance (SED) and their families by strengthening local communities' ability to respond. These efforts center primarily on building strong collaboration between schools, families, and children/youth, the New Hampshire Division of Children, Youth and Families (DCYF), behavioral health providers, and their communities, and using evidence-based frameworks to deliver high-quality supports and services. New Hampshire has made significant progress in implementing a system of care (SOC) approach to children's mental health in the past seven years with a CMHI System of Care grant. The following work has been done in the State to further this effort:
· Development of a program to serve high-need children and youth with a SOC and high-fidelity Wraparound model
· Partnership with the New Hampshire Department of Education (DOE) on the use of Wraparound in schools, which is being implemented with a CMHI SOC Grant awarded to the New Hampshire Department of Education
· Partnership with a county to implement SOC and Wraparound in that specific region, with support from a CMHI System of Care grant
· Establishment of RSA 135-F SOC for Children's Behavioral Health, a state statute that mandates the Department of Health and Human Services (DHHS) and New Hampshire Department of Education to partner on expanding the SOC in New Hampshire.
· Creation of a State Youth Treatment Plan with the assistance of a Substance Abuse Block Grant (SABG) and Governor's Office for Emergency Relief and Recovery (GOEFFR) dollars to help identify strategies for youth and merge the system of care approach with the SUD treatment of youth.
· In FY22, New Hampshire DHHS implemented a statewide mobile crisis response, and the connection to 988 was provided to all ages. Development and implementation have included integration throughout the Children's System of Care, including schools, community mental health, care management entities, the Division of Children, Youth and Families, and residential settings.
· In FY22, the Transformation of Residential Treatment included a voluntary pathway to episodes of residential treatment and residential levels of care. Also implemented through a vendor contract has been the comprehensive assessment of the treatment process to determine eligibility for residential care and provide a level of care recommendation. Additionally, aligning with the Family First Prevention Service Act (FFPSA), BCBH worked collaboratively with DCYF to ensure that comprehensive assessment for the treatment process supports DCYF needs and youth court-involved through DCYF seeking residential treatment.
· During FY22, a $4.2 million contract was approved to develop a new Children's Behavioral Health Resource Center (CBHRC). Working in collaboration with other institutions, family groups, providers, and youth and families, the CBHRC is strengthening the network of behavioral health supports for children across the State. The CBHRC is designed to help address the current shortage of resources by improving the capacity of providers, educators, and agencies to deliver high-quality, research-based practices across the State. The CBHRC will focus on providing evidence-based training, technical assistance, and easy-to-access information about strengths-based and youth-centered practices and approaches to best address the behavioral health needs of children up to the age of 21 years.
· During FY22, BCBH collaborated closely and consulted around using the Child and Adolescent Needs and Strengths (CANS) Assessment tool with DCYF Juvenile Justice. The Juvenile Justice transformation work, through SB 94, promotes earlier engagement in community-based services and minimizes youth involvement in the formal legal system. Assessing and making referrals to appropriate services and supports will decrease the need for future judicial involvement. RSA 169-B:10(2021). The CANS assesses and supports decision-making around referrals and treatment.

Division of Long-Term Supports and Services
The State operates Glencliff Home (GH), a nursing facility for individuals with serious mental illness and intellectual disabilities. In partnership with community providers, the BMHS works closely with the Division of Long-Term Supports and Services to facilitate transitions to various community settings, including enhanced family care, independent apartments, and supported housing. BMHS has recently entered a contract to establish four 5-bed specialty residential programs (20 beds total) for individuals transitioning out of GH or for those at NHH on the waitlist for GH who have serious mental illness and complex medical needs. Additional work is underway through New Hampshire's Money Follows the Person (MFP) Demonstration, which includes a specific pilot focused on transitioning a cohort of GH residents.

NHCarePath, the Aging and Disability Resource Center (ADRC)/No Wrong Door (NWD) System of Access, is a collaborative effort between the DHHS Division of Long Term Supports and Services, BMHS, community mental health centers, area agencies, and community providers. Residents of any age, income level, or ability can access information on services and supports, assistance with daily living needs, and care options at home or in the community through NHCarePath. Effective cross-agency partnerships ensure "no wrong door" in accessing caregiver support, resources for developmental disabilities, elderly, and adult supports, financial assistance, housing and community-living options, Medicaid, mental health supports, personal and legal rights,

treatment for substance use disorders, transportation, and military or veterans services. Given the complexity of systems and supports, NHCarePath employs options counselors to assist people in exploring the range of choices available. NH Easy is another interagency collaboration to ensure access to resources across DHHS. Through one portal, individuals and families can screen for eligibility, identify options, and apply for cash, medical, nutrition, childcare assistance, Medicare beneficiary, and long-term care assistance.

The BMHS works closely with the Bureau of Developmental Services to align and integrate services for individuals served by both systems. To formalize this partnership, language is included in contracts for both the community mental health centers (serving individuals with MI) and the Area Agencies (serving individuals with ID) to:

1. The Contractor shall collaborate with the Area Agency {or CMHC} that serves the region to address processes that include:
1. Enrolling individuals for services who are dually eligible for both organizations;
2. Ensuring transition-aged individuals are screened for the presence of mental health and developmental supports and refer, link, and support transition plans for youth leaving children's services into adult services identified during screening;
3. Following the "Protocol for Extended Department Stays for Individuals served by Area Agency" issued December 1, 2017, by the State of New Hampshire Department of Health and Humans Services, as implemented by the regional Area Agency;
4. Facilitating collaborative discharge planning meetings to assess individuals who are leaving NHH to re-engage them with both the CMHC and Area Agency representatives;
5. Ensuring annual training is designed and completed for intake, eligibility, and case management for dually diagnosed individuals and that attendees include intake clinicians, case managers, service coordinators, and other frontline staff identified by both CMHCs and Area Agencies. The Contractor shall ensure the training utilizes the Diagnostic Manual for Intellectual Disability 2, which is specific to intellectual disabilities, in conjunction with the DSM V;
6. Planning for each person who receives dual case management by outlining the responsibilities of each organization and expectations for collaboration between the organizations and
7. Participating in shared service annual treatment meetings to assess quality and progress towards treatment goals and monitoring continued need for dual services when waivers are required for services between agencies.

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

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

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Council advises developing the state plan for the Mental Health Block Grant (MHBG) by providing input to BMHS throughout the application planning and development. Every two years, the Council assists in the design of the timelines for the MHBG application. BHPAC's involvement in preparation for the application reinforces their statutory responsibilities and their understanding of grant priorities, strategies, and requirements. Throughout the year, on an ongoing basis, all BHPAC committees work individually to identify and prioritize areas of need; each committee reports areas of concern; members solicit data regarding grant expenditures and budgets and provide comments and recommendations.

The BHPAC reviews and comments on plan goals and the individual sections, both required and requested, of the plan application. Several members actively contribute to plan content in a structured system primarily managed by the MHBG Program Planner for this application year. The required state agencies take an active role in the informational and communications process between these agencies and consumers on the Council.

The BHPAC was oriented to this year's Block Grant application at their October and December 2022 meetings. In April, the Council reviewed the drafted planning priorities, progress on the 2022-2023 goals, and program budgets. The Planning Committee was also provided with all the previously submitted application sections for review and input.
During this grant application year, many changes occurred within BHPAC itself. The committee transitioned from the MHPAC (Mental Health Planning/Advisory Council) to the BHPAC (Behavioral Health Planning/Advisory Council) to support the integration of mental health and substance use and better address the collaborative efforts across the department. The Chair resigned in December of 2022, and a new Chair, Michelle Wagner, was vetted and voted in unanimously in April 2023. During this time, Vice-Chairs were also vetted and decided upon. Throughout the transition period, the MHBG Program Planner kept members of the BHPAC apprised of the MHBG application. In December 2022, the MHBG Program Planner prepared an application overview and timeline. At the next quarterly review meeting in April 2023, the acting MHBG Program Planner reviewed the previous MHBG application, the most recent URS tables, new application goals, and the input process moving forward. Feedback was solicited at each meeting. The BHPAC met again on July 11, 2023, for additional updates on Planning Sections. Feedback was collected (see Minutes in response below). An emergency meeting was scheduled for August 22, 2023, to review the draft MHBG application, receive public comments, and provide final feedback and revisions to the draft application.

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

New Hampshire has several mechanisms to plan and implement community mental health, substance misuse prevention, SUD treatment, and recovery support services, including:

1. New Hampshire 10-Year Mental Health Plan (2019) that sets the vision and strategic priorities for New Hampshire's comprehensive mental health system.
2. Governor's Commission on Alcohol and Other Drugs Strategic Plan sets the strategic direction for the State's Alcohol and Other Drug service system.
3. Children's System of Care (SOC) outlines priorities specific to the state's delivery of services for New Hampshire children (up to age 21) with behavioral health needs.
4. The New Hampshire Suicide Prevention Strategic Plan sets the priorities specific to statewide suicide prevention strategies, programs, policies, and funding.

