Implementing a System of Care for Children's Behavioral Health in New Hampshire

Year 1 Report

December 1, 2016

Executive Summary

In May 2016, New Hampshire State Senate Bill 534-FN (SB 534-FN) was passed, which paved the way for the development of a comprehensive system of care for children's behavioral health services in the state. Meeting the demands of this bill will help to unify the delivery of related services across the state, addressing structural barriers and improving behavioral outcomes for New Hampshire's children. This report describes current conditions both in terms of targeted program delivery and the expenditures associated with these programs, a first step in the state's progress towards these goals.

The push to create a system of care in New Hampshire started in earnest in 2010, when the NH Children's Behavioral Health Collaborative (CBHC) was formed (see Appendix I). The CBHC is an unprecedented coalition of over 50 organizations, which came together to study New Hampshire's existing children's behavioral health systems. This group studied the strengths and challenges of meeting children's behavioral health needs in the state, releasing a plan for improvement based on input from hundreds of stakeholders around the state. The NH Departments of Education (DOE) and Health and Human Services (DHHS), which had representation on the original steering committee of the CBHC, provided critical vision for a statewide system of care.

Through the work of the CBHC, DHHS received a system of care grant in 2012 from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) division. The work conducted under this four-year grant addressed barriers to access for critical services, ensuring that youth and family voices are at the forefront of system and program development, with a focus on cultural and linguistic competence among service providers. This included the creation of the Families and Systems Together (FAST) Forward program, an attempt to reach a group of children whose needs were previously not met effectively. The work conducted under this grant is limited in scope, and thus it has not created a complete department-wide system of care approach. It has provided some foundational structures and practices that are essential in moving this work forward. In the coming years, systems and financing changes will be examined to sustain and expand this work.

Building on the results yielded by the SAMHSA grant, and in the context of new legislation, the Vulnerable Families Research Program at UNH's Carsey School of Public Policy, with financial support from the Endowment for Health, will support the DOE and DHHS to comply with the provisions outlined in SB 534. This support entails providing technical and analytical assistance associated with the development of a plan for establishing and maintaining a system of care, including in the production of this and subsequent reports.

This report highlights the important steps that have been taken since the passage of SB 534-FN. We identify over $100 million dollars of expenditures towards child behavioral health services in New Hampshire, highlighting the fact that many of these services are more intensive intervention efforts and relatively fewer funds go towards preventative practices, which would reduce costs over the long term. We also examine the consistency of these services with a system of care approach, noting that—although there are notable bright spots—there are a number of areas where alignment is minimal. Finally, we describe planned or actual changes in services that have or will occur in an effort to improve alignment with a system of care.

It is important to underscore that the important and necessary cross-departmental collaboration envisioned in SB 534-FN has only begun and much of our children's behavioral health system remains fragmented and uncoordinated. Federal grants have provided seed funding to pilot interventions focused on prevention and early intervention; however, children's

behavioral health expenditures are currently focused on children and families with the most acute needs. Identifying cross-departmental strategies to improve outcomes associated with children's behavioral health will continue over the coming year.

I. Introduction

The promotion of children's behavioral health is a necessary precursor for the physical and economic health of New Hampshire. Behavioral health is governed by the complex interactions between mental and physical health and social relationships. When a child's behavioral health needs are not met, she will likely suffer in other ways as well, for example, by becoming disengaged and underperforming in school. In this way, unmet behavioral health needs can drive other poor outcomes for children. Unfortunately, children requiring behavioral health services often do not get the care they require. More than fifteen years ago, the Surgeon General warned that the majority of the roughly one in five children with a diagnosable mental disorder receive no, or inappropriate, care;[1] few would argue that there has been enough progress on this front since.

The costs of behavioral health challenges extend beyond those who face them. Not only are children with unmet behavioral health needs less likely to reach their own educational and economic potential, but they are also more likely to negatively impact those around them and the broader community. Those who deal with severe behavioral health challenges are more likely to suffer from addiction, fall victim to depression or self-harm, or remain disconnected from work and school, and thus often pose greater demand on public institutions and assistance programs.[2]

There are significant challenges that New Hampshire must face in order to meet comprehensive behavioral health needs: a mental health workforce that is insufficient to meet demands, inadequate public and private health insurance, and a significant need for the integration of care.[3] For these reasons, it is crucially important that New Hampshire works towards a system of care approach to behavioral health. Such a system recognizes that behavioral supports come in many forms, and embody a number of important characteristics. Ultimately, one expects a system of care that is efficient, free of access gaps, and responsive to the needs of the individual and his family—in ways that are both preventative and intervening. This Year 1 Report is an important step in this direction, detailing expenditures on relevant aspects of behavioral health systems in New Hampshire, as well as describing some of the obstacles that hinder a fully functional system of care.

While this report focuses on fiscal expenditures, we know far too well the other costs associated with poor behavioral health in childhood. As children grow into adults, untreated needs can result in lost productivity, early pregnancy, attenuated educational attainment, poverty, addiction, physical health challenges, and even death.[4] Of course, all of these outcomes are interconnected and assigning causality can be difficult. It is beyond the scope of this report to

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[1] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General—children and mental health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[2] Insel, T. R. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry,165*(6), 663-665. Retrieved from http://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2008.08030366

[3] Covert, S. *Children's mental health services in New Hampshire: where we are now, where we need to go, and how to move forward.* Concord, NH: Endowment for Health, New Hampshire Department of Health and Human Services, National Alliance on Mental Illness-New Hampshire. 2009.

[4] Duncan, G. J., & Brooks-Gunn, J. (1997). The effects of poverty on children. *The Future of Children, 7*(2), 55–71. Brooks-Gunn, J., Duncan, G. J., & Maritato, N. (1997). Poor families, poor outcomes: The well-being of children and youth." In J. Brooks-Gunn & G. J. Duncan (Eds.), *Consequences of growing up poor*. New York: Russell Sage Foundation.

detail all of these costs and relationships. Rather, we draw attention to these matters in order to provide context for understanding the importance of behavioral health. As we endeavor to promote widespread behavioral health, it must be acknowledged that the backdrop is a New Hampshire where one in ten children are poor[5] and an opioid epidemic will take the lives of roughly 500 people this year alone.[6]

Despite such challenges, there are reassuring signs regarding child behavioral health services in New Hampshire. This report documents over $100 million dollars spent on child behavioral health services in New Hampshire in a year, expenditures which provide invaluable services to families throughout the state. The passage of SB 534 indicates that there is widespread support for rethinking and improving aspects of the state's systems. Furthermore, largely through smaller-scale, grant-funded projects, efforts have already been underway for a number of years to move New Hampshire towards a system of care model. These efforts focus not only on acute care and intervention, but also on prevention and healthy socioemotional development for all children. With continued focus on these matters, a more comprehensive, gap-free, and efficient system of child behavioral health services can emerge in New Hampshire.

