

Appendix D: Small Group Notes

Berlin Group A
MaryLou Krambeer

Focus 1. Basics

- Treatment gap very large
- Proper treatment in youth essential
- % of Americans with mental illness
- Community impact in NH
 - o (policy gaps, lack of attention)
- Alcohol treatment declining
- ******Mental health and substance abuse connected – absolutely**
- Insurers don't pay for substance abuse
- Back-up in emergency rooms
- # of admissions per bed

Focus 2. Stigma

- Getting better, more talking
- # suicides in NH (184)
- Suicides twice as high in Coos
- ****Young children exposed to domestic violence**
- Bullying – also connected to mental health
 - o Lack of parenting skills

Focus 3. Populations...

- People afraid of losing guns if they admit they have a mental illness
- Criminal justice % of mentally ill
 - o Probably does not include substance abuse
- Older adults – not focused
Funding for elders (Medicare office only)
- ***** Endless cycle of drugs... (prescribing)**

Focus 4. Responses/solutions

- **Increased funding for mental health**
- Local services for local patients
- Infrastructure around the state
 - o Crumbling – cuts, cuts, cuts
 - o Low wages – high turn-over
 - o Lost ground
- Development of community teams
- Child psychiatrist = access to
 - o Use Dartmouth now – video conf

Priorities

- Homelessness
- monitor prescriptions
- ***Increased funding

- ***access to local services at the community level
- recognition of prominence and need for services
- consideration - funding and services for No. part of state (Franklin, Keene, Concord Hospital)
- infant/early childhood care (huge studies show impact of domestic violence)
- **increase early intervention**

- **education programs**

- **reduce stigma**
- crime based
- drug court
- ***substance abuse**

Solutions

- implement state of NH prescription monitoring
- local care
- Medicaid expansion
- change reimbursements

- improve infrastructure (funding to community mental health centers, find an alternative to stabilize people closer to home, intensive community residential program, crisis beds...)
- access (1x a week) to child psychiatry - we need residents

- **Review Coos County initiatives to address early childhood issues including mental health**
- early childhood care to reduce exposure to abuse
- drug court
- get our message to legislators
- public education to reduce stigma and increase understanding
- get our message to legislators
- change reimbursements
- Medicare pay for outreach
- not just office visits regarding elders

Berlin Group B
Deb Stewart

What stands out for you about the challenges we face?

What are the implications of these challenges for our community?

What are you noticing as indicators of increased need for services?

What recent public policy decisions have had impacts on mental health and substance abuse?

How can we work together – LOCAL/REGIONAL/STATEWIDE/FED

What promising strategies are already in place to improve mental illness and substance abuse disorders?

What 2-3 strategies do we need?

Focus 1. Understanding the Basics

- We have a high rate of BOTH MH & SUB abuse – specifically in the North Country
- High rate of suicide
- We are the second to last in being able to access treatment
- 1st for underage alcohol
- *access to treatment
- *no access for impatient to treatment
- Drug and alcohol only 4 outpatient
- AA is active
- Stresses the resources that are available
- Limit/lack of licensed mental health counselors/therapists
- Shortage of credentialed, licensed medical mental health providers
- Medicare
- Police are constantly having a presence at hospital
- Recognizing that one needs treatment
- Increase in need for mental health resources
- *budget cuts/program cuts
- Reimbursement issues

Promising - *educating young moms and families

- The ECE Initiative funded by Tillotson
- Parenting skills
- *continuing education for families/recognizing sign & symptoms
- That mental health issues are not shameful

Focus 2. Stigma

- We suffer – from ignorance that people w/ a mental health issue are dangerous
- Community may not support policy budget because of lack of understanding
- Prevention
- Do we truly understand the consequences of bullying...
- Resilience in our community and families
- We are the “stigma”

Focus 3. Populations for unique attention

- Economics/economically disad.
- Berlin’s population/need
- Poverty level is high
- Prisons → families
- High aging population
- Homeless population
- < Lack of shelters ←→housing
 - You need to have an address to receive services
- No more ONE-WAY tickets to Berlin
- Keep programs that are in place!
- People need to have *a sense of PURPOSE
- 1. Create focus groups
- 2. *Teach the focus groups to be peer mentors (missionaries)
- More accessibility to services for mental health
- There’s no money going to resources
 - Mental health
 - Police
- Every regional hospital should have a Receiving Facility
 - There are none in Coos County