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

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

New Hampshire Behavioral Health Planning & Advisory Council (BHPAC)
The Mission of the Council is to bring individuals with lived experience with mental illness and families representing children and adults throughout the life span, and other stakeholders together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of public mental health services and systems of care in New Hampshire.

The Council's purpose is to represent and advocate for adults of all ages with or at risk of Serious Mental Illness (SMI) and for children and adolescents under age 18 with or at risk of serious emotional disturbances (SED). The Council will, not less than once a year, review state mental health plan(s) and submit any recommendations to the State. The Council will monitor, review, and evaluate the allocation and adequacy of mental health services within the State.

The Council is charged with focusing its statutory duties in a manner that will strengthen and improve the public mental health system.

BHPAC maintains the required membership ratios following the guidelines outlined in Public Law 102-321, the currently approved By-Laws of BHPAC, and any subsequent regulations of Council membership. The number of appointed members may be as many as 35. All required state agencies are represented, along with various adult consumers, parents of children with severe emotional disturbances, and family members of both adults and youth.

There is robust advocacy representation for both adults and youth. NAMI-NH and several Peer Support Agencies and Recovery Clubhouses are represented. Peers are involved in the BHPAC as active members.

Several representatives and administrators from the Community Mental Health Centers (CMHCs) participate collaboratively. Although limited block grant dollars are supporting CMHC programs, they are encouraged to serve to advocate for the inclusion of their voice in state mental health solutions.

Quarterly BHPAC meetings provide structure for MHBG updates, monitoring reports, and Committee work and reports. The BHPAC is a tremendous resource to the State. Its members are enthusiastic and intellectually curious problem-solvers passionate about monitoring and improving the New Hampshire mental health system. The quarterly meetings provide an excellent opportunity to highlight successes in programming throughout the system and to inform community stakeholders of current program initiatives supported by the MHBG.

The Directors (or their designee) of the BMHS and BCBH are asked to update the Council. The Council actively engages in dynamic discussions with these Directors about the status of the behavioral health programs, with emphasis on the Community Mental Health Agreement (for adults), progress with the implementation of a System of Care (SOC) approach to treatment (for youth), and the NH 10-Year Mental Health Plan.

The following subcommittees also meet every quarter:

The Legislative Advocacy Committee
Selects and presents advocacy issues to the Council with recommended positions on state and federal legislative and regulatory changes affecting mental health and actively promotes positions approved by the Council.

The Membership and Nominations Committee
Responsible for assisting in receiving and reviewing applications, maintaining the membership roster, and nominating members and officers of the Council.

The Planning Committee
Responsible for receiving membership applications, assisting with the application review process, nominating members and officers to the Council, and maintaining a current membership roster.

The Children & Youth Committee
Coordinates and communicates information about children's mental health issues. Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of best practices in Children's Behavioral Health.

The Housing and Homelessness Committee
Actively engages with stakeholder organizations to influence policy and ensure housing access for individuals served by the public mental health system. Advocates on legislation and regulatory matters related to funding and programs to serve persons with mental illness who are experiencing housing instability.

The Co-occurring Disorders Committee
Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of co-occurring disorder strategies.

The Reversing Stigma Committee
Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of Reversing Stigma strategies.

The Transitional Care Committee
Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of Transitional Care strategies.

The Workforce Development Committee
Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of Workforce Development strategies.

The CCBHC Committee
Provides input into planning and development activities and initiatives to support consistency, accountability, and sustainability of CCBHC strategies in New Hampshire.

Due to the COVID-19 pandemic, many of the subcommittees could not meet. During early 2021, committee rosters were reviewed by BMHS and updated chairs and co-chairs were assigned. Early in 2021, these committees began re-forming and meeting more consistently.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Olivia Afshar	State Employees		105 Pleasant St Concord NH, 03301	Olivia.R.Afshar@dhhs.nh.gov
Lisa Beck	State Employees	DOE- Vocation Rehabilitation	25 Hall Street concord NH, 03301	lisa.m.beck@doe.nh.gov
Palana Belken	Providers	NHHRC	1 Washington Street, Suite 3114 Dover NH, 03821	Palana@NHHRC.org
Melinda Bellanti	Providers		2 Wall Street, Suite 200 Manchester NH, 03101	bellantm@mhcgm.org
David Blacksmith	Persons in recovery from or providing treatment for or advocating for SUD services		377 South Willow Street Manchester NH, 03103	David.b@otrtw.org
Emily Boulton	Providers	New Hampshire Housing Authority	32 Constitution Drive Bedford NH, 03110	eboulton@nhhfa.org
Robin Brenner	Providers		2 Wall Street Manchester NH, 03101	brennerr@mhcgm.org
Greg Burdwood	Providers		544 Islington Street Portsmouth NH, 03801	greg@connectionspeersupport.org
Jill Burke	State Employees		105 Pleasant St Concord NH, 03301	Jill.a.burke@dhhs.nh.gov
Laura Byrne	Providers		2 Blacksmith St Lebanon NH, 03766	laura@h2rc.org
Julie Christenson - Collins	Providers	Greater Nashua Mental Health	2 Wall Street Manchester NH, 03101	Christenson-Collinsj@gnmhc.org
Terri Clyde	Providers		85 North State Street Concord NH, 03301	tclyde@naminh.org
Josh Colwell	Providers		350 Court Street Laconia NH, 03246	jcolwell@sobrietycentersofnh.com

Sheila Considine - Sweeney	Providers		100 West Pearl Street Nashua NH, 03060	considine-sweeneys@gnmhc.org
Tina Dulac	Providers		544 Islington Street Portsmouth NH, 03801	tina@connectionspeersupport.org
Nancy Fennell	Providers		1 Pillsbury Street Concord NH, 03301	nfennell@healthynh.org
Peter Fifield	Providers		798 Central Avenue Dover NH, 03820	Peter.Fifield@WDHospital.org
Nicole Fortune	Family Members of Individuals in Recovery (to include family members of adults with SMI)			fortunenicole@rocketmail.com
Ryan Fowler	Providers		2 Blacksmith Street Lebanon NH, 03766	RFowler@h2rc.org
Tracey Frye	State Employees		25 Hall Street Concord NH, 03301	tracey.l.frye@doe.nh.gov
Heather Gaylord	Providers		P.O. Box 2032 Concord NH, 03302	hgaylord@riverbendcmhc.org
Erica Gilbert	Providers		102 Court Street Laconia NH, 03246	erica@navigatingrecovery.org
Molly Gray	Family Members of Individuals in Recovery (to include family members of adults with SMI)			gray_molly@hotmail.com
Cassi Haberler	Providers		1 Eagle Square Concord NH, 03301	cassi@nhcadsv.org
Barb Holstein	Family Members of Individuals in Recovery (to include family members of adults with SMI)			rochesteryr@aol.com
Jessica Howard	State Employees		105 Pleasant St concord NH, 03301	Jessica.A.Howard@dhhs.nh.gov
Jennifer Hunter	State Employees		25 Hall Street Concord NH, 03301	Jennifer.F.Doris@doe.nh.gov
Sean Jameson	Others (Advocates who are not State employees or providers)			sdjameson05@gmail.com
Nina Jenssen	Providers		544 Islington Street Portsmouth NH, 03801	nina@connectionspeersupport.org
Catalina Kirsch	Providers		1230 Rt 16 Ossipee NH, 03864	continuum@c3ph.org
Melissa Knibbs	State Employees		105 Pleasant St Concord NH, 03301	melissa.m.knibbs@dhhs.nh.gov
Diana Lacey	State Employees		105 Pleasant St Concord NH, 03301	Diana.M.Lacey@dhhs.nh.gov
Michelle Ladue	Providers		328 Union Avenue Laconia NH, 03246	michelle@onepeer.org
Emily Lawrence	Providers		464 Chestnut St Manchester NH, 03105	LawrenceE@waypointnh.org
			3277 White	