II. Requirements and Organization

Chapter 135-F:6 of An Act to Implement a System of Care for Children's Behavioral Health in New Hampshire outlines four elements which must be included in this Year 1 Report: the total cost of children's behavioral health services; the extent to which the state's behavioral health service systems are consistent with a system of care;[7] a description of any actual or planned changes in department policy or practice or developments external to the departments that will affect implementation of a system of care; and any other available information relevant to progress toward full implementation of a system of care.[8]

Child behavioral health services in New Hampshire are provided by an array of public and private entities. For the sake of clarity, the findings of this report (found in section IV) are organized such that each major program within the universe of child behavioral health services in New Hampshire is first examined in isolation, with the costs, consistency, changes, and relevancies for each being presented. The state's child behavioral health service systems exhibit varying degrees of consistency with a system of care. We present the degree of consistency between elements and each of the eleven characteristics of a system of care to as outlined in SB 534. This report categorizes using a traffic light rating system:

- Green: there is significant consistency with a system of care, with perhaps minor challenges remaining.
- Yellow: consistency with a system of care is emerging, although there are significant obstacles to consider.
- Red: efforts to align with a system of care have not begun, or there are major impediments to achieve consistency with a system of care.

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[5] Schaefer, A., Carson, J. A., & Mattingly, M. (2016). *Overall declines in child poverty mask relatively stable rates across states.* Durham, NH: Carsey School of Public Policy, University of New Hampshire.

[6] The State of New Hampshire. (2016). The opiate/opioid public health crises: Update on the State of New Hampshire's comprehensive response. Retrieved from http://www.dhhs.nh.gov/dcbcs/bdas/documents/state-response-opioid-crisis.pdf

[7] See Appendix II for a complete description of the characteristics of a system of care as outlined in state statute.

[8] Specifically, this report addresses this requirement for children from birth through age 21.

In the discussion we tie together major themes found throughout programs, aggregate findings to the extent possible, and provide an overall sense of remaining obstacles and the path ahead for a system of care in New Hampshire. Before turning to findings and discussion, however, we begin with a brief summary of the limitations inherent in this report.

III. Limitations

The primary limitation of this report relates to the estimation of the "cost" of child behavioral health services in the state. Such an endeavor is challenging from methodological, logistical, and semantic perspectives. In this report, we interpret "cost" rather narrowly, defining it as the sum of all state expenditures that have a primary focus on the promotion of children's behavioral health. Specifically, we estimate fiscal year expenditures, and note that this might not capture more periodic investments. Additionally, these expenditures illustrate only what was spent, not what the actual costs of services would be if made fully available. Perhaps more importantly, such a definition of "cost" does not entail those human and societal costs that result from unmet behavioral needs. Ultimately, such an inquiry is beyond the scope of this report.

Even when examining only fiscal year expenditures, limitations remain. The use of multiple departmental data and reporting systems require us to present State Fiscal Year (SFY) 2015 expenditures at some points for some services, and SFY 16 expenditures for others. Specifically, DHHS expenditures typically refer to SFY 2015 while DOE expenditures are typically reflective of SFY 2016. Each table indicates the reference year for estimates presented therein. Additionally, the detailed expenditures presented in this report reflect state and federal funding exclusively, as these are the only levels at which such fiscal data are readily available. School districts and communities do receive funding from other sources, such as local taxes, grants, and contributions from local businesses and philanthropic organizations. The total spending on child behavioral health services from these local sources is assumed to be substantial, but ultimately cannot be included here. There are also instances of state and federal aid where it is difficult to determine direct allocations. For example, federal allocations under the Individuals with Disabilities Education Act currently total nearly $43 million, and though many of these funds may go to behavioral health related services,[9] these expenditures are not captured here, as it is challenging to tease out the specific purpose of these dollars. Similarly, because children may receive services paid by multiple funding streams or programs, it is difficult to quantify the number of children receiving specific services from particular funding sources. Another related example is Catastrophic Aid, which is a state source of funds used by school districts that seek reimbursement for students whose cost exceeds 3.5 times the average per pupil costs. Last year there were more than 830 students whose costs met this threshold. Districts may be reimbursed with Catastrophic Aid funds for activities such as residential placement, behavioral support, psychological and counseling services, and occupational services. These services may be provided by a host of personnel, including paraprofessionals, school counselors, school social workers, school psychologists, and special education teachers. The DOE does not systematically collect fiscal data on how these staff expenditures may provide behavioral health

[9] For instance, students diagnosed with an Emotional Disturbance often require modified behavioral services that are paid for out of these funds.

services. More generally, it is exceedingly difficult to disentangle the share of many funds that go to behavioral services as opposed to other academic supports.

IV. Findings

Here we present findings for four major programs: the Department of Children, Youth and Families; Division for Behavioral Health; Behavioral Health at School; and Bureau of Developmental Services. For each program area, we provide a brief description; estimate total expenditures; describe the program's consistency with a system of care approach; document any actual or planned changes; and highlight any other additional relevant information.

A. Department of Children, Youth and Families (DCYF)

DCYF manages protective and preventative programs on behalf of New Hampshire's youth and their families, providing a wide range of family-centered services with the goal of meeting the safety, permanency, and wellbeing needs of parents and their children and strengthening the family system. Expenditures in DCYF come in a number of areas, including Child Protection, Juvenile Justice, the Sununu Youth Services Center, Juvenile Diversion, and the Child Care Scholarship. The total behavioral health services expenditures for DCYF for SFY 2015, found in Table 1, are over $34 million, over half of which comes from Medicaid funding.

Table 1.

Expenditures, Department of Children, Youth and Familes, Children's Behavioral Health Services in New Hampshire, SFY 2015

Name	Funding Source	Level of Support	Description	Total Expenditures
Child Protection	General Funds	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intesnive in home supports, therapeutic foster care, and shelter care services.	$1,355,894
	Title IV-E funds	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	$1,878,171
	TANF	Tertiary	In home therapy services, intensive in home supports and treatments.	$75,898
	Title IV-A Emergency Assistance	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	$792,357
	Medicaid	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intesnive in home supports, therapeutic foster care, and shelter care services.	$8,669,277
Juvenile Justice	General Funds	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intesnive in home supports, therapeutic foster care, and shelter care services.	$1,780,172
	Title IV-E funds	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	$2,345,316
	TANF	Tertiary	In home therapy services, Intensive in home supports and treatments.	$110,304
	Title IV-A Emergency Assistance	Tertiary	intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	$4,368,873
	Medicaid	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intesnive in home supports, therapeutic foster care, and shelter care services.	$11,899,853
Sununu Youth Services Center	General Funds	Tertiary	Screening and assessment for Behavioral Health and Substance use disorders, individual family and group counseling, restorative justice circles, psychiatry and medication management.	$1,345,994
Juvenile Diversion	Juvenile Justice block grant	Secondary	Juvenile diversion services for first time offending youth	$183,806
Child Care Scholarship	Federal Funds		Enhanced rate for children with emotional disability	$3,545
		Primary	behavioral support consultation services for early learning centers for children with emotional disabilities.	$130,000
PTAN		Secondary	Behavioral support consultation services for early learning centers for children with emotional disabilities.	$130,000
Family Resource Centers	Federal and state dollars	Primary and Secondary	Prevention, treatment activities such as Home Visiting and other family preservation programming.	$1,751,128
TOTAL				**$36,820,587**

There are a number of aspects of DCYF services reflective of a system of care. The service array is comprised of several community-based services that meet many of the population's behavioral health needs, including some that are designed and delivered in the youth's home or in a community setting (e.g., foster home). DCYF also utilizes a Solution Based Case Work approach, which allows for family- and youth-developed objectives related to child welfare or juvenile justice involvement. Trauma-informed care has been an emerging practice within DCYF and other collaborators, providing the opportunity for New Hampshire to work towards becoming a trauma-informed system. Like other program areas within DHHS, DCYF generates fiscal and service utilization reports on a regular basis.

The Sununu Youth Services Center (SYSC), part of the juvenile justice system within DCYF, is an institutional facility for 13 to 17 year olds. While not community-based, SYCS services include those designed to meet the behavioral health challenges that the majority of their served population experiences. Within SYSC, Youth Advisory Boards allow youth to develop leadership and advocacy skills and provide some input into program development. SYSC staff conduct assessments of every youth upon entering the facility, and permanency planning teams ensure better transitions upon their departure. Across DCYF more broadly, a protocol is being developed that will identify and transition youth in need of adult behavioral health services. Table 2 shows the consistency of DCYF services with the individual characteristics of a system of care.

The Child Development Bureau oversees funds to help support family access to quality early learning opportunities for young children who are not yet in school. Services that help support young children with behavioral health needs include an enhanced rate for early learning centers who serve children identified with special behavioral health needs. In addition, the Preschool Technical Assistance Network (PTAN) is a grant-funded statewide technical assistance and support network that promotes quality, developmentally appropriate and culturally competent early childhood education.[10]

[10] Additionally, PTAN supports a system of professional development will align with the priorities of the NH Special Education State Performance Plan (SPP) relative to preschool special education, including Indicators 6 (Preschool Settings), 7 (Child Outcomes), 8 (Parent Involvement), 12 (Early Transitions), and 17 (State Systemic Improvement Plan).

Table 2.

Consistency with a System of Care, by Characterstic, Department of Children, Youth and Families.

	Program/Element				
System of Care Characteristic	Child Protection	Juvenile Justice	Sununu Youth Services Center	Juvenile Diversion	Child Care Scholarship
(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.					
(b) An absence of significant gaps in services and barriers to access services.					
(c) Community-based care planning and service delivery, including services and supports for children from birth through early					
(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which					
(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.					
(f) An efficient balance of local participation and statewide administration.					
(g) Integration of funding streams.					
(h) A performance measurement system for monitoring quality and access.					
(i) Accountability for quality, access, and cost.					
(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.					
(k) Effective identification of youth in need of transition services to adult systems.					

There have been a number of recent changes as program areas embrace a system of care approach. DHHS has opened access to services that were once only available to children and youth involved in DCYF through such cases including as abuse or neglect, Children in Need of Services (CHINS), delinquency, or other court involvement. Making initial investments and opening access to these services has provided a broader array of support to children who require additional services to remain in their home and community. These include intensive in-home behavioral health treatment and supports, respite care, crisis stabilization, access to flexible funding, and family-peer support services. In addition, requirements for contractors to adhere to Culturally and Linguistically Appropriate Service (CLAS) standards are now a department-wide practice. Unfortunately, there are gaps in the service array for this population, such as mobile crisis and crisis stabilization services and evidence-based treatment options. More broadly, gaps appear in the areas of prevention and early intervention, with less than ideal linkages to primary care, public health, and early childhood interventions. Additional areas that also require further development include fiscal flexibility, blended funding, and the developing and applying outcome measures associated with a system of care.

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

B. Division for Behavioral Health (DBH), Bureau of Drug and Alcohol Services (BDAS), Bureau for Children's Behavioral Health (BCBH), and the New Hampshire Hospital

DBH seeks to promote respect, recovery, and full community inclusion for adults who experience a mental illness and children with an emotional disturbance. DBH has divided the state of New Hampshire into community mental health regions. Each of the ten regions has a DBH contracted Community Mental Health Center (CMHC) and many also have Peer Support Agencies. The newly developed BCBH brings to DBH a focus on children, youth, and families experiencing behavioral health issues, by developing programming with an appreciation of the system of care approach. Also within DBH, the Bureau of Drug and Alcohol Services (BDAS) serves people who are experiencing substance misuse disorders by implementing an array of preventative approaches and campaigns, as well as treatment for all populations.

CMHCs are private, not-for-profit agencies that have contracted with the state to provide publicly funded mental health services to individuals and families who meet certain criteria for services, including, but not limited to, 24-hour emergency services, assessment and evaluation, individual and group therapy, and community-based rehabilitation services. All CMHCs have specialized programs for older adults, children, and families.

New Hampshire Hospital provides acute, inpatient psychiatric services for children and adults needing active treatment and other essential supports within a continuum of care. Although not community-based, NH Hospital is a critical part of the overall behavioral health system for children and youth, providing a safety net when the management of symptoms and behaviors become acute.

The total behavioral health services expenditures for these programs for SFY 2015 was $61 million (see Table 3). Roughly three-quarters of these expenditures fall under general Medicaid spending, much of which supports the operation of CMHCs.

Table 3.

Expenditures, Division for Behavioral Health, Children's Behavioral Health Services in New Hampshire, SFY 2015

Name	Funding Source	Level of Support	Description	Total Expenditures
General Medicaid	Federal	Primary, Secondary, and Tertiary	Services to include: All services provided by CMHC's, and private Medicaid providers, includes all inpatient,	$23,613,857
	General	Primary, Secondary, and Tertiary	outpatient and pharmacy claims related to Behavioral Health Services.	$23,613,857
NH Hospital	General Funds	Tertiary	Acute psychiatric hospital care for children.	$3,800,000
	Medicaid	Tertiary		$5,344,743
System of Care grant	Federal dollars		Four-year grant to build and implement the infrastructure and programming to serve children and youth with Severe Emotional Disturbances and who are at risk for out of home placement.	$4,000,000
Student Assistance Program	Federal Grant dollars	Secondary and Tertiary	Prevention education, school-wide awareness activities, brief individual counseling, group sessions, parent education, and referral to community services	$511,692
Family Resource Centers	Federal and State dollars combined	Primary, Secondary, and Tertiary	Alcohol and drug prevention contracts.	$9,469
Contracted services	Federal and State dollars combined	Primary, Secondary, and Tertiary	Substance misuse treatment services, screening, assessment, outpatient treatment and residential treatment.	$203,431
RENEW Transition Intervention	Balancing Incentive Program Grant	Tertiary	Training and coaching support and infrastructure development for Community Mental Health Center staff to provide a research-based intervention.	$328,619
TOTAL				**$61,425,668**

Most of the CMHC's service planning for children with behavioral health needs is done at the community-level. While also comprehensive and clinically appropriate, the service array associated with CMHCs is not necessarily flexible enough to change according to the needs of the population. In this way, CMHCs may not be consistent with a system of care approach. Furthermore, CMHCs exhibit some gaps in services considered clinically necessary and appropriate for some of the population. For instance, there are relatively few services for very young children. However, one CMHC has engaged with BCBH to pilot and provide a collaborative model of Assertive Community Treatment (ACT) and High Fidelity Wraparound for children and youth.

The NH Hospital has recently made an investment in this work by hiring an administrator who will be dedicated to aligning the work of the hospital with a system of care. Although this work is just beginning, the goal is to help to improve the level of service provided to the population NH Hospital serves.

A system of care approach is evident in the Families and Systems Together (FAST) Forward program, designed and managed by BCBH, and initiated through a federal System of Care grant in 2012. FAST Forward serves youth with serious emotional disturbances who are at risk for out-of-home placements and repeated hospitalizations—a group whose needs are not met by traditional service streams and programs. Programming under FAST Forward includes a High Fidelity Wraparound model with care coordination, intensive in-home behavioral health treatment and supports, respite care, crisis stabilization, and peer support services. The blending of funding and services across DHHS as part of the FAST Forward program has closed some access gaps that previously existed. However, there remains a gap between DCYF and DBH around cross-system access to and utilization of Wraparound. In addition, there remains a gap between DBH programs and prevention activities, early childhood programs, and primary health care, created in part by policy barriers and funding silos. Table 4 shows the consistency of these services with the individual characteristics of a system of care.

Table 4.

Consistency with a System of Care, by Characterstic, Division for Behavioral Health (DBH), including Bureau of Drug and Alcohol Services (BDAS), Bureau for Children's Behavioral Health (BCBH), and the New Hampshire Hospital.

	Program/Element			
System of Care Characteristic	Community Mental Health Centers	Bureau of Drug and Alcohol Services	New Hampshire Hospital	FAST Forward
(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.				
(b) An absence of significant gaps in services and barriers to access services.				
(c) Community-based care planning and service delivery, including services and supports for children from birth through early				
(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which places an emphasis on early identification, prevention, and treatment and uses an individualized wraparound approach for children with complex needs.				
(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.				
(f) An efficient balance of local participation and statewide administration.				
(g) Integration of funding streams.				
(h) A performance measurement system for monitoring quality and access.				
(i) Accountability for quality, access, and cost.				
(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.				
(k) Effective identification of youth in need of transition services to adult systems.				

The DHHS has recognized the importance of focusing on children's behavioral health in New Hampshire and has made changes to their departmental structure to align with this focus. The creation of the DBH was a reorganization effort to renew focus on behavioral health in general and align practices and programs within the department that have a primary focus of mental health and substance misuse. The last phase of this reorganization was the development of the BCBH. This is the first time the DHHS has had a bureau dedicated to the practice and issues affecting children's behavioral health. BCBH manages work and programming developed under the system of care grant awarded to the DHHS in 2012, as well the State Youth Treatment Planning grant awarded to the DHHS in 2015. Work conducted with support from these grants aligns with or utilizes a system of care approach in design and has created a foundation for the work required under SB 534.

Beginning in October 2013, the DHB funded a three-year project to build a research-based intervention for transition-age youth with serious emotional disturbance called RENEW into the state's community mental health system. RENEW is a nationally recognized intervention consistent with Wraparound.[11] The Balancing Incentive Program funded the infrastructure development of RENEW. Over the three-year period, 293 youth were served with strong fidelity across the centers and improved outcomes for the youth in the areas of behavior, earned credits, internships, and grade point average. The mental health centers created new collaborative models with their local high schools and the implementation of RENEW is being maintained in six of the ten mental health centers.

This year, BDAS managed the incorporation of a comprehensive substance use benefit into the NH Medicaid state plan. This benefit is for all populations, allowing for screening and assessment for identification, as well as both outpatient and inpatient treatment options. While there are still gaps in the service array, BDAS has been working diligently on strategies to fill the gaps and address workforce issues. In response to the current opioid crisis, BDAS and BCBH have done considerable work to improve this program area. For instance, BCBH is a recent recipient of a grant to produce a plan to align children's substance use service provision with a system of care approach.

Since the development of BCBH, there has been an inclusion of BCBH staff in all aspects of the work with in the Division. The Mental Health Planning and Advisory Committee, and the workgroup that implements a mental health block grant, now have staff from the BCBH. This helps to ensure the inclusion of appropriate youth-focused practices, and that a portion of the block grant directly addresses children's issues. Additionally there is now BCBH staff on workgroups that address areas such as the New Hampshire Hospital waitlist, Medicaid Managed Care and behavioral health service delivery, First Episode Psychosis (FEP), Modular Approach to Therapy for Children (MATCH), and the Child and Adolescents Needs and Strengths tool (CANS).

[11] Eber, L., Malloy, J. M., Rose, J., & Flammini, A. (2013). School-based wraparound for adolescents: The RENEW model for transition-aged youth with or at-risk of EBD. In H. Walker, F. Gresham, (Eds.), *Handbook of Evidence-Based Practices for Emotional and Behavioral Disorders: Applications in Schools* (pp. 378-393), NY: Guilford Press.

Over the past four years, DHHS has been engaged in work associated with a system of care Grant from SAMHSA. Awarded in 2012, this grant's purpose was to develop and implement changes to the infrastructure for children's behavioral health and implement programming that aligns and utilizes a system of care approach. This grant allowed the DHHS to make changes to its infrastructure and to create FAST Forward.

There have been a number of recent changes relevant to a system of care as a result of the FAST Forward program. The wraparound model used under FAST Forward was designed to engage, identify, and address family and youth needs, and to provide the necessary services to address those needs. To a limited extent, the communities participating in FAST Forward wraparound teams have had an opportunity to identify how making small changes can affect a child's experience or access to services. Incremental changes in some communities are starting to emerge. The FAST Forward approach is not intended for all children, as it is most effective for those with intense behavioral health needs, but DHHS and DOE intend to use it as exemplar from which to inform other programs. The evaluation of FAST Forward and related projects can provide a foundation for performance around quality, cost, and access.

There are also planned changes around FAST Forward programming. Modifications to the Medicaid to Schools rule will assist in the expansion of the behavioral health services that may be provided in schools, such as the Wraparound model. There will also be an expansion of the FAST Forward, where Wraparound Coordinators will work to expand access for high-need populations.

C. Behavioral Health in Schools

New Hampshire public schools provide an array of behavioral health services to students. Isolating those school-based activities where behavioral health is the primary focus is particularly challenging, as the diffuse purpose of schools means that behavioral health is often affected by a wide range of educational programming. However, Federal Title funds (as defined under the Elementary and Secondary Education Act) are, in many instances, directed towards behavioral health supports. These include Title I (improving the academic achievement of the disadvantaged), Title II (preparing, training, and recruiting high quality teachers and principals) and Title IVb (21st century community learning centers). Table 5 shows an estimate of Title program expenditures for behavioral health services in the State of New Hampshire for SFY 2016. These expenditure estimates were generated from queried responses by over half of the school districts in the state. Therefore, total behavioral health expenditures through these Title programs are likely considerably higher than those captured here. In addition, behavioral health expenditures in schools go beyond those through the Title programs, and this should not be interpreted as an exhaustive analysis.

Table 5.

Expenditures, Titles I, II, and IVb programming, Children's Behavioral Health Services in New Hampshire, SFY 2016

Category	Description	Level of Support	Title I Expenditures	Title II Expenditures	Title IVb Expenditures	Total Expenditures
PBIS	Positive Behavior Interventions and Supports is a tiered process whereby schools identify the needs of students at a Universal screening level. Students are provided with positive interventions to support a strong culture of behavior within a school. PBIS then supports students as needed at a secondary and tertiary level, increasing interventions as appropriate in order to achieve positive beahviors in students.	Primary, Secondary, and Tertiary	$67,803	$10,395	$0	$78,198
Responsive Classroom	An approach to education that emphasizes social, emotional, as well as academic growth in a strong and positive school community	Primary	$6,914	$234,217	$0	$241,131
Service Providers (social workers, counselors, etc.)	Schools often utilize paraprofessionals, social workers, and counselors in order to support student needs. These individuals may work with small groups of students, individuals, in an inclusive setting, or be used for pull out supports. These services often result in strong relationships for students with Behvioral Health needs.	Primary	$3,506	$805,390	$0	$808,896
Other Programs	N/A	N/A	$0	$65,345	$0	$65,345
Speakers and PD	Teachers constantly strive to learn from experts in order to better serve their students. Professional Development opportunities and guest speakers provide a means for teachers to learn about their students with Behavioral Health needs or about how to implement a program to support these students. Such opportunities often lead to school-wide interventions or individual changes in teacher practice in the classroom.	Tertiary	$0	$81,753	$0	$81,753
Instructional Rounds	Instructional Rounds include the training of teachers and leaders to objectively observe practices taking place in the classroom. After practices are observed, teachers are able to obtain feedback about effectiveness and work with peers/mentors/administrators in order to change practice to best meet the needs of students or are recruited to share outstanding practices with colleagues.	Tertiary	$0	$22,966	$0	$106,619
21st Century After School Program	Provides students with extended day and extended year services. The programs promote after school learning and summer school activities, both focused on ensuring students have a safe, healthy environment to receive remediation and enrichment for their academics. The programs also support healthy relationships with peers and adults, and promote family and community engagement through information nights and celebrations.	Secondary	$0	$0	$3,600,000	$3,600,000
Other unidentified programs and services	N/A	N/A	$0	$26,500	$0	$0
TOTAL			**$78,223**	**$1,246,565**	**$3,600,000**	**$4,924,788**

Title I supports schools seeking to maintain a continuum of services for students with behavioral health needs who meet Title I criteria. All supports are based on individual schools' needs assessments. As such, schools provide services that are specific to their students. These supports may be provided by specialists, such as adjustment counselors and homeless liaisons, or by whole school programs such as Positive Behavior Interventions and Supports (PBIS), School Wide Integrated Framework for Transformation (SWIFT), and Responsive Classroom.

Title I programs throughout the state include pre-kindergarten and kindergarten as a way to support young learners and to create a continuum of care. Additionally, family and community engagement and outreach is a major component of the Title I program, and schools accessing Title funds must demonstrate the ways in which they include families and communities into their support and service delivery systems.

Title I plans ensure that school-based services include family and community engagement strategies. The E3 Fatherhood program run through Title I includes a three-pronged approach to supporting young single fathers and their children in order to best access academics, academic alternatives, and community-based supports.

Grant applications for Title I funds go through an approval process whereby it is ensured that programs and services are aligned with their needs assessments and problems of practice. This process often means that grants are reviewed multiple times, that discussions take place around the impact of programs and services on student learning, and that onsite monitoring visits to are conducted.

Finally, Title I ensures quality through onsite visits and continued support of programs and services within schools. Because schools and districts utilize their funds based on their needs assessments and problems of practice, they often assess whether a program is meeting the needs of students and supporting them to their level of expectation. Often when a program is not meeting the needs of a school and its students, the program will be discontinued and the school will include new and different activities in their Title I grants in order to best meet the needs of students.

Title II supports the professional growth of educators, including administrators, teachers, counselors, and paraprofessionals. Like Title I funds, Title II is used by schools to support their needs. Many schools use Title II funds to support children's behavioral health by training teachers on school-wide programs such as PBIS, Responsive Classroom, Response to Intervention (RTI), SWIFT, book studies, workshops, and guest speakers. Title II funds are also spent on staff members who provide direct services to students with behavior health issues. Title II funds augment the use of Title I funds to support the inclusion of families and community organizations. Title II funds can support professional learning so that schools can accurately and appropriately find and utilize supports from community based organizations that seek to support the varied needs of students.

Schools and districts utilize their Title II funds based on their needs assessments and problems of practice. When a program or practice does not work a school or district will change the ways in which they use their Title II funds. Often when a program is not meeting the needs of a school and its students, the program will be discontinued and the school will include new and different activities in their Title II grants in order to best meet the needs of students.

Title IVb supports the implementation of the 21st Century Afterschool Program. This program supports students continuing their learning and receiving supports after the normal school day has ended. Program goals include extended school day activities and enrichment activities. Title IVb conducts regular onsite visits with their program coordinators and site coordinators. These visits ensure performance measures are being met and that students are being served appropriately by the program.

Schools throughout New Hampshire seek to support all students, and particularly those who need additional resources in order to access an appropriate, rigorous, and individualized education. The DOE 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 DOE 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 intention of the law. Schools and districts use needs assessments to ensure the neediest students have access to appropriate supports. Through their needs assessments, schools identify students who are struggling with behavioral health issues and work with care providers, community members, parents, and at times students themselves in order to choose the best intervention based on a student's needs. The process itself demonstrates elements of a system of care.

The Bureau of Integrated Programs also works to align funding streams to support schools and districts. Through the grant application process, funds can be allocated to best support schools, students, and programs. Schools often align their goals in Title I, II, and IVb to ensure that students have access to a comprehensive system of support. Education consultants and Bureau employees work to support the alignment of funds where applicable. Schools annually conduct a needs assessment, based on student performance data and a number of indicators that identify students as being at risk of academic failure.

Schools incorporate identification and prevention strategies through PBIS, RTI, and Responsive Classroom programs. They also incorporate wraparound approaches by using personnel supports. For schools designated as a Focus or Priority School, additional supports exist, such as a Tri-Annual Review process to ensure access and quality of programming and services. These schools also receive additional professional development through Quarterly Meetings and an annual educator Summer Summit. Table 6 shows the consistency of these services with the individual characteristics of a system of care.

While the DOE has made significant progress to establish Multi-Tiered Systems of Support in schools to promote the social and emotional health of all students, the provision of workforce development for school personnel that includes training and coaching to develop PBIS, trauma-informed care, and school mental health are still underfunded. Further, gaps remain in the linkages between school and community-based providers, fueled, in part, because of policy and funding disincentives to collaboration.

Table 6.

Consistency with a System of Care, by Characterstic, Behavioral Health in Schools

System of Care Characteristic	Program/Element		
	Title I	Title II	Title IVb
(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.			
(b) An absence of significant gaps in services and barriers to access services.			
(c) Community-based care planning and service delivery, including services and supports for children from birth through early			
(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which			
(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.			
(f) An efficient balance of local participation and statewide administration.			
(g) Integration of funding streams.			
(h) A performance measurement system for monitoring quality and access.			
(i) Accountability for quality, access, and cost.			
(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.			
(k) Effective identification of youth in need of transition services to adult systems.			

Recognizing the need to better support families and children that struggle with mental and behavioral health challenges, the DOE recently created the Office of Student Wellness (OSW). Through the efforts of this office, school behavioral health services are now more consistent with a system of care in many aspects. The OSW supports and manages over $30 million in federal funds to pilot Safe School/Healthy Students, Now is the Time (NITT), Project Advancing Wellness and Resilience Education (AWARE), and system of care Sustainability and Expansion grants. Realignment at the DOE has placed school food and nutrition services, and nursing contracts, under the OSW. In addition, the OSW has broadened its scope of work to support seven domains of wellness: emotional, environmental, intellectual, social, personal, occupational, and physical. A defined focus on all areas of student wellness enabled additional, internal collaboration to take place. These collaborations included: working with Title II personnel to improve teacher professional development through the State Education Agency for Higher Education (SAHE) program, developing a relationship with the school nutrition program, and overseeing New Hampshire school nursing. Additionally, OSW has collaborated with the Bureau of Special Education to advance programming such as Creating Trauma Sensitive Schools, Pyramid State Project, and Occupational Therapy Mental Health.

The OSW also aimed to strengthen the knowledge, abilities, and skills of project partners and our communities through technical assistance, training, and strategic communication. The OSW provided multiple training opportunities for educators, mental health professionals, families, youth, and community members across the throughout the state. Offerings addressed topics such as resiliency, suicide prevention, and social emotional learning.

The OSW and Endowment for Health contracted with a consultant to conduct a survey of best practices in family and youth engagement, an in-depth environmental scan, and a gap analysis. In conjunction with the consultant, the OSW State Management Team (inclusive of EFH) created two best practice white papers entitled, “A Study of Best Practices in Parent Engagement and Leadership Development” and “A Study of Best Practice in Youth Engagement and Leadership Development”. The group, with assistance from a consultant, will develop and implement practice profiles for a common approach for both family and youth engagement across the state of NH. This will result in practitioners identifying opportunities to embed principles and approaches for family and youth engagement within professional development opportunities across New Hampshire.

The OSW offered several activities to improve cultural and linguistic competence within New Hampshire school districts. For instance, in collaboration with the Office of Minority Health and Refugee Affairs and the New Hampshire Equity Partnership, a 40-hour train-the-trainer module was developed. Through this, 30 trainers were certified to deliver this diversity and cultural competence programming to schools and other family-based organizations statewide. This programming allows participants to explore concepts of culture and diversity as they relate to their own personal cultural values, and to link these concepts to their own professional practice. Additionally, culture and diversity trainings were offered to state and community members including early childhood. The OSW and CLC Advisory Committee hosted New Hampshire's first School Discipline Guidance Conference in partnership with New England Equity Assistance Center of Brown University, drawing over 70 school administrators and educational leaders. The conference provided a technical assistance and networking session on the U.S. Department of Education and the U.S. Department of Justice's Discipline Guidance to assist schools in meeting the school discipline obligations required by federal law.

In addition to these changes already made, there are also changes planned for the near future. The OSW is addressing the need for a consistent Multi-Tiered System of Supports for Behavior and Wellness (MTSS-B) by clearly articulating the definition, developing a framework, identifying needed infrastructure, and creating supporting documents that address training and coaching. This work will result in a model that will: be effectively and clearly articulated to districts and be used for training; ensure that Medicaid-funded behavioral health services are extensively leveraged and effectively implemented within a MTSS-B framework; develop and implement a functional system to evaluate student level outcomes (such as academic performance, attendance, behavior incidents, suspension, etc.); ensure implementation of SB 534 requirements by aligning policy in the DOE with that of the DHHS; and develop and effectively implement a school-based model of family-and youth-driven wraparound services.

D. Bureau of Developmental Services (BDS)

BDS provides an array of services to children and young adults who have intellectual disabilities. The Early Supports and Services program area provides early screening, assessment and treatment for very young children (up to age 3). In addition to serving children with medical and development issues BDS also provides services related to behavioral health issues. BDS has not been fully involved or incorporated into this steam of work as of yet, so this represents a future opportunity. Table 7 shows behavioral health expenditures for BDS.

Table 7.

Expenditures, Bureau of Developmental Services, Children's Behavioral Health Services in New Hampshire, SFY 2015

Name	Funding Source	Level of Support	Description	Total Expenditures
BDS and Special Medical Services	Federal and general funds	Primary and Tertiary	Psychiatry and Psychology consultation services for 0-21 being served by Developmental Services and Special Medical Services programming	$143,119
Early Supports and Services/ Developmental Services	Federal funds	Primary	Early assessment, diagnosis and treatment	$340,187
TOTAL				**$483,306**

As indicated in Table 7, psychiatry and psychology consultation services are a part of the behavioral health services in this program area. All the services provided by this program area are community based and are voluntary and treatment is based upon a person-centered approach. BDS does have a robust family voice and leadership organization for the families that it serves. Additionally, BDS and DCYF have partnered for years and shared resources cross-departmentally for children, youth, and young adults with intense developmental service needs. However, its alignment to the system of care characteristics is quite limited at this time.

Table 8.

Consistency with a System of Care, by Characterstic, Developmental Services

System of Care Characteristic	Program/Element		
	Early Supports and Services	SMS	Developmental services
(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.			
(b) An absence of significant gaps in services and barriers to access services.			
(c) Community-based care planning and service delivery, including services and supports for children from birth through early			
(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which			
(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.			
(f) An efficient balance of local participation and statewide administration.			
(g) Integration of funding streams.			
(h) A performance measurement system for monitoring quality and access.			
(i) Accountability for quality, access, and cost.			
(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.			
(k) Effective identification of youth in need of transition services to adult systems.			

V. Discussion

The total estimated expenditures on child behavioral health services in New Hampshire are over $100 million dollars in a year. This is a substantial amount, especially considering that limitations in collecting expenditures data suggest that this should be considered more of a floor estimate than a ceiling. Given that child behavioral health is such a meaningful area of investment, it is important to evaluate planning efforts and systemic changes. It is important to underscore that some of the work done to align services with a system of care has been grant funded, and therefore the sustainability of funding must be examined.[12] Furthermore, most integrated work done to date has come as the result of federal grants, and there remains significant siloing of work streams across departments.

Another noteworthy finding from this report is that the bulk of expenditures are at the treatment and intervention level. Relatively little spending is found at the prevention level, which includes domains like early education, screening for developmental concerns (and subsequent referrals to appropriate treatment for those who are identified), and behavioral health services for very young children. Emphasizing prevention efforts might accrue cost savings due to reducing future expenditures related to those needing more in-depth, expensive treatment services.

Work surrounding and supporting this Year 1 Report represents critical initial steps towards realizing a system of care in New Hampshire. While this report details a number of fronts on which behavioral health services are becoming more consistent with a system of care approach, there remains work to do. Statutory requirements for future installments of this report dictate much of the work in store. Beginning in 2017, this report must include an interagency agreement; identified actions for maximizing federal and private insurance funding participation in the system of care; necessary changes to statutes, policies, procedures, and provider contracts; and identification of access gaps, as well as plans to close them. Beginning in 2018, this report shall include future demands for services of a system of care; identification of shortages in the workforce; identified planned amendments to the Medicaid system; and estimated numbers of children awaiting service. Beginning in 2019, this report will include detailed statistical information on services and service recipients; outcome measures; financial information with comparisons to other states, and an assessment of other influences external to the DHHS and DOE. This work outlined for the next three years provides a guide to achieving the goals of the statute. During 2017, the steering committee formed to oversee this report will continue to meet, after assessing the current membership, and will develop plans to both better integrate DOE and DHHS and to better align all service with one another and with a system of care approach.

[12] See Appendix III for a list of relevant grants.

Appendix I: Children's Behavioral Health Collaborative

New Hampshire's Children's Behavioral Health Collaborative (CBHC) is an unprecedented coalition of over 50 organizations, which came together to study New Hampshire's existing children's behavioral health systems. The CBHC and its members and stakeholders have designed an ambitious roadmap for improving the behavioral health of children, youth and families through a comprehensive state plan released in March 2013. This plan brought together local communities, providers and administrators from all child-serving systems and – perhaps most importantly – families that have children struggling with a range of social, emotional, mental and behavioral health needs. Their commitment, together with best practice recommendations, are beginning to change the paradigm for how the state and its communities and providers care for children and promote their well-being.

Following a nationally recognized best practice approach known as system of care, the Collaborative' s vision is an integrated and comprehensive service delivery structure that is family- and youth-driven, community-based, and culturally and linguistically competent. The Children's Behavioral Health Plan also sets a course of action within five core strategy areas: policy, resources, services, workforce, and advocacy.

New Futures – a non-profit, non-partisan advocacy and policy organization – became the organizational home for the CBHC in 2014, hiring a full-time Director to lead the CBHC's efforts. New Futures has a strong track record for effective communication, policy change, and grassroots advocacy development. The CBHC created the necessary infrastructure for implementation of the state plan including effective communication vehicles and workgroup structure.

There are six workgroups of the CBHC: behavioral health equity, communications and social marketing, evaluation, policy, school behavioral health, and the workforce network. The Communication and Social Marketing Workgroup developed capacity for strategic communications including hosting successful children's mental health awareness day activities annually and earned media coverage focused on the importance of children's behavioral health. The Evaluation Workgroup is currently developing shared indicators for the children's behavioral health system and a platform for ongoing data collection and analysis. The Policy Workgroup has begun implementation of a proactive bipartisan policy agenda, which began with strengthening governance through passage of SB 534. The Policy Workgroup has also worked to identify opportunities to advance the plan through complementary health care transformation efforts (e.g. 1115 Medicaid waiver). The Behavioral Health Equity Workgroup has developed a best practice guide for implementation of the National Standards for Culturally and Linguistically Appropriate Services and through a learning collaborative structure has encouraged changes in organizational policies. Using a similar approach, the School Behavioral Health Workgroup has served as a learning collaborative for school district staff seeking to improve their responses to students with emotional and behavioral health needs. The Workforce Network is the largest of the CBHC's Workgroups and includes a number of sub-committees involving hundreds of participants. This Workgroup has led efforts around workforce development provisions in the plan including:

- Conducted a study, in partnership with Antal Consulting, to understand staff retention and other workforce challenges within NH's community mental health centers.
- Researched and developed a practice model for high fidelity wraparound including a training and coaching model.

- Prioritized implementation of evidence-based practices and identified a funding source for implementation.
- Completed core competencies for the children's behavioral health workforce and cross-walked with curricula within Institutions of Higher Education for the children's behavioral health workforce.
- Developed online training modules.
- Developed a practice model for youth and family peer support.
- Assisted the NH Department of Education to develop a Multi-Tiered System of Support implementation model that blends school behavioral health with Positive Behavioral Interventions and Support (PBIS) and a school-centric system of care model.

Over the coming year, the CBHC has prioritized the following goals:

1. Implementation of a shared measurement system that has capacity to collect, analyze, and disseminate data.
2. Engage more youth and families in the work of the CBHC through strengthened partnership with existing youth and family organizations.
3. Increase awareness of the need to strengthen the children's behavioral health system.
4. Increased regional presence/partnership with statewide work through better continuous communications.
5. Continue to strengthen our advocacy capacity and advance policies consistent with a system of care approach.

Appendix II: Characteristics of a System of Care

1. A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.

2. An absence of significant gaps in services and barriers to access services.

3. Community-based care planning and service delivery, including services and supports for children from birth through early childhood.

4. Service planning and implementation based on the needs and preferences of the child or youth and his or her family, which places an emphasis on early identification, prevention, and treatment and uses an individualized wraparound approach for children with complex needs.

5. Services that are family-driven, youth-guided, community-based, and culturally and linguistically compete.

6. An efficient balance of local participation and statewide administration.

7. Integration of funding streams.

8. A performance measurement system for monitoring quality and access.

9. Accountability for quality, access, and cost.

10. Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.

11. Effective identification of youth in need of transition services to adult systems.

Appendix III: A Description of Grants

Partners for Change: The NH Division for Children, Youth and Families in collaboration with the Dartmouth Trauma Interventions Research Center received an investment for the U.S. Administration for Children and Families to improve the mental health of children and families served by the child protection and juvenile justice systems. Partners for Change is implementing universal screening for mental health and trauma symptoms; increasing access to evidence-based trauma treatment; and improving oversight of psychotropic medication prescribing.

FAST Forward: The NH Division for Children, Youth and Families received an investment from SAMHSA to establish a coordinated, individualized approach for children with complex behavioral health needs, to expand family-to-family support, education, and leadership programs, to develop youth leadership and peer supports, to increase workforce development, and to ensure outcome measurement.

Safe Schools Healthy Students and Project AWARE: The NH Department of Education received two investments from SAMHSA to pilot and create road maps for schools to improve early childhood social and emotional development (ages 0 – 5); to reduce bullying, violence, and substance abuse within school-aged children through positive climate and child-centered discipline and supports; to improve outcomes for children with behavioral health conditions and needs; and to support children and families/caregivers through their genuine participation in decision-making and support mechanisms.

Project Linking Action for Unmet Needs in Children's Health (LAUNCH): The NH Division of Public Health Services and its key partners received an investment from SAMHSA to improve coordination across early childhood-serving systems in a high-need urban area that is serving as a best practice model for other communities in the state. Project LAUNCH is engaging primary care practices in early screening and assessment of behavioral health conditions, risks and needs; providing home-based services for families with young children who have or are at risk for behavioral health disparities; and delivering training to increase the skills and abilities of families and child care teachers to support their children's well-being and success.

NH Nexus Project: The National Alliance on Mental Illness (NAMI) New Hampshire received an investment from the SAMHSA to reduce suicide incidences through a systemic approach to identify high risk youth under the age of 25. The project is engaging regional networks and key statewide acute care facilities in universal and targeted best practice interventions, linkages, systems change, and promotion of resources.

FAST Forward for Children and Youth 2020: The NH Department of Education's Office of Student Wellness received an investment from SAMHSA to continue expansion and sustainability of a state-level system of care for children, youth and their families. FAST Forward 2020 will partner with three regions to improve the transition into the K-12 educational system for young children; improve the educational and social-emotional outcomes for children and youth; expand the array of services to the highest need children and youth with behavioral health challenges; actively involve parents and youth in all aspects of service delivery and

support; and ensure that systems, supports and policies are aligned with National Standards for Culturally and Linguistically Appropriate Services.

Monadnock Region System of Care: Cheshire County received a grant from SAMHSA to implement a regional plan that creates a more integrated system of care for children and youth with severe emotional and behavioral health needs, and their families. This investment follows a nearly two-year planning process during which a community readiness assessment and asset mapping/gap analysis were completed accompanied by strong community organizing efforts. Family and youth involvement was sustained throughout the planning process. The Monadnock Region System of Care will strengthen partnerships between families and youth, providers, multiple school districts, and related initiatives; expand capacity for peer supports; and broaden the array of services and supports available in the community. A regional website will use strategic communications to inform the public of the plan's efforts and connect families and youth to resources. The project has renewed hope in a community and region known for its collaborative work through the integration of the family voice into every component of the work.

State Youth Treatment Planning Grant: DHHS, Bureau for Children's Behavioral Health received a two-year planning grant to create a comprehensive plan to enhance the system for treating children and youth who have substance misuse disorders. This work seeks to create a youth focused approach to providing substance misuse treatment, which must be aligned with the System of Care approach and characteristics. Once the plan is developed, the DHHS plans to apply for an implementation grant to then implement the goals and strategies identified.