Solutions:

- Education of MH for both sides
- Mental Health
 - A receiving facility
- Promises
 - ECE Initiative/Create Focus Groups
- Challenges
 - Financial
 - Isolation

Berlin Group C
Cimbria Badenhausen

- *What stands out for you?
- *What are the implications of these changes?
- *What are the indicators of increased need for service?
- *What recent public policy decisions have had impacts?
- *How can we work with local, regional, state, FED decision makers to create healthier communities?
- *What promising strategies are already in place?
- what 2-3 do we need?

Table – C

- Pre-Survey
- Review
- Group Norms (listening & language)
- Consider “reporting out”
- 4 foci
- Please summarize: why are you here?

Brainstorm:

Focus 1. Understanding the Basics

- What needs to be done to better prevent and respond to MI and SUD?
 - o What do you notice?
 - o What is most important?
- Treatable
- Treatment gap
- Co-occurring disorders
- 1st in nation underage alc
- Costs in \$\$ (opportunity cost)
- Stigma even though prevalent
- Small % actually treated per year
- Points on continuum of mental health
- Varying levels – severity of illness
- Addiction-related deaths

Key Issues – importance to you

- Budget financing out – eliminated
- # ppl covered – reduced access even more
 - o More expensive to go untreated
 - o Due to stigma
- 2008 10-year plan 2 little pieces
 - o Actually done

Focus 2. Stigma and other key challenges

- Priorities in education – what society considers inept
- Is info accurate? Do we know truth in #'s?

- Number actually greater? (continuum)
- **Do we want to know?**
- What % of people who committed violent acts? (shooters)
- Not treating all who need treatment
 - embarrassment
 - \$ cost
 - recorded disability
 - standing in community
 - *→level of conscious
 - Stigma – even professionals
- **Economic conditions** exacerbate
 - o Another barrier →MAS low
- Cultural – physical good reason not mental
 - only in emergency
- % of people w/ misconceptions alarming – ALL %'s
 - o Major ignorance

What can be done? Compassion

Education: children's stories showing route to find health and help

*being (walking) in other's shoes

(sitting in wheelchairs)

Intangible: what is the "wheelchair"?

*discussions about helping those suffering?

Behavioral: recognizing strengths and successes

Focus 3. Populations for unique attention

- 2 prisons in Berlin
- Haven't defined problem when inmates released
 - o Where will they live? % MI/SUD
- Disability benefits = poor – sole means of income
 - o Another stressor to anyone – exacerbate
 - o Poor people disposed to MI/SUD
- Higher income cloaks issues not being reported
 - o (clinics) stigma & prejudice
- Military culture prizes resilience acts as a barrier
- All pops at risk comprise majority of pop
- Biological disposition
- Addiction as brain disorder
- Youth: pops not getting continuous treatment – resources
 - o ↓ Lack of pediatric psych

Reporting Out:

1. Challenge stigma
 - MI/SUD are treatable
 - Investment not cost
 - Treatment GA
 - Stunned by 1st in the nation alc
 - Ec conditions influence +/-
 - Do we want to know real #'s? or deal
 - Veterans need special care
 - Prison pops – case mgrs Enough?

- All pops at risk comprise majority of our pop
 - Open to all pops – generic treatments
 - Simple treatments for all

Go back to treatments that worked

2. How do we use all info gathered at forums to rebuild resources?

Focus 4. Response and solutions

- Public recognizes importance of allocating resources
 - ➔ Saves \$
- Making funding more available
- **Increasing education about issues (disturbing, disbelief)**
- Telepsychiatry/counseling
- Workforce development
- **Prioritize – national importance in NH (vs. liquor stores)**
- Appropriate/supportive housing: (energy sheet?)
- Low impact
- Lobbying and education of policymakers/legislators/leader/influences
- More forums like this
- Provide parents/family members opportunity to speak (find voice)

Responses and Solutions

- Family education: all family members
 - Caregivers➔tools for success/coping
- **Relationships – good boundaries PRESERVE - treatment/relation**
- Being understood – people respond
- Can be MI or SUD and a high achiever (Carly Simon)
- People need structured long-term care available
- NOT moving people during treatment – need to rebuild services
- **Expansion of Medicaid to low-income**

IN NORTH COUNTRY

- Finding a way to increase communication – HIPPA?
 - Listening/helping – in spite of HIPPA
 - How does someone trying to help get around privacy issues?
 - Duty to report – ethical issues, duty to warn

Concord Group A
Amy Pepin

No substance abuse questions on pre-test

Focus 1.