Stacie LeClerc	Providers		Mountain Highway North Conway NH, 03860	sleclerc@blueheroncounseling.org
Ken Lewis	Providers		5 Pine Street Extension Nashua NH, 03061	kenl-hearts@comcast.net
Tanya Lord	Providers		125 Airport Road Concord NH, 03301	Tanya.Lord@atwhealth.com
Kevin Luebkert	Providers		36 Clinton Street Concord NH, 03301	Kevin.Luebkert@dhhs.nh.gov
Meaghan Marhan	Providers		377 South Willow Street Manchester NH, 03103	Meghan.m@otrtw.org
Ebony Martin	Providers		85 North State Street Concord NH, 03301	emartin@naminh.org
Amanda Marusarz	Providers		377 South Willow Street Manchester NH, 03103	Amanda.m@otrtw.org
Lisa McCann	Family Members of Individuals in Recovery (to include family members of adults with SMI)			lmccann@ne-family.com
Adam Moulton	Providers		Webster Street Laconia NH, 03246	adam@reverencehouse.com
Samantha Pelletier	Providers		401 Cypress St Manchester NH, 03103	pelletis@mhcgm.org
Fred Poisson	Providers		544 Islington St Portsmouth NH, 03801	fred@connectionspeersupport.org
Hannah Raiche	Providers		40 Park Lane Contoocook NH, 03229	hannahraiche@nafi.com
Sharon Reynolds	Providers		55 Summer Street Rochester NH, 03867	sharon@infinitypeersupport.org
Karen Richi	Providers		24 Vernon Street Keene NH, 03431	karen@monadnockpsa.org
Doug Robertson	Family Members of Individuals in Recovery (to include family members of adults with SMI)			thereddouglass1988@gmail.com
Paula Rockwell	Family Members of Individuals in Recovery (to include family members of adults with SMI)			poetrygirl2012@gmail.com
Ginger Ross	Providers		130 Pembroke Road Concord NH, 03301	gingerross23@gmail.com
Susan Seidler	Providers		108 Pleasant Street Claremont NH, 03743	susan.seidler@steppingstonenextstep.org
Barbara Slayton	Providers		119 Central Street Franklin NH, 03235	bslayton@gm.sau18.org
			85 North State	

Bret Smith	Providers		Street Concord NH, 03301	bsmith@naminh.org
Randy Stevens	Providers		401 Cypress Street Manchester NH, 03103	stevensr@mhcgm.org
Sharon Stout	Providers			sprice@designandformat.com
Ann Strachan	Providers		1145 Sagamore Avenue Portsmouth NH, 03801	astrachan@granitepathways.org
Kerri Swenson	State Employees		105 Pleasant St Concord NH, 03301	Kerri.R.Swenson@dhhs.nh.gov
Daryll Tenney	State Employees		105 Pleasant St Concord NH, 03301	Daryll.C.Tenney@dhhs.nh.gov
Vic Topo	Providers		10 Tsienneto Rd Derry NH, 03038	vtopo@clmnh.org
Michelle Wagner	Providers	NAMI NH	85 North State Street Concord NH, 03301	mwagner@naminh.org
Suzanne Weete	Providers	Community Partners	25 Old Dover Road Rochester NH, 03867	suzanneweete@communitypartnersnh.org

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Currently SAMSHA block grant program planner and advisory chairs are working on a new flyer, application and increasing awareness statewide to fill all vacancies. We are hoping to have these spots filled by our next meeting in January 2024.

BHPAC Membership (7/6/2023)

Last	First	Affiliation	Email
Afshar	Olivia	BDAS?	Olivia.R.Afshar@dhhs.nh.gov
Bauman	Adele	BMHS	Adele.C.Bauman@dhhs.nh.gov
Beck	Lisa	DOE, Vocational Rehabilitation	lisa.m.beck@doe.nh.gov
Belken	Palana	NHHRC, Director of Operations	Palana@NHHRC.org
Bellanti	Melinda	Mental Health Center of Greater Manchester	bellantm@mhcgm.org
Blacksmith	David	On the Road to Wellness	David.b@otrtw.org
Boulton	Emily	New Hampshire Housing	eboulton@nhhfa.org
Brenner	Robin	The Mental Health Center of Greater Manchester	brennerr@mhcgm.org
Burke	Jill		Jill.burke@dhhs.nh.gov
Byrne	Ryan	H2RC, H2RC-NH Specific HR Coordinator	RFowler@h2rc.org
Christenson-Collins, LICSW	Julie	Greater Nashua Mental Health	Christenson-Collinsj@gnmhc.org
Clyde	Terri	NAMI NH	tclyde@naminh.org
Colwell	Josh	Sobriety Centers of NH, Business Development Officer	jcolwell@sobrietycentersofnh.com
Considine Sweeney	Sheila	GNMH	considine-sweeneys@gnmhc.org
DePalo	Renee	Grafton County NH Alternative Sentencing	rdepalo@co.grafton.nh.us
Dix	Chrissie	Connections PSA	chrissie@connectionspeersupport.org
Doris	Jennifer	Administrator II, DOE_Student Social & Emotional Wellness	Jennifer.F.Doris@doe.nh.gov
Dulac	Tina	Connections Peer Support	tina@connectionspeersupport.org
Fennell	Nancy	Behavioral Health Clinicial Learning Collaborative	nfennell@healthynh.org
Fifield	Peter	Wentworth Douglass/The Doorway-Dover, SUD Program Manager	Peter.Fifield@WDHospital.org
Fortune	Nicole	Family Member	fortunenicole@rocketmail.com
Fowler	Laura	H2RC, Executive Director	laura@h2rc.org
Frye	Tracey	NH Department of Education	tracey.l.frye@doe.nh.gov
Gaylord	Heather	Riverbend	hgaylord@riverbendcmhc.org
Gilbert	Erica	Navigating Recovery of the Lakes Region, Family Services Coordina	erica@navigatingrecovery.org
Gray	Molly		gray_molly@hotmail.com
Haberler	Cassi	NHCADSV	cassi@nhcadsv.org
Holstein	Barb		rochesteryr@aol.com
Jameson	Sean	Mental Health Advocate	sdjameson05@gmail.com
Jenssen	Nina	Connections Peer Support	nina@connectionspeersupport.org
Kirsch	Catalina	Carroll County RPHN, CoC Facilitator	continuum@c3ph.org
Knibbs	Melissa		Melissa.M.Knibbs@dhhs.nh.gov
Ladue	Michelle	One Peer to Another	michelle@onepeer.org
Lawrence	Emily	Waypoint	LawrenceE@waypointnh.org
LeClerc	Stacie	Blue Heron, Clinical Director	sleclerc@blueheroncounseling.org
Lewis	Ken	H.E.A.R.T.S. Peer Support Center	kenl-hearts@comcast.net
Lord	Tanya	Foundation for Healthy Communities, Patient and Family Engagem	Tanya.Lord@atwhealth.com
Luebkert	Kevin	NHH	Kevin.Luebkert@dhhs.nh.gov
Marhan	Meaghan	On the Road to Wellness	Meghan.m@otrtw.org
Martin	Ebony	MHCGM Peer Specialist	martineb@mhcgm.org
Marusarz	Amanda	On the Road to Wellness	Amanda.m@otrtw.org
McCann	Lisa		lmccann@ne-family.com
McDonough	Jacky	Connections Peer Support, Executive Director	jacky@connectionspeersupport.org
Moulton	Adam	Reverence House, Founder	adam@reverencehouse.com
Raiche	Hannah		hannahraiche@nafi.com
Reynolds	Sharon	Infinity Peer Support	sharon@infinitypeersupport.org
Richi	Karen	Monadnock Peer Support	karen@monadnockpsa.org
Robertson	Doug		thereddouglass1988@gmail.com
Rockwell	Paula	Family Member	poetrygirl2012@gmail.com
Ross	Ginger	Founder Choices Recovery Trainings	gingerross23@gmail.com
Seidler	Susan	Stepping Stone/Next Step Peer Support Agency, Executive Directo	susan.seidler@steppingstonenextstep.org
Silvey	Melissa	Infinity Peer Support Agency, Executive Director	melissa@infinitypeersupport.org
Slayton	Barbara	Franklin School District, Coordinator of School Wellness	bslayton@gm.sau18.org
Smith, CRSW, NCPRSS, CPS	Bret	Mental Health Center of Greater Manchester	smithbre@mhcgm.org
Stevens	Randy	Mental Health Center of Greater Manchester	stevensr@mhcgm.org
Strachan	Ann	Seacoast Pathways, Executive Director	astrachan@granitepathways.org
Swenson	Kerri		Kerri.R.Swenson@dhhs.nh.gov
Tappan	Josh	One Peer to Another	josh@onepeer.org
Topo	Vic	CLM CMHC, Director	vtopo@clmnh.org
Wagner	Michelle	NAMI NH	mwagner@naminh.org
Weete	Suzanne	Community Partners/DMHA	suzanneweete@communitypartnersnh.org

New Members who need to return their completed application

SUD Members from Olivia's list

Members whose emails have bounced back

Lunday	Tyler	SOS RCO, CRSW, Family Recovery Supervisor	tlunday@sosrco.org
Allen	Christine	Monadnock Peer Support Agency, Executive Director	christine@monadnockpsa.org

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	6	
Parents of children with SED	0	
Vacancies (individual & family members)	31	
Others (Advocates who are not State employees or providers)	1	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**38**	**40.43%**
State Employees	10	
Providers	44	
Vacancies	2	
Total State Employees & Providers	**56**	**59.57%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	3	
Individuals/Family Members from LGBTQI+ Populations	6	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**104**	

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Footnotes:

BHPAC committee members and SAMSHA Block grant program planner are new to this counsel. Due to this there was a lapse in the meeting the requirements of attendees. Work groups are already in process to improve the flyer, application and to broaden membership across the state with a main focus on individuals with lived experience and family members of those with lived experience.

The BHPAC membership was not being tracked appropriately and new processes are now in place. The chair took an anonymous survey to obtain the below data, due to this there is not accurate information about who is a family member or person in recovery/lived experience. plans are in place for this information to be accurate in the next application.

Individual in recovery 11

family members 12
Parent of children with SED 3
other (not state employees or providers) 11
state employee 2
providers 8

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

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

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://www.dhhs.nh.gov/news-and-media/community-mental-health-services-block-grant-fy-2024-2025-application

Public Notices
Date: August 11, 2023
Close Date: August 19, 2023
Contact:

Bureau of Mental Health Services
| BMHS@dhhs.nh.gov

Community Mental Health Services Block Grant FY 2024-2025 Application
Request for Public Comment

The Bureau of Mental Health Services is seeking comments from the community on the FY 2024-2025 Application for the SAMHSA Community Mental Health Services Block Grant (MHBG).
Please review the MHBG Application Draft .pdf Icon and share your feedback with us through our MHBG Public Comment Survey.

The MHBG Public Comment Survey will be open from August 11, 2023 through August 18, 2023.

If the survey link does not work, try typing www.surveymonkey.com/r/CH7QBM7 into your browser's address bar.
To learn more about the block grant, please visit the SAMHSA Block Grants webpage.

To encourage responses, the Public Notice invited people to respond in several ways: via email to the Bureau of Mental Health Services at: BMHS@dhhs.nh.gov, and also at the following Survey Monkey link: www.SurveyMonkey.com/r/CH7QBM7

BMHS staff created the Survey Monkey response system to allow a person to respond with general comments about the entire application (on an Overall Comments page), or to any individual section (on the Section Comments page). There was also a provision for a person to change their comments on any section, after entering them, to change their response before submitting them as final comments.

For each comments section, there was a question asking "How satisfied are you with Application Section (1-22)" and five buttons to choose from:

Very Satisfied
Satisfied
Neutral
Dissatisfied
Very Dissatisfied

This allowed quantitative reporting of the level of satisfaction for each section. In addition, for each comments section, there was a box labeled "Comments" that allowed the person to type in any text comments they had about the section.

In reporting the result, the textual comments submitted were compiled for each section, and a comparative satisfaction score was

displayed for all submitted comments to that section. These scored were also graphed out on a bar chart display.

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

https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/ffy-2022-23-block-grant-app-plan.pdf

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

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

N/A

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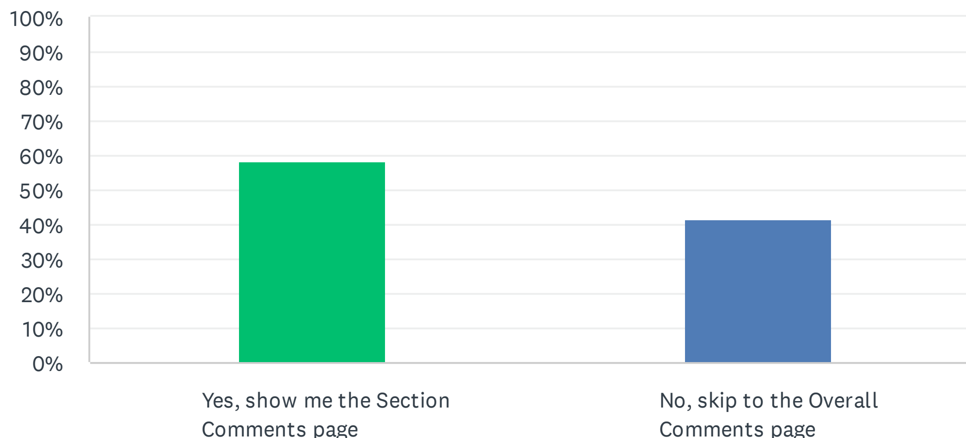
Footnotes:

Q1 Would you like to comment on a specific section within the grant application?

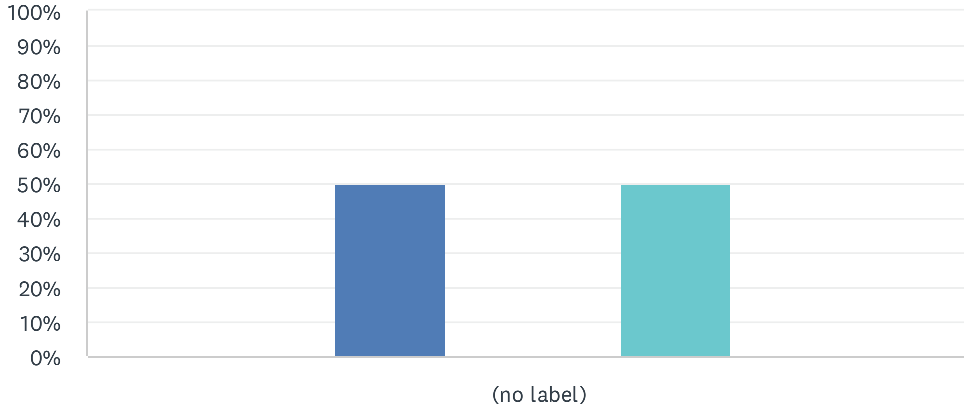
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, show me the Section Comments page	58.33%	7
No, skip to the Overall Comments page	41.67%	5
TOTAL		12

Q2 How satisfied are you with Application Section 1, Access to Care, Integration, and Care Coordination?

Answered: 2 Skipped: 10

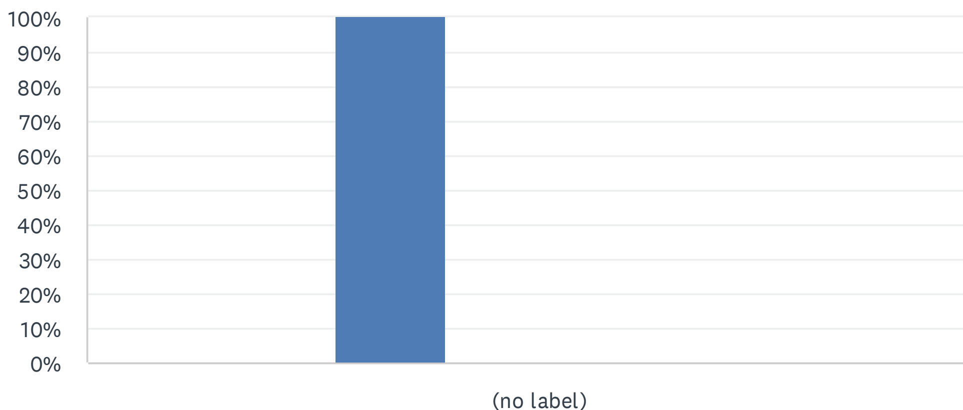


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2	3.00

#	COMMENTS	DATE
1	I had care provided to my son at CLM in Derry/Salem NH. At the time they did help with their ES. However when an IEA was out in place we as parents were not aware that our son could be arrested. Does even seem like this should happen. Then after that he went to CLM but keep getting moved from therapists to therapist. Stating that he wasn't participating. However the questions were what are you going to do now. Not talking about what just happened and trying to help him see what he just experienced. Then we were told for months there was not a psychiatrist available for him. But after 6 months he did finally get access to a psychiatrist but only to have the psychiatrist not want the family involved and to have her write a prescription then say he can go get it if he wants to. Why would any psychiatrist say that to someone with a mental health condition and write the prescription for almost a year. So he was all set and didn't have to return. Very disappointed with the outcome of community mental health.	8/15/2023 6:39 PM
2	Review of 10 yr plan and initiatives like CTI are positive.	8/14/2023 6:04 PM

Q3 How satisfied are you with Application Section 2, Health Disparities?

Answered: 1 Skipped: 11

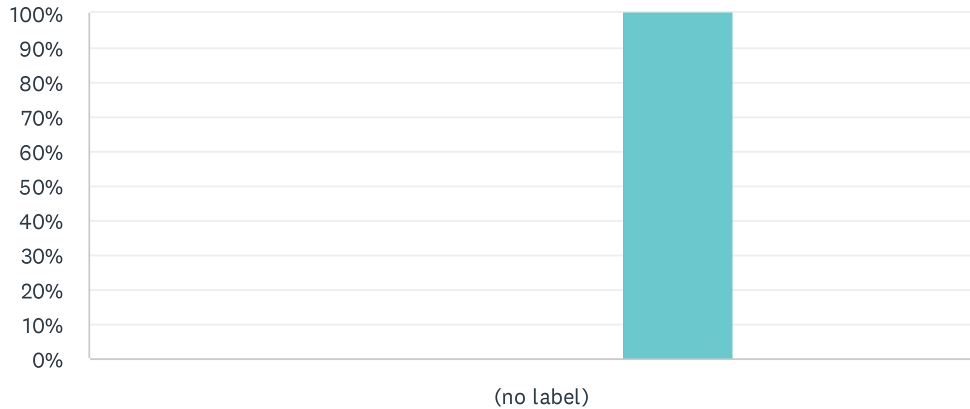


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1	2.00

#	COMMENTS	DATE
1	Limited information provided about the diversity of staff serving clients. CMHCs aware of responsibility to provide interpreters, but do they? Do any have interpreters on staff?	8/14/2023 6:04 PM

Q4 How satisfied are you with Application Section 3, Innovation in Purchasing Decision?

Answered: 1 Skipped: 11



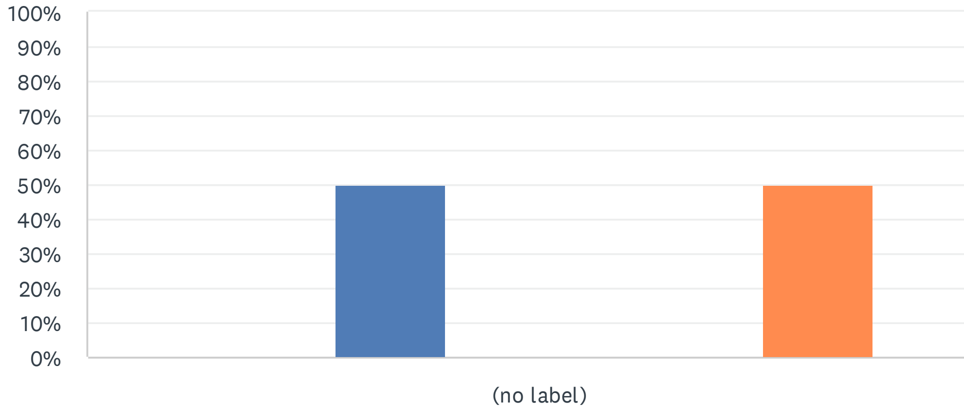
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	1	4.00

#	COMMENTS	DATE
1	NH has been innovative in some areas. Is there a way to incentivize Community Health Centers and CMHCs working together more vs the redundancies in the 2 systems?	8/14/2023 6:04 PM

Q5 How satisfied are you with Application Section 4, Evidence-Based Practices for Early Interventions to Address Early Serious Mental Health Illnesses (ESMI)?

Answered: 2 Skipped: 10



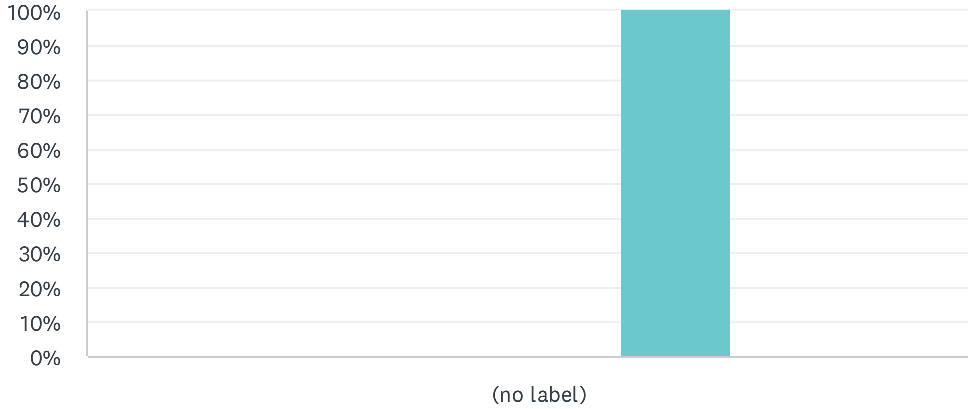
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	50.00% 1	0.00% 0	0.00% 0	50.00% 1	2	3.50

#	COMMENTS	DATE
1	Where can you go to get these services and to have them appropriately received by the patient? It's very hard to find mental support and services without waiting for weeks.	8/15/2023 6:39 PM
2	Grateful to (finally) see more statewide FEP services. Please keep funding and supporting these programs.	8/14/2023 6:04 PM

Q6 How satisfied are you with Application Section 5, Person Centered Planning (PCP)?

Answered: 1 Skipped: 11

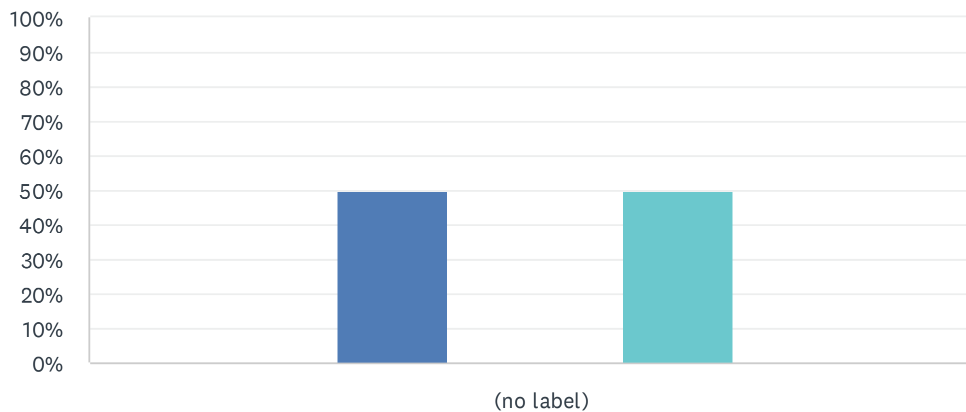


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	1	4.00

#	COMMENTS	DATE
1	Person Centered seems like it would also include more flexibility around choice without negative impact to providers...how do we ensure providers aren't inadvertently incentivized to not truly allow each person to develop their own recovery path? Also, wouldn't person centered include the MH and SUD or MH and Physical to talk to one another, so people don't have to be the ones burdened with making sure they share information or that the information they have is accurate and up to date.	8/14/2023 6:04 PM

Q7 How satisfied are you with Application Section 6, Program Integrity?

Answered: 2 Skipped: 10



	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2	3.00

#	COMMENTS	DATE
1	Is there program integrity? I don't believe there is…Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care, I question quality and necessary care being delivered on a daily basis and feel that care to many in the mental health is prescribing medication and hoping they don't return for further treatment or care.	8/15/2023 6:39 PM
2	Monitoring is good, quality improvement is good, doing the right things is good. Where are the outcomes? Do people get better?	8/14/2023 6:04 PM

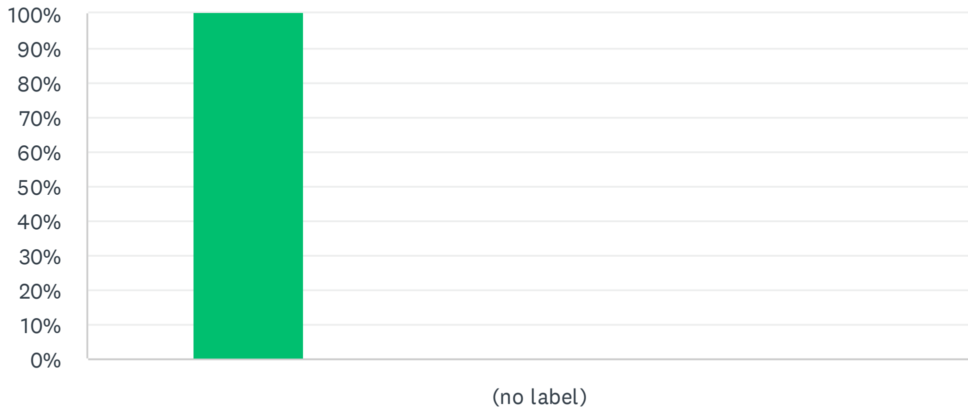
Q8 How satisfied are you with Application Section 7, Tribes?

Answered: 0 Skipped: 12

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0	0.00

Q9 How satisfied are you with Application Section 8, Primary Prevention?

Answered: 1 Skipped: 11



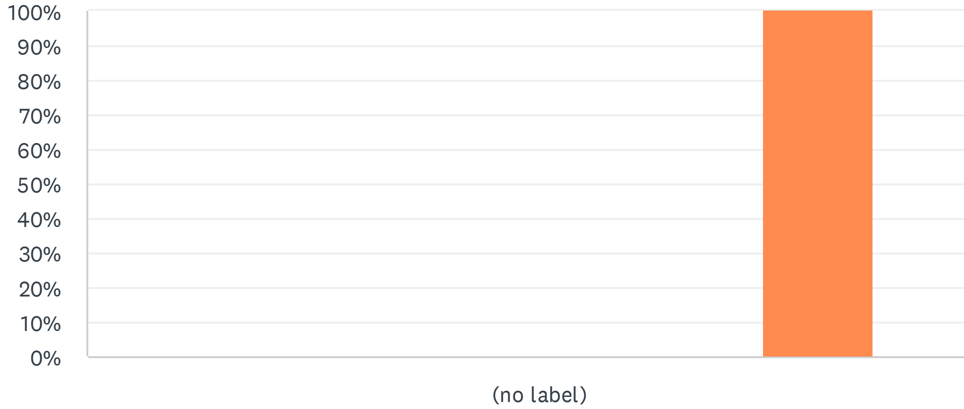
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1	1.00

#	COMMENTS	DATE
1	There is no section 8?! Why arent we doing anything about prevention?	8/14/2023 6:04 PM

Q10 How satisfied are you with Application Section 9, Statutory Criterion for MHBG?

Answered: 1 Skipped: 11



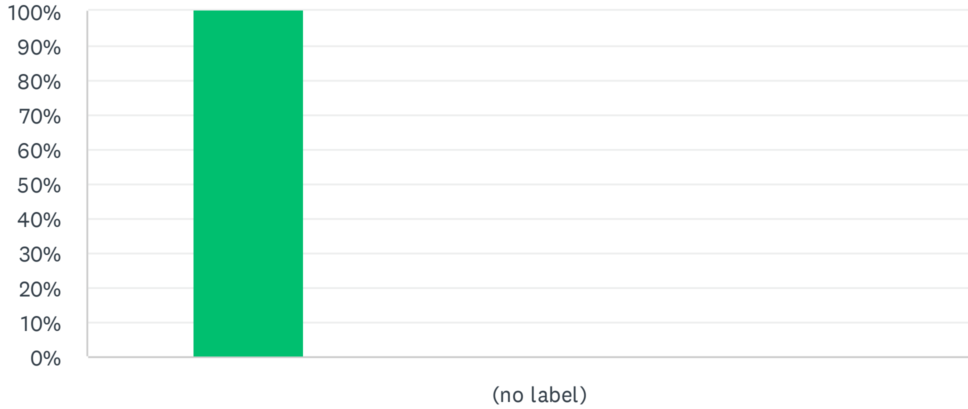
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	1	5.00

#	COMMENTS	DATE
1	Thankful for CMHCs and Peers Supports and statewide crisis. Hope more funding can help with more improvements. Why are there so many SUD providers with various levels of professionalism? Can there be SUD services at all CMHCs and Peer Support Agencies? Is all crisis required to also see SUD or work with SUD providers? Need more services in schools by CMHCs rather than by one person hired in a school who cant see everyone - can we fund more collaborations?	8/14/2023 6:04 PM

Q11 How satisfied are you with Application Section 10, Substance Use Disorder Treatment?

Answered: 1 Skipped: 11



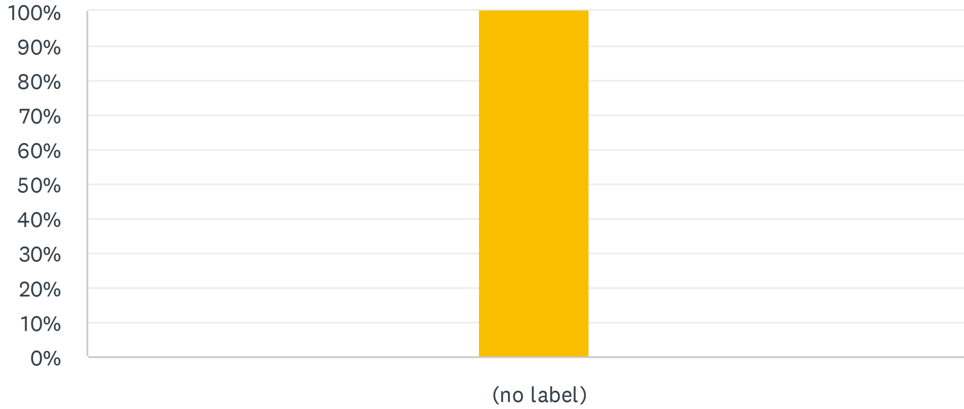
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1	1.00

#	COMMENTS	DATE
1	No Section 10?! SUD and MH services should be more coordinated and collaborated in NH...they seem so separate.	8/14/2023 6:04 PM

Q12 How satisfied are you with Application Section 11, Quality Improvement Plan?

Answered: 1 Skipped: 11



	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	3.00

#	COMMENTS	DATE
1	Mentions only plans for entities it oversees...what about DHHS and its departments - do they ever have their own quality improvement plans?	8/14/2023 6:04 PM

Q13 How satisfied are you with Application Section 12, Trauma?

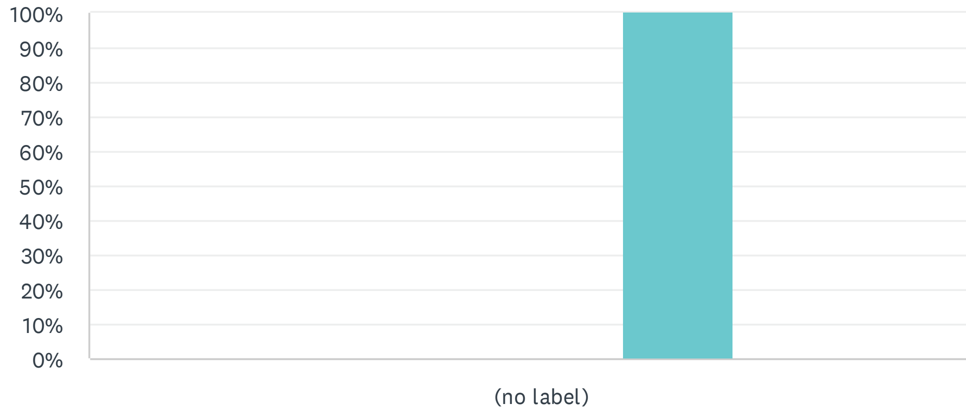
Answered: 1 Skipped: 11

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	1	5.00

#	COMMENTS	DATE
1	Having peers on staff support agencies being better able to address trauma. Any thoughts about the importance of authenticity, transparency, and less burdens on people (paperwork!) as other ways to help people who have trauma disorders?	8/14/2023 6:04 PM

Q14 How satisfied are you with Application Section 13, Criminal and Juvenile Justice?

Answered: 1 Skipped: 11



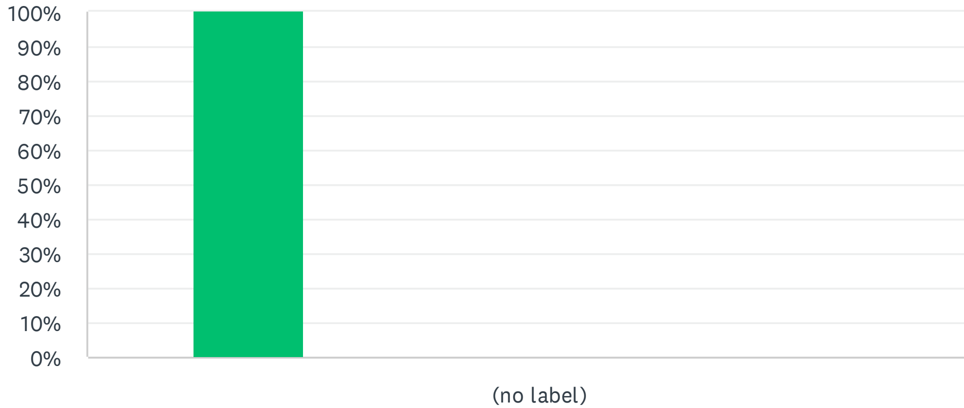
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	1	4.00

#	COMMENTS	DATE
1	Seems like a good start - how available is MH in our correction facilities? where is collaboration required? why arent the MH experts at CMHCs and DHHS consulting more with jails and prisons?	8/14/2023 6:04 PM

Q15 How satisfied are you with Application Section 14, Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD)?

Answered: 1 Skipped: 11

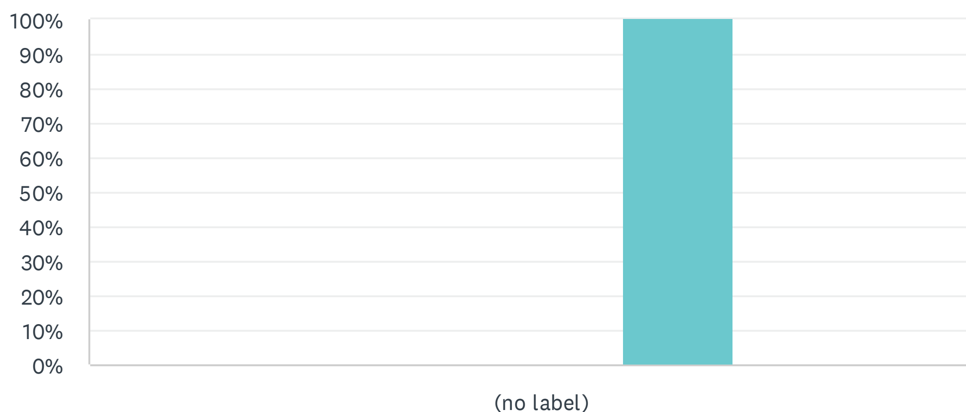


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1	1.00

#	COMMENTS	DATE
1	There is no Section 14?! Do we require SUD programs or CMHCs to offer medications for SUD (along with treatment, of course)?	8/14/2023 6:04 PM

Q16 How satisfied are you with Application Section 15, Crisis Services?

Answered: 1 Skipped: 11

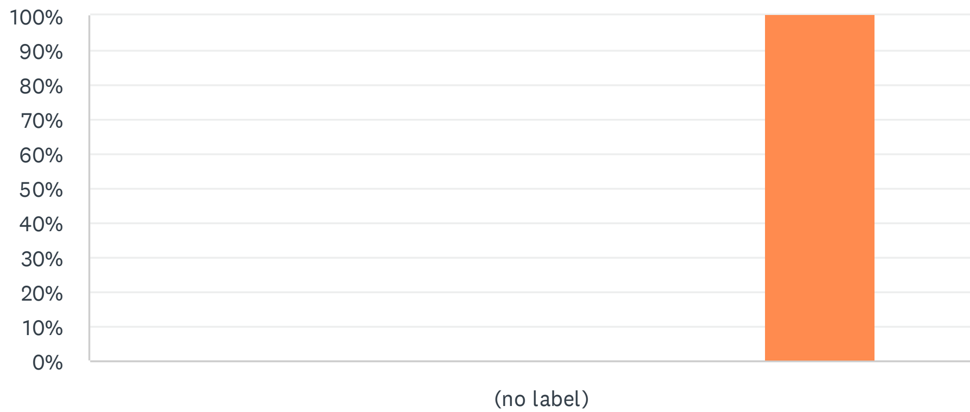


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	1	4.00

#	COMMENTS	DATE
1	Glad its available statewide...but it has had some serious problems. Will funding help improve it? Why aren't there more apartments and/or crisis stabilization centers across the state?	8/14/2023 6:04 PM

Q17 How satisfied are you with Application Section 16, Recovery?

Answered: 1 Skipped: 11

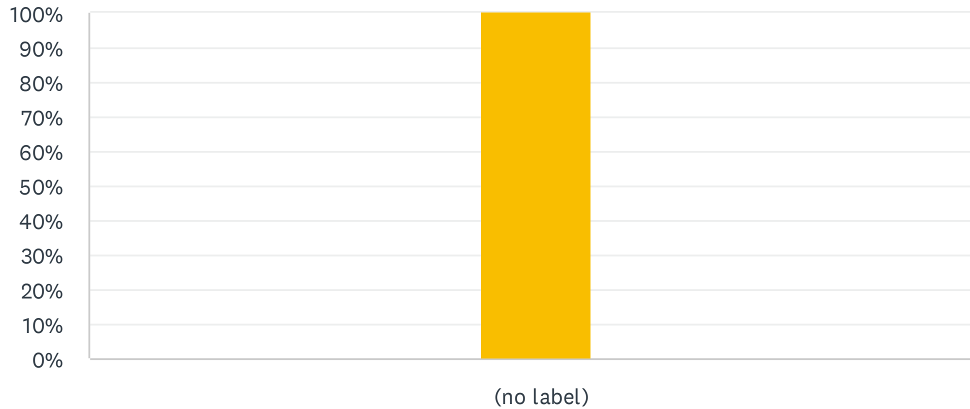


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	1	5.00

#	COMMENTS	DATE
1	Grateful that NH has peer support agencies. Don't understand why some don't collaborate with their local CMHC the way others do?	8/14/2023 6:04 PM

Q18 How satisfied are you with Application Section 17, Community Living and the Implementation of Olmstead?

Answered: 1 Skipped: 11



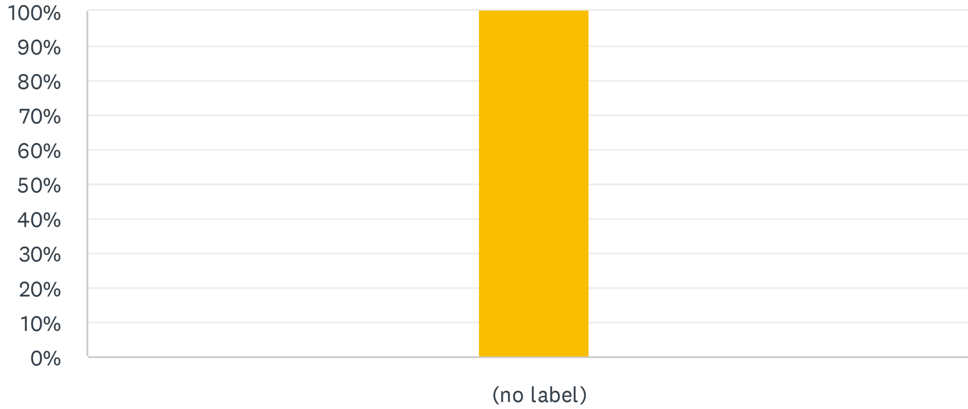
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	3.00

#	COMMENTS	DATE
1	We need more housing!	8/14/2023 6:04 PM

Q19 How satisfied are you with Application Section 18, Children and Adolescents M-SUD Services?

Answered: 1 Skipped: 11



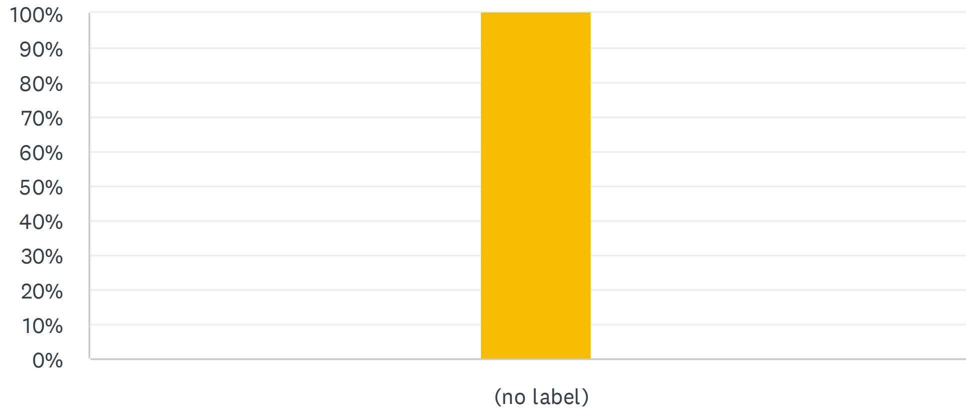
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	3.00

#	COMMENTS	DATE
1	Why isn't the program 7 Challenges mentioned here? Can NH do more to encourage SUD and MH providers to work together for our kids?	8/14/2023 6:04 PM

Q20 How satisfied are you with Application Section 19, Suicide Prevention?

Answered: 1 Skipped: 11

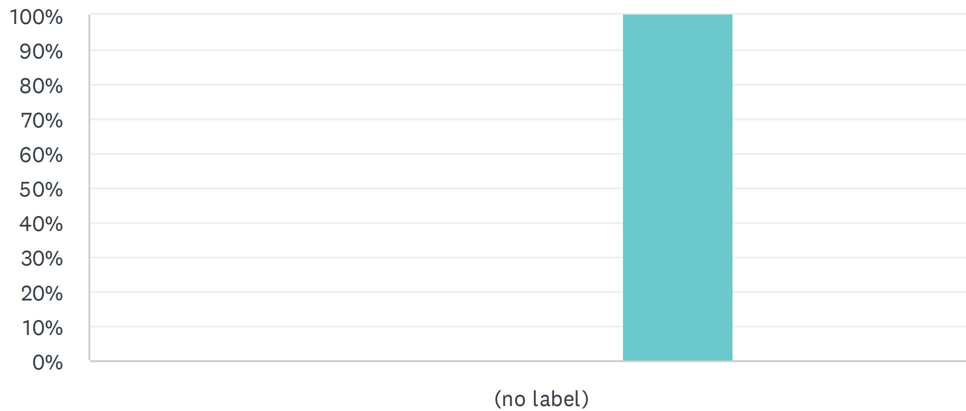


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	3.00

#	COMMENTS	DATE
1	Haven't some CMHCs also implemented or trained on Zero Suicide? Why are only SUD providers mentioned? Aren't CMHCs also trained in Suicide screening, assessment, and CALM?	8/14/2023 6:04 PM

Q21 How satisfied are you with Application Section 20, Support of State Partners?

Answered: 1 Skipped: 11

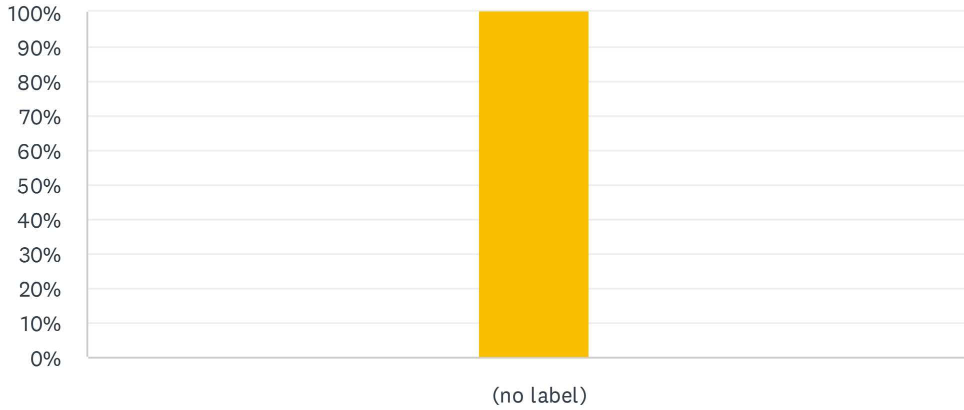


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	0.00% 0	100.00% 1	0.00% 0	1	4.00

#	COMMENTS	DATE
1	Lots of partnership mentioned. Last part isn't finished yet...should there be more with DOE, DOC, and HOUSING!!!	8/14/2023 6:04 PM

Q22 How satisfied are you with Application Section 21, State Planning - Council and Input on the Mental Health- Substance use disorder Block Grant Application?

Answered: 1 Skipped: 11



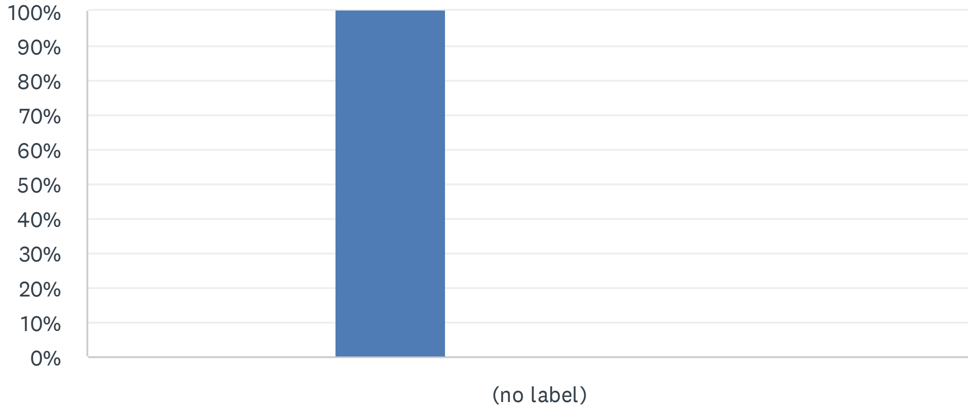
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1	3.00

#	COMMENTS	DATE
1	Who is on the Council? How was this comment period advertised (I only knew about it from a forwarded email)? Are there "subject matter" experts (people from CMHCs/PSAs/people who use services) asked to review sections to provide feedback in initial stages?	8/14/2023 6:04 PM

Q23 How satisfied are you with Application Section 22, Public Comment on the State Plan?

Answered: 1 Skipped: 11



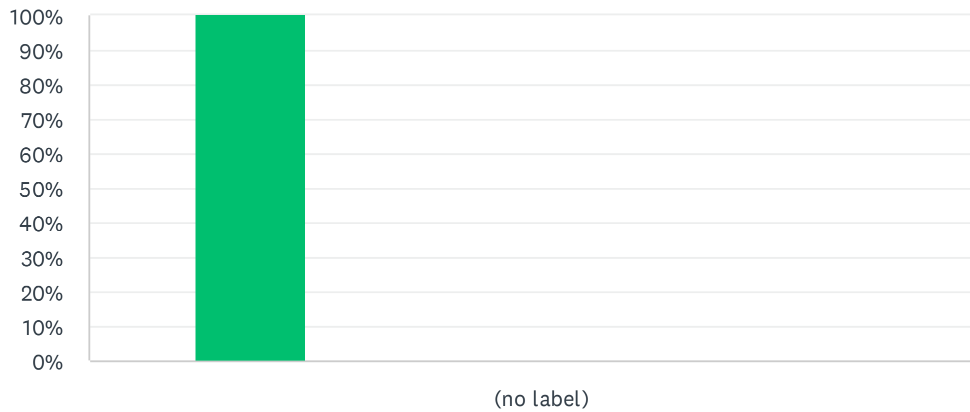
Very Dissat... Dissatisfied Neutral Satisfied Very Satisfi...

	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	100.00% 1	0.00% 0	0.00% 0	0.00% 0	1	2.00

#	COMMENTS	DATE
1	Posting on website and limited feedback doesnt seem like enough...	8/14/2023 6:04 PM

Q24 How satisfied are you with Application Section A, Finance?

Answered: 1 Skipped: 11

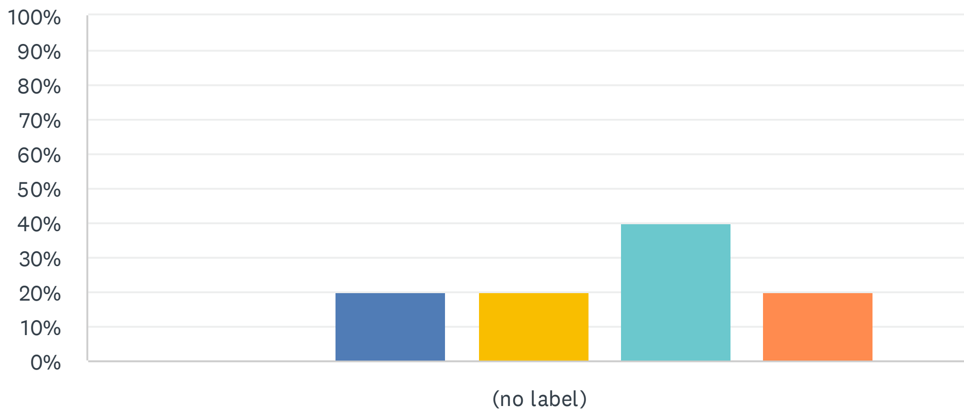


	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1	1.00

#	COMMENTS	DATE
1	Looks blank...?	8/14/2023 6:04 PM

Q25 How satisfied are you with the application as a whole?

Answered: 5 Skipped: 7



	VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	20.00% 1	20.00% 1	40.00% 2	20.00% 1	5	3.60

#	COMMENTS	DATE
1	DHHS does a lot with limited resources. Increase in more accessibility statewide (rather than only in certain areas) is positive and highlighted. (But more is needed.) Many things like MH and SUD and MH in schools still seem so separated - is there opportunity for more collaboration? Increase in peers is a plus. I feel like there is more going on in CMHCs than is here (and there is a lot here)...like I noted 7 Challenges...but is there even more? Many things are about what others are doing within CMHCs/Peer Support/SUD...is there any opportunity to say what state is doing/will do in more places? How is the state making the 10-year plan come to be in all these different areas? Thank you for the opportunity to review and comment.	8/14/2023 6:11 PM