

CHILDREN'S MENTAL HEALTH SERVICES IN NEW HAMPSHIRE:

*Where we are now, where we need
to go, how to move forward*

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This document is a compilation of NH-based data on issues affecting the children’s mental health delivery system in the state of NH and is produced in partnership with the Endowment for Health, the NH Department of Health and Human Services and NAMI-NH.

MENTAL HEALTH CARE IN NH – A SYSTEM IN CRISIS

NH's mental health care system is under assault. With a significant shortfall in state revenues, community mental health centers' budgets have been slashed and the Tobey School, a state run residential treatment program for youth with serious emotional disturbances, has closed. In assessing the situation, Department of Health and Human Services Commissioner Nick Toumpas stated, "NH's mental health care system is failing, and the consequence of these failures is being realized across the community. The impacts of the broken system are seen in the stress it is putting on local law enforcement, hospital emergency rooms, the court system and county jails, and, most importantly, in the harm under-treated mental health conditions cause NH citizens and their families."ⁱ

According to the US Surgeon General, one in five children has a diagnosable mental health disorder, and the vast majority of these youth—even those with the most severe impairments—receive no or inappropriate care.ⁱⁱ

"As the state's budget fluctuates, so does our budget and stability. Our programs that are dependent on state funding find it nearly impossible to keep going—we constantly feel threatened." Administrator of a NH community-based programⁱⁱⁱ

Insurance coverage and geography are the most prevalent issues that prevent children from receiving sufficient care for mental health issues.^{iv}

CHALLENGES TO PROVIDING MENTAL HEALTH SERVICES IN NH

NH does not have adequate resources to meet the state's mental health needs and the resources it does have are not always used efficiently. Services traditionally have

been delivered through distinctly separate programs. This "silo" approach makes it difficult to provide optimum care and treatment. Those with treatable mental health conditions too often fail to receive appropriate services in a timely manner, resulting in increased emergency department visits, placements in acute care facilities, incarceration, or homelessness.^v Challenges to the delivery of mental health care include:

- ❖ **A mental health workforce that is insufficient to meet the needs of NH children.**^{vi} While recruitment and retention is a problem in every region, there are extraordinary geographic differences in NH's mental health services. Half of all child psychiatrists are located in two southeastern counties and Carroll and Coos Counties have *no* practicing child psychiatrists. A significant portion of Northern NH has been designated a mental health professional shortage area.^{vii} There is also considerable variation in how rural emergency mental health care is provided. The Foundation for Healthy Communities identified seven rural hospitals that have no contract in place with their regional community mental health center.^{viii}
- ❖ **A need for improved service integration.** Almost 20% of children using mental health services use multiple types of service agencies.^{ix} Youth with co-occurring mental health and substance use disorders often are involved with the state's child protection system, the juvenile justice system, as well as mental health centers.^x Typically, communication and coordination between systems is poor.^{xi}
- ❖ **Inadequate public and private insurance coverage for mental health services.** Many families have insurance plans with no mental health coverage or are uninsured altogether;^{xii} 12% of families with children who have severe emotional disturbance

ⁱ Norton, J.W., 2009.

ⁱⁱ Norton, S., Tappin, R., McGlashan, L., 2007.

ⁱⁱⁱ Wilson, M., 2009.

^{iv} Tappin, R., Norton, S., 2007.

^v Antal, P., 2009.

^{vi} Norton, S., Tappin, R., McGlashan, L., 2007.

^{vii} Norton, S., Tappin, R., McGlashan, L., 2007.

^{viii} Antal, P., 2009.

^{ix} Tappin, R., Norton, S., 2007.

^x NAMI-NH, 2009.

^{xi} Norton, J.W., 2009.

^{xii} Tappin, R., Norton, S., 2009.

report not having adequate insurance to cover mental health services.^{xiii} Even families who have insurance find that the number of covered office visits is limited and co-pays present a huge financial challenge.^{xiv} The vast majority of children seen by community mental health centers are covered under Medicaid. However, their parents often have no insurance and are unable to receive treatment if they also have a mental illness.^{xv}

Within family focus groups it was not uncommon to hear statements such as, *“We have changed from weekly to biweekly appointments due to insurance.”* – *“We had to adjust the diagnosis to get it covered.”* – *“He was booted out of the hospital with a limited stay.”^{xvi}*

WHAT FAMILIES WANT

- ❖ Accessible, timely, integrated, and comprehensive home and community-based services that are based upon individual need, not ability to pay
- ❖ Collaboration and coordination between all providers and systems
- ❖ A consistent, well trained, and sufficient mental health workforce, including the availability of child psychiatrists in every region of the state
- ❖ Educational programs for parents of children with mental health issues
- ❖ Available and accessible peer support groups for youth with mental illness, support groups for siblings, and parent-to-parent connections.^{xvii}

Parents want to be part of the solution. Families want to work in partnership with NH as it addresses the challenges facing the state’s mental health care system.^{xviii}

IMPROVING MENTAL HEALTH SERVICES IN NH

To rebuild the state’s mental health system will require significant effort, including:

- ❖ A commitment to providing integrated care and reducing fragmentation of the service system.^{xix}
- ❖ Increasing the array of community-based mental health services including the development of crisis response teams, Assertive Community Treatment Teams and intensive outpatient service teams.
- ❖ Developing and retaining a sufficient and qualified workforce by ensuring adequate resources to pay and maintain staff, investing in academic education and ongoing training for the mental health workers, and developing a strategy to increase the number of experienced psychiatrists in NH.^{xx}
- ❖ Improving NH’s technology infrastructure to access more complete data on service provision and outcomes.^{xxi}
- ❖ Working in partnership with consumers and their family members to improve mental health care. Those using services have a unique perspective and can provide valuable insights about what works and does not work.^{xxii}

^{xiii} Antal, P., 2009.

^{xiv} NAMI-NH, 2007.

^{xv} Tappin, R., Norton, S., 2009.

^{xvi} NAMI-NH, 2007.

^{xvii} NAMI-NH, 2007.

^{xviii} NAMI-NH, 2007.

^{xix} Norton, J.W., 2009.

^{xx} Norton, J.W., 2009.

^{xxi} Tappin, R., Norton, S., 2007.

^{xxii} Antal, P., Burbank, M., 2008.

EARLY CHILDHOOD MENTAL HEALTH

Supporting healthy emotional development is as crucial as teaching a child to speak or take his or her first steps. The ability to form healthy emotional relationships early in life is the foundation for the infant's growth into an emotionally healthy adult. When children with significant emotional problems are not identified in a timely way or do not receive appropriate treatment, their problems tend to be long lasting, requiring more intensive resources and services over time. For these children there is an increased likelihood of poor academic outcomes, peer rejection, adult mental health concerns, and adverse affects on their families and communities.ⁱ

Approximately 10%-20% of preschool children experience significant challenging behaviors. There are approximately 75,022 children under five living in NH (2007 census); using the conservative estimate of 10%, the NH Association for Infant Mental Health estimates that over 7,500 young children in our state need mental health services.ⁱⁱ

Early childhood mental health is the social/emotional well-being of children ages birth to age six which promotes the capacity to experience, manage and express emotions, develop and sustain stable relationships with others (adults and peers), safely explore the environment to learn, and demonstrate developmentally appropriate behavior.ⁱⁱⁱ

CHALLENGES TO PROVIDING EARLY CHILDHOOD MENTAL HEALTH SERVICES IN NH

In its 2009 report, the NH Association for Infant Mental Health found that the state does not have adequate

mental health services to meet the needs of young children and their families. Early childhood mental health screening and evaluations are not consistently provided. Even for children who have been identified, many services are simply not available. A child may be identified as needing mental health services, but the family may find there is no place to go for assistance.

- ❖ Mental health screening is not consistently implemented or included as part of regular well child checkups.
- ❖ There is no approved process for determining eligibility for children birth to four. Not all of NH's community mental health centers provide evaluation and intervention services for children under four.
- ❖ More than half of early care and education providers reported that there are not enough mental health services to which to refer young children.^{iv}

Families participating in focus groups convened by the National Alliance on Mental Illness - NH did not believe that their primary care physician had the skills to address mental health issues and were unaware of available resources and supports. More than half of families reported that someone other than their child's doctor identified their child's mental health issues and nearly half said mental health screening was not a part of their child's annual physical.^v

"I wonder if pediatricians too often 'write off' parents' concerns and take a 'wait and see' approach when they should be referring to the appropriate professional for assessment. Our child is now six and is receiving excellent [special education] services in school, but we wish we had known what questions to ask or who else to go to when we first noticed some behaviors and lagging development when she was around two."^{vi}

ⁱ Ableman, D., Antal, P., Oldham, E., Printz, P., Brallier, S., Nelson, D., Schrieber, E., and Brandt, K., 2009.

ⁱⁱ Ableman, D., et al, 2009.

ⁱⁱⁱ Ableman, D., et al, 2009.

^{iv} Ableman, D., et al, 2009.

^v NAMI-NH, 2007.

^{vi} Ableman, D., et al, 2009.

WHAT FAMILIES WANT

- ❖ Increased and consistent mental health screening for young children
- ❖ Readily available information, referral, and follow up
- ❖ More trained mental health professionals who are available locally
- ❖ Access to mental health services through pediatricians and physician's offices
- ❖ Coordination of services among physicians, mental health providers, and early childhood settings
- ❖ Coverage, including private insurance, for childhood mental health services^{vii}

One mother reported that Healthy Kids Insurance refused to pay for a psychologist's services because her child, who was three, was too young to need mental health treatment. The psychologist had to write Healthy Kids a letter explaining the need for services and only then was payment made.^{viii}

IMPROVING EARLY CHILDHOOD MENTAL HEALTH SERVICES IN NH

- ❖ For NH to adequately meet the mental health needs of young children and their families will require the development of an effective screening, referral, and eligibility process that is part of NH's overall early childhood system. Once children with mental health issues have been identified, comprehensive and coordinated services must be available statewide and provided in a timely manner. For NH to move forward will require:
- ❖ Increasing public awareness of the importance of early intervention and how it can eliminate or reduce problems later on in life.

- ❖ Educating families about the early warning signs of emotional problems in young children.
- ❖ Increasing the capacity and competency of NH's mental health system to support young children (birth through age five) and their families.
- ❖ Providing funding, including insurance coverage, for early mental health care.
- ❖ Including mental health screening as part of regular well-child checkups.
- ❖ Making mental health screening available through a variety of settings, including preschool, childcare, and primary care settings.
- ❖ Providing families with better information about how to access local resources.
- ❖ Encouraging families to be active partners in the early intervention process by providing follow up to referrals and better family supports.
- ❖ Providing training on mental health screening and assessment for educators, childcare workers, and others who regularly interact with young children.
- ❖ Improving coordination of services among health care professionals, mental health providers, the State of NH, and families.
- ❖ Ensuring coordination of supports for children and families during transitions (i.e., making the move from early supports and services to school)^{ix}

"Screen early, screen often, and make referrals."
NH Health Provider^x

^{vii} Ableman, D., et al, 2009.

^{viii} Ableman, D., et al, 2009.

^{ix} Ableman, D., et al, 2009.

^x Ableman, D., et al, 2009.

MENTAL HEALTH SERVICES IN SCHOOLS

Twenty years ago, mental health services for children and youth were provided in hospital, residential, and clinical settings. Today mental health services are available in a variety of community-based settings; school being one of the most important. In 2003 the President's New Freedom Commission on Mental Health found that schools "are in a key position to identify mental health problems early and to provide a link to appropriate services." The Commission recommended that school-based mental health programs be improved and expanded to include prevention, early intervention, and intensive treatment and recovery-oriented services.ⁱ

As many as 55,756 children ages 5 – 19 have a diagnosable mental health disorder and almost 14,000 have a serious emotional disturbance. Most of these children are educated in the New Hampshire public school systemⁱⁱ

"Instead of our meetings being productive and trying to meet Sam's needs, they were spending time trying to resolve who exactly was responsible for what: the school district, the community mental health center, or the area agency. No one could agree. In private meetings with each agency they would encourage us to get the ball rolling. Each one thought the other was not doing their job and should do more. In addition, every one told us if something was not done, the outcome for Sam would not be good." NH Parentⁱⁱⁱ

CHALLENGES TO PROVIDING MENTAL HEALTH SERVICES IN NH SCHOOLS

As NH schools strive to provide mental health services to their students, they confront a variety of challenges.

ⁱ Malloy, J., Malloy, M., Taub, J., 2007.

ⁱⁱ Norton, S., Tappin, R., 2009.

ⁱⁱⁱ Norton, J.W., 2009.

- ❖ NH has a shortage of qualified mental health professionals. Half of the schools surveyed by the NH Center for Public Policy Studies in 2008 reported that community mental health resources were inadequate. Turnover, particularly in rural parts of the state, is a significant issue.^{iv}
- ❖ Schools can be a valuable source for early identification of mental health problems, yet almost half of NH schools do not provide school-wide screening for behavioral or emotional problems. Formal training for school staff on the identification of potential mental health issues is relatively uncommon.^v
- ❖ While most communities want to meet the needs of youth, school personnel operate in one manner and mental health providers in another. The various systems do not work together despite significant expenditure of effort and resources.^{vi}
- ❖ Medicaid is the primary funder for both school-based mental health services and community mental health centers, yet relatively few schools have formal agreements with their local mental health center.^{vii}
- ❖ Although significant resources are being devoted to mental health services in schools, information on the diagnoses, the types of services provided, and perhaps most important, the outcomes associated with services, are not well documented. Almost 1/3 of schools do not collect any data on services being provided for mental health specific needs.^{viii}
- ❖ NH's substance use rates are generally higher than other states. In 2003 almost half of the state's high school students reported current alcohol use and one in three reported binge drinking.^{ix} Yet only 39% of NH schools provide substance abuse counseling.^x

^{iv} Norton, S., Tappin, R., 2009.

^v Norton, S., Tappin, R., 2009.

^{vi} NAMI-NH, 2009.

^{vii} Norton, S., Tappin, R., 2009.

^{viii} Norton, S., Tappin, R., 2009.

^{ix} NAMI-NH, 2009.

^x Norton, S., Tappin, R., 2009.

- ❖ In the NH Center for Public Policy 2008 survey, 40% of schools reported that gaining parental cooperation and consent was a barrier to providing treatment.^{xi}
- ❖ NH legislation increasing the dropout age from 16 to 18 will have a significant impact on the demand for mental health services, given the demonstrated association between mental health issues and school drop-out rates.^{xii}
- ❖ Relative to population size, NH is the 7th state in the nation in terms of receiving refugees. NH schools are seeing more and more children who have been victims of war-related trauma and political violence.^{xiii}

A school psychologist reported that in order for a child to readily access a child psychiatrist, the situation must rise to a crisis level, such as the student is suicidal, homicidal, has committed a crime, or is the subject of a formal Children in Need of Services (CHINS) petition.^{xiv}

WHAT FAMILIES WANT

- ❖ School personnel who are educated about children's mental health issues and community resources
- ❖ Collaboration and coordination between all providers and systems
- ❖ Educational programs for parents of children with mental health issues
- ❖ Available and accessible peer support groups for youth
- ❖ Family support groups and parent-to-parent connections^{xv}

^{xi} Norton, S., Tappin, R., 2009.

^{xii} Norton, S., Tappin, R., 2009.

^{xiii} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xiv} Norton, S., Tappin, R., McGlashan, 2007.

^{xv} NAMI-NH, 2007.

IMPROVING MENTAL HEALTH SERVICES IN NH SCHOOLS

School-based mental health services can increase access to care, especially for children who might not otherwise seek services, and improve mental health treatment for NH children. To provide optimum mental health services in NH schools will require:

- ❖ Ongoing and open communication with all stakeholders—school staff, clinicians, social service agencies, and families—to improve service integration and ensure better coordination for those children needing the most services.^{xvi}
- ❖ Developing formal partnerships between schools and community mental health centers in order to maximize the benefit of Medicaid resources.^{xvii}
- ❖ Identifying and addressing intra-agency structures or policies that may be barriers to providing integrated mental health care.^{xviii}
- ❖ For school personnel working with refugee students, training in cultural competency and strategies to support children who have experienced trauma.^{xix}

75-80% of all children who receive mental health services receive those services in school.^{xx}

^{xvi} Norton, S., Tappin, R., 2009.

^{xvii} Norton, S., Tappin, R., 2009.

^{xviii} NAMI-NH, 2009.

^{xix} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xx} Malloy, J., Malloy, M., Taub, J., 2007.

MENTAL HEALTH SERVICES FOR ADOLESCENTS AND YOUNG ADULTS

Adolescence and young adulthood is a time of unique vulnerability. It is also the time when psychiatric disorders most often are diagnosed. Half of all lifetime mental illnesses start by age 14 and three quarters by age 24. Serious and chronic mental illnesses that involve thought disorders such as schizophrenia and bipolar disorder are most commonly diagnosed in late adolescence or early adulthood. Across the entire lifespan, the highest rate for depression is between the ages of 15 and 24. Depression and disruptive behavior disorders in adolescents often predispose young people to substance abuse.ⁱ

In New Hampshire, 51,000 youth are estimated to have a mental, emotional, or behavioral disorder, with 16 % of these cases involving either a significant or extreme functional impairment.ⁱⁱ

The two leading causes of death among NH youth are unintentional injury (52%) and suicide (19%)—with alcohol use playing a key role in both.ⁱⁱⁱ

“I got so depressed that I would start making myself throw up ‘cause I felt like I was in control of something ... I would be able to get my stress out, because I would feel better for a little while afterward. But then it would get worse and worse.” NH teenage girl^{iv}

CHALLENGES TO PROVIDING SERVICES TO ADOLESCENTS AND YOUNG ADULTS

In 2009 the National Academy of Sciences reported that between 14-20% of young people suffer from one or more mental, emotional, or behavioral disorders.^v

ⁱ Tappin, R., Norton, S., 2007.

ⁱⁱ Norton, S., Tappin, R., McGlashan, 2007.

ⁱⁱⁱ NAMI-NH, 2009.

^{iv} Baber, K., Bean, G., and Harrington, L., 2006.

^v Wilson, M., 2009.

- ❖ Suicide incidence rates in young people have risen dramatically over the last several decades. Youth with disorders such as depression, substance use disorder, and aggression are at an increased risk for suicide attempts.^{vi}
- ❖ According to two independent surveys, a significantly higher percentage of NH teens use marijuana as compared to youth across the nation. Alcohol and cocaine use also is slightly higher than the national average.^{vii}
- ❖ Young women aged 16-24 are at the greatest risk of experiencing physical or sexual violence.^{viii} Among girls and women with substance use disorders, up to 70% report having been sexually abused before the age of 17.^{ix}
- ❖ Youth with co-occurring mental health and substance use disorders have alarming rates of trauma histories. Victims of physical and/or sexual violence are at increased risk of significant mental health and substance use problems.^x
- ❖ NH has a shortage of substance abuse treatment professionals and programs. Finding a provider with the expertise to treat co-occurring disorders in adolescents is even more difficult.^{xi}
- ❖ Eating disorders typically develop during adolescence or early adulthood; over 90% of those who have eating disorders are between the ages of 12 and 25. Co-occurring disorders, such as depression and anxiety, are extremely common. Eating disorders have the highest mortality rate of any mental illness.^{xii}
- ❖ Of youth responding to community mental health center’s consumer survey, only 38% reported that they had been offered services to deal with their alcohol and/or drug issues.^{xiii}

^{vi} Tappin, R., Norton, S., 2007.

^{vii} Tappin, R., Norton, S., 2007.

^{viii} Baber, K., Bean, G., and Harrington, L., 2006.

^{ix} NAMI-NH, 2009.

^x NAMI-NH, 2009.

^{xi} NAMI-NH, 2009.

^{xii} Tappin, R., Norton, S., 2007.

^{xiii} Antal, P., Burbank, M., 2008.

- ❖ Youth of color who also experience poverty are unlikely to get mental health evaluations and services through mainstream venues, often their first opportunity to receive mental health care is while incarcerated.^{xiv}
- ❖ In NH, a sizeable and growing group of multiply traumatized and highly vulnerable refugee and non-English speaking minority youth are in need of mental health services.^{xv}
- ❖ Help for high school students with mental health problems making the transition to adulthood is limited. The transition planning process varies from school district to school district and the mental health component is often not addressed in either the school or mental health community.^{xvi}

“Four years ago, my girlfriend got pregnant, but threw me out because I was using and she didn’t like having me using around the baby. So, I got sober, got a restaurant job, got to have my son with me every other weekend. My mom even let me move back in with her. But it got to be too much—I didn’t have any health insurance and couldn’t afford to go see a doctor about drugs for the depression, so I started using. Now I sleep on my friends’ couches when they let me. And I haven’t seen my son in over a year. I love him more than anything, but it just wasn’t enough.” 23 year old NH father with co-occurring disorders^{xvii}

WHAT FAMILIES WANT

- ❖ Integrated and coordinated mental health and other community-based services
- ❖ Educational programs on diagnoses, treatment options, strategies for managing symptoms or behaviors, community resources, and how to pay for services

^{xiv} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xv} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xvi} NAMI-NH, 2007.

^{xvii} NAMI-NH, 2009.

- ❖ Standard practices to help youth transition to adult mental health services
- ❖ Resource specialists to coordinate care and provide information on resources
- ❖ Crisis response teams trained in children’s issues^{xviii}

IMPROVING MENTAL HEALTH SERVICES FOR ADOLESCENTS AND YOUNG ADULTS

To adequately address the mental health needs of adolescents and young adults NH will need to make a substantial commitment to expanding services that includes:

- ❖ Increasing access to services.^{xix}
- ❖ Better transition planning for youth.^{xx}
- ❖ Drug and alcohol screening and referral services and integrated treatment for youth with co-occurring mental health and substance use disorders.^{xxi}
- ❖ Supports to improve social connections and community involvement for youth.^{xxii}
- ❖ Providing girls and young women with information about mental health—particularly depression, anxiety, and stress—and providing care when necessary.^{xxiii}
- ❖ Providing sexuality education and easy access to reproductive health care.^{xxiv}
- ❖ Training for mental health providers in cultural competence and youth trauma.^{xxv}

^{xviii} NAMI-NH, 2007.

^{xix} Antal, P., Burbank, M., 2008.

^{xx} Antal, P., Burbank, M., 2008.

^{xxi} Antal, P., Burbank, M., 2008.

^{xxii} Antal, P., Burbank, M., 2008.

^{xxiii} Baber, K., Bean, G., and Harrington, L., 2006.

^{xxiv} Baber, K., Bean, G., and Harrington, L., 2006.

^{xxv} Porche, M., Fortuna, L., Rosenberg, S., 2009.

MENTAL HEALTH CARE FOR VULNERABLE POPULATIONS

Even under the best of circumstances accessing mental health services can be a challenge. For those who are vulnerable—a single mother with mental illness living in a homeless shelter, a bullied gay seventh grader who is dealing with depression, a newly arrived Somali refugee, a teen with bi-polar condition who is struggling with drug dependency—the task of obtaining appropriate mental health care can be completely overwhelming.

“Some of (the refugee boys), especially if they experienced their father being shot, they are angry. – They easily mix with bad kids and pick up their behaviors. – They end up with the wrong people and messing themselves up.”^{vi}

“There needs to be an easier path to help – we are losing our young people to substance use and mental illness and they are our future!” NH father whose two older sons died of drug overdosesⁱⁱ

CHALLENGES TO PROVIDING MENTAL HEALTH SERVICES TO VULNERABLE POPULATIONS

In this economy, NH is struggling to provide even basic community mental health services; addressing the complex needs of vulnerable populations is incredibly difficult.

- ❖ Workforce shortages make access to mental health and substance use treatment difficult and nearly impossible in some parts of the state.ⁱⁱⁱ
- ❖ Treatment for substance use and mental disorders are typically provided by separate programs and funded by different systems of care, resulting in individuals with co-occurring disorders falling through the cracks.^{iv}

ⁱ Porche, M., Fortuna, L., Rosenberg, S., 2009.

ⁱⁱ NAMI-NH, 2009.

ⁱⁱⁱ NAMI-NH, 2009.

^{iv} NAMI-NH, 2009.

- ❖ The pervasive stigma associated with mental illness and substance abuse is a barrier to accessing treatment.^v
- ❖ Trauma and psychosocial stress can lead to alcohol abuse and addiction.^{vi}
- ❖ Young people with co-occurring disorders put a significant strain on NH’s health care, social service, and juvenile justice systems.^{vii}
- ❖ Homeless children are exposed to more adverse health conditions and more chronic stressors that affect their long-term emotional and physical well-being.^{viii}
- ❖ Services to sexual-minority youth are minimal to nonexistent.^{ix}
- ❖ Girls and young women who have been victims of sexual abuse have increased risks of developing depression and other mental health problems, including suicidal behaviors.^x
- ❖ Refugees are only eligible for health care benefits for the first eight months of resettlement; a period that is spent obtaining housing and employment, with little time to attend to mental health concerns.^{xi}
- ❖ Language and literacy barriers make it extremely difficult to access needed care.^{xii}

WHAT FAMILIES WANT

- ❖ Assistance to obtain safe and adequate housing^{xiii}
- ❖ Home and community-based services accessible to all families^{xiv}

^v NAMI-NH, 2009.

^{vi} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{vii} NAMI-NH, 2009.

^{viii} Baber, K., Bean, G., Harrington, L., 2006.

^{ix} Baber, K., Bean, G., Harrington, L., 2006.

^x Baber, K., Bean, G., Harrington, L., 2006.

^{xi} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xii} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xiii} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xiv} NAMI-NH, 2009.

- ❖ Specialized training for public and private providers^{xv}
- ❖ Supports (including interpreter assistance) and services that are culturally sensitive^{xvi}
- ❖ Access to affordable and responsive mental health services^{xvii}

“The most important thing we can do for any person is to place them in a community where they feel safe, where they feel loved, where they feel respected ... (we must) provide opportunities for people of African descent to have the chance to be in leadership positions, to express themselves, to be in control of their experience and to define for themselves what’s happening or what’s going to happen.” Community provider

IMPROVING MENTAL HEALTH SERVICES FOR VULNERABLE POPULATIONS

A coordinated effort on the part of mental health and primary care providers, social services, schools, and communities will be needed to deliver mental health care to NH’s most vulnerable children and youth. Recommendations for improving care include:

- ❖ Implementing strategies to improve workforce recruitment and retention in the community mental health system.^{xviii}
- ❖ Increasing mental health services in schools. Less stigma is associated to intervention provided in schools^{xix} and students are more likely to have consistent mental health treatment, a critical component to successful outcomes.^{xx}
- ❖ Educating children and adolescents about violence and ensuring schools and community programs are safe for all children.^{xxi}
- ❖ Routine screening for mental health, suicide risk, and substance use problems in pediatric and primary care settings.^{xxii}
- ❖ Training educators and providers about the needs of sexual-minority youth.^{xxiii}
- ❖ Training those working with traumatized children and youth with specific attention given to different cultures, community, and family interventions.^{xxiv}
- ❖ Offering a wide variety of youth centered activities including: drop in centers, after school programs, youth leadership opportunities,^{xxv} programs for girls and young women, and support programs for sexual-minority youth.^{xxvi}
- ❖ **For youth with co-occurring mental health and substance use disorders:**
 - Early assessment and intervention.
 - Increased access for integrated care.
 - Funding for new treatment technologies.
 - Better collaboration between mental health, substance use, and primary systems of care.^{xxvii}
- ❖ **For NH’s refugee communities:**
 - A medical home model of care that can help to coordinate health care and social services.
 - Expansion of the Dartmouth’s Project for Adolescent Trauma and Treatment to serve additional youth and families.^{xxviii}

^{xv} NAMI-NH, 2009.

^{xvi} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xvii} NAMI-NH, 2009.

^{xviii} NAMI-NH, 2009.

^{xix} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xx} Norton, S., Tappin, R., 2009.

^{xxi} Baber, K., Bean, G., Harrington, L., 2006.

^{xxii} NAMI-NH, 2009.

^{xxiii} Baber, K., Bean, G., Harrington, L., 2006.

^{xxiv} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xxv} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xxvi} Baber, K., Bean, G., Harrington, L., 2006.

^{xxvii} NAMI-NH, 2009.

^{xxviii} Porche, M., Fortuna, L., Rosenberg, S., 2009.



- Family centered post-resettlement programs that address feelings of isolation and connect refugees with social resource groups that can provide information, social connections, and needed resources.^{xxix}
- Increased support from trained interpreters, community health workers, and paraprofessionals.^{xxx}

^{xxix} Porche, M., Fortuna, L., Rosenberg, S., 2009.

^{xxx} Porche, M., Fortuna, L., Rosenberg, S., 2009.



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