- Not enough SA info
- 20 % of deaths in US addiction relates
= public health crisis
- over prescription = addiction
- community supports and positive attitudes very impactful
 - o esp. for kids mental health/S.U.D. also for adults
- language important
 - o mental health
 - o mental illness
 - o substance use/abuse
 - o addiction
 - o **behavioral health**
- *missing recovery and resiliency information
- treatment gap is real
 - o access to effective tax large
 - o we pay for a lot of ineffective taxes
- MH/SUD tax is also provided by peers and others in community
- System in NH divides MH and SUD
- It's about a human being well about healthcare
- ER wants MH/SUD patients out – doesn't see them as their patients
- Silos

Focus 2.

- Silos
- Stigmatizing language
 - o However language that describes illness → mental illness/substance abuse
 - o Conveys the illness and discomfort
- P.11 cultural differences → does not adequately capture the disparities in health and access to care for MH/SUD – needs more continued attention
- Cultural difference also = poverty as well
- Shows the point that we move away from oppression and disparity when we are uncomfortable/don't know what to do
- Also large Native American population in the SA recovery community
- Missing from Stigma section =
 - o Good news → research re? interventions promising proactive for reducing public stigma in adults = contact w/ people in recovery
 - o True for MH/SUD and other health probs = cancer, etc.

- Link between mental illness and violence is a myth being perpetuated
- Should we be talking about the conditions assoc. w/ violence that people w/ MH/SUD experience?
- Think about all social and health related issues that push people towards violent acts
- Let's inoculate children and families w/protective factors
 - o Social connectedness
 - o Adaptive behavior
- Protective factors should be part of primary care check-ups

Focus 3.

- Frenzy re: bullying adds
- Stigma to kids w/ emotional and behavioral challenges. Again more likely to be victim than bully
- Systemic and societal refused to recognize addiction in adolescence leads to lack of id + treatment for chronic illness
- Youth → SUD very prevalent + many substances
- People who are isolated in their communities for a variety of reasons
 - o Refugees
 - o Dept. of hard hearing
 - o Vision impaired
- First episode of psychosis is a unique pop there is evidence that we can intervene and reduce disability
- Young adults/transition age youth and confidentiality barriers for family

Veterans →

- Suicide and walking wounded and impact on families and children
- Volunteer armed services separates experience of war from public consciousness
- National guard was not created to be troops overseas
- PTSD does not now have the same stigma that it once has and de-stigmatized PTSD (some) for other populations as well

Elders – very complex

- over prescribed
- MH/SUD not id'd in healthcare
- Isolation

Focus 4.

- acute solutions as opposed to prevention, etc.
- no solutions related to SUD
- children's behavioral health plan not references
- speaks to recognizing early signs as prevention of mental health not prevention before signs or symptoms
- look at outcome data
- Intuit Mental Health Initiatives
- Response and solutions looking at peer to peer support, family to family support
- Screening of youth needs to be across all ages and stages
- How do we affectively require higher ed. To train in

- Effective practices and policies
- Confidentiality
- Boundaries, etc.

Solutions:

- break down institutional barriers that keep us from providing integrated health care
- psychiatrists need a system that integrated whole body and SUD into their treatment
- screening protocols across healthcare spectrum
- track changes and improvements – on ore related to A.C.A. so we have data
- create health resilience delivery systems that are not part of traditional healthcare system
- need to actively create and support opportunities for youth, consumers, adults, recovering people to be policy leaders and decision makers
- focus groups w/ youth were done this summer and reports created that could add youth voice

Group B Concord
Kim Crowley

1. The Basics

- MH/SA co-occur, but services separate
 - o Missing something
- Treatment is effective - \$ are worth it
- Cost of not treating vs. the cost of treating
- Continuum- \$ in treatment and prevention
 - o All stages
- Prevention not even mentioned in this section
- Catastrophes get attention to # beds → reactive vs. proactive
- Access problem – lack of psychiatrists

2. Stigma and other Key Challenges

- Talks about cultural difference, but not rural vs. urban → important here
- Important to remember – stigma is probably the biggest barrier
- Resource “Anonymous People” film all-around NH, 20th/21st, fundraiser
- Great that all levels at the table. Not us/them
- Parity and Medicaid expansion
- Subs-Ab very little covered
- Isolation by culture – refugee populations
- Geographic isolation – access to groups, trust

3. Populations/Special Attention

- have to re-learn everything from grad school, no longer applies

NEED:

- Thinking out of the box
- Need collaboration instead of whose pile it is
- Concern for veterans care
- No residential adolescent tax in NH
- Recovery is lifelong. Lack of access
 - o Expensive past 30 days
 - o Lack of sober living environments
- 2 guidance counselors for 900 students - rushed
 - o no one trusts them
 - o 1 hour wait just to see them

Special populations

- need licensed drug and alcohol counselors available in each school
- need to push for funding and collaborate

- alcohol funds don't go to prevention
 - o goes to general fund instead
- homeless and mental illness gap
- older adults – gap
- pregnant women

Responses and Solutions

- push for funding
- alcohol funds to prevention instead of general fund
- collaboration
- engage biz & gov't sectors not just non-profit
- sell prevention work to the government – we pay the price for neglecting it
- more community based outpatient care
- effective management, not just cure or prevention
- Have MH/SA embedded in care
- Reduce the need to go to a lot of different places for services
- Meals are like insulin or prostheses. Separation creates stigma
- Schools are not even listed on resources
- Don't eliminate things that are proven to work
- Recommendations in guide are from 2008
 - o How many have been accomplished?
- Can't even find the New Hampshire recommendations anywhere n net – w/ extensive Googling – 10 yr plan)
- Dept of corrections – why are most people in jail?
- Shift costs from jails to treatment

Top Priorities to better prevent and treat mental illness and substance use disorders:

- Prevention priority. Research Support → cost/benefit
- *Youth: training for teachers on how to respond. Availability when school is out./Systemic training for everyone. Not a punishment but resource. Be safe. Fear of retaliation because of mandated reporting.
- Better education for providers, consumers, and families, (esp. self-management to recognize need for help + where to go).
- More access to treatment, detox, knowledge that there's a solution to problems can afford. Esp. young people.
- Integrate substance abuse + mental health into general care. Not separate. All +esp. elders
- Engage the biz. Sector. So much comes down to \$/Providers often barred from testifying if receiving funding

Community Solutions and Next Steps

- It's a maze. 2-1-1 is available, but people don't know
- Handout suicide preventions and other resources before summer recess and other critical times
 - o Poster with QR scan codes @ boys and girls club, after school programs
- Health class – addressed only once
 - o Needs reinforcement throughout the year

- Schools can call presenters in from outside. Ex. Cap Reg Community Prevention Coalition or other
- Schools in denial. Don't notice right under their noses. Teachers overwhelmed.
- Teachers need to pay more attention to what the kids are doing. Teachers need to have basic knowledge at least. Need someone to refer to. They are not equipped to help.
- Make prevention attractive to be funded
- (Dover?) students presented needs to town council. Get youth advocacy.
- Youth driven changes. Hear the voices of the youth who live it.
 - o Some across the lifespan
- 2-way street: If consumer driven, you need to educate consumer about possibilities in the first place. Need to people (provider – consumer) working toward the same goal sharing knowledge
- providers need to be more consultants other paternalistic dictators

Final Priorities:

- Youth in the school system (and out of school system)
 - o Get funding to open doors to outside presenters
- We need to make this a priority (lifespan too -50+ issues), normalize it (addresses stigma, locations, groups, biz sector involvement)
- Alcohol fund needs to actually go to treatment and prevention (transparency on where it's actually going)

Concord Group C
Tracy Hardekopf

Brainstorm:

- Non-integration of behavioral health into medical system/primary care system
- Opiate-addicted babies
- Lack of resources to treat co-occurring
 - o MH vs. AOD vs. co-occurring
- Lack of resources for those who are ready for immediate treatment
- Public awareness – need to improve
- Stigma – assume people w/ MH dangerous
- **Personal safety and civil rights**
- ***Treatment w/ dignity**
- Lack of support for caregivers
- More treatment services
- Educate/Advocacy
- Expansion of hospital services
- Lack of access to MH/AOD services
- Cost of services prohibitive
- Lack of respectful treatment and providers
- Lack of implementation of current research
- Own perspectives may be barrier
- Dearth of upcoming providers
- Suspension of benefits/SSDI w/ incarceration
- Advocacy
- Lack of state beds
- Overwhelmed system
- How significant % of population have MH DX
- Children being born to addictive mothers
- Generational impact of addiction
- Family structure impacted
- Manipulation by individual w/ MH/AOD
- Competing interests
- Younger generations informed/target to
- Cost impact of addiction on health system
- More public information/education
- Public mores accepting of physical impairments rather than MH/AOD
- Social acceptance; support needed
- Stigma because their victimization by MH/AOD may not have been resolved
- Access – Rehab = lack of \$
 - o Hospital – line of service for psychiatry
- GAP – what we know and how to function
- Alternatives to Prison
- Dignity/respect – not dangerous

Parity Act

- Attitudes and belief – macro level of change
- Stigmas – not one initiative fund
- Vacancies in Mental health
- Brain Drain
- Positives → what can you do
- Perspectives on treatment

Bullying – circumstances

- Impact social media
- Access is a challenge
 - o But resources just don't exist
- 1.5 years for residential Program
- Advocacy – impact on family members
- Lack of state beds – ER waits
- \$\$\$ “Needs don't go away just because you can't find them”

Layer

- Mental Health Leading to incarceration/punishment
- SS gone at 30 days – suspend benefits
- Housing lost
- Education for police (?)
- Crisis intervention teams
- Civil Rights – honoring rights but creating situation
- Resources – at release > = zero
- Visual example – Nashua/Manchester = 20%
- Suicide – military →
- Veterans track in court system for mental health
- Children – opiate addiction
 - o Parents rights over children's rights
- Dcyf – opiate use babies
<Human relationships→
- fundamentally unable to relate to others
- Entire family
- Identified patients
- Go beyond – family
- Clinical intervention –
 - o Intimacy relationships
 - o {what does this issue due to primary relationships
- co-dependency {game around illness}
- family blame –
- Conflicts – kids should not be effected
- Cycle – family {better together}
- Compassion – service announcements; education
- Global
- Compassion is gone
- Youth – lack of compassion – Media exposure
- Disease causes victims
- Chronic Illness w/ societal impact
- Violence

- Sympathy decreased
- Day to day life impacted
- Come help – education
- Population has disbelief about Illness
- Social support – legalize Marijuana?
- Active Victims – resourced – trauma
- Fear – push advocacy – impacted
- \$
- Social worker
- Opiated addiction
- Access – Instant!
- Inexpensive – Incense
 - o K2
 - o Spice
 - o Bath salts

Questions and Priorities:

- MH defined at times as crime
- Recognizing MH/AOD a family and community issue
- Budgetary support
- Rights vs. safety needs
- Turnover of Community MH providers/practitioners in agency – abandoned
- Stop seeking care after a few visits without outcomes
- Stigma
- Defining MH event as crime
- Recognizing it's a family/community
- Rights of parent/person vs. other
- Dollars
- Media – the storyteller defines the culture
- Turnover in provider ranks
- Combative clients charged criminally furthering CJ & MH system
- Overwhelmed system
- \$ lack of funding
- More people in long term recovery tell their success story to better encourage funding - Recovery **does** work

Solutions:

- More public awareness campaigns
- Educate patients about parity act
- Trained peer support specialists not utilized – no mention in material
- Provide more cross-training for LADAC's to diagnose and treat mental illness
- Patient advocates
- Integrate behavioral health into primary care system
- Bring education to middle/H.S.
- Roadmap how to maneuver system
- Public education on what is already known about the brain, mental illness and substance abuse

Recommendations:

- Screening; assessment improvement
- Parity between MH; AOD providers
- Environmental; behavior assessments for client
- ***integrated care in a healthcare setting**
- Expansion of this treatment line at hospitals
- Interns
- Train police about M.H.
- Public service announcements/Education
- Training primary care providers to take behavioral and environmental histories of their families
 - to screen and refer
- PCP – screening at every healthy visit

Additional information:

- Long term recovers need to share stories! – Speaker Bureau
- *Americorp/Vista/Able volunteers
- *Peer to peer programs in education settings for better acceptance at younger ages
- Gap in veterans benefits needs to increase
- Peer support available in ERs when pts. as M.H. + S.A. issues come in

Concord Group D
Kathy Mathis

1. Understanding Basics

- gap in treatment between diagnosis and treatment
 - o who will be there to help?
- 90% major crisis (as a society)– so many without treatment
- more than 20% deaths are substance abuse/addiction
- no change since 1963 (attitude of Live Free or Die)
 - o unfunded mandate – NH 20 years behind the nation
- if it's not profitable, hospitals don't advocate for service
- insurance may cover 30 days, but mental illness is a continuum
- what is mental wellness? Where is the education?
 - o Give healthy coping mechanisms
 - o Parents and schools are responsible

2. Stigma and Key Challenges

- “stigma” prevents education on mental health
- what you don't understand, causes fear
- mental health is a disease like other diseases (diabetes, etc.) and needs to be managed appropriately
- mental illness is not willful – but people believe it is and don't want to support treatment
- community has “elephant in room”- name the elephant, identify it, treat it
- we need to expose how we treat our veterans
 - o (because of stigma, they don't talk)
 - o careers are at stake
- mental illness can be treated
- make as many people as possible understand
 - o only people who experiences it really know
- people need to see these statistics –
 - o we need a strategy for channeling info down to LOCAL level
- these statistics are grossly underestimated or under-reported, as dramatic as they are
- also people deny that they have a problem – unlike other diseases like asthma, diabetes, or cancer. Implications because of perceived stigma
- stigma prevents people who recover from speaking out
- a lot of fear around using illegal substances
- prescription abuses doctor hosp + use personal strategies to avoid discovery

4. Responses and Solutions

- everything listed is reactive!
 - o Where is prevention, education?
 - o Need to get to root of problem
- w/out community support you can't expect or support true and sustained recovery
- there is no single women's recovery place in NH

- need more facilities (more silver houses)
 - more peer-support centers
- need healthy continuum recovery plans/treatment
- 10-year plan has not been followed
 - no a little increased capacity
- people who look for treatment can't find a bed
- elected officials are essentially deaf to problem
- more education in systems:
 - hospitals
 - correctional system
 - healthcare providers
 - schools
 - enforcement
- drug courts and mental health courts are active. That's good

KEY PRIORITIES:

- put focus on primary prevention and not focus solely on the problem when it becomes acute
- stop ignoring tobacco-related addiction in mental health treatment. Tax revenue not being used for treatment – it's unethical
- reduce stigma through education on all levels
 - one size does not fit all. Strategy needed
- stop speaking to the choir; media; physicians; people who think they are unaffected – need to hear and get this message. Get the under 24 yr old. College campuses – young adults
- more long-term treatment facilities – needs to be cost effective 0 we need to make a financial commitment to rehab. CHANGE ECONOMICS >liability vs. investment
- more out-patient crisis teams – prevent using emergency and hospital beds
- we need a clear process for communication and intervention in need. Family needs more input with health system. Integrate our systems
 - let patient tell their story

Solutions/Recommendations:

- Greater community coalition to design creative, integrative working connection that discover, prevent, treat and support: police, parents, pastors, health providers, etc.
- D.A.R.E. program does not work. Education for youth in schools. Alternative to D.A.R.E. Needs to be more holistic emotional intelligence. Public health officers under-utilized. They can be a resource. Get media to start talking about it more. Print and social media – effective messaging – change attitude of educator – need evidence-based data – how do we change values?
→ role models are effective and riveting, real stories, recovery
- promote economic benefit of changed attitude towards illness/mental abuse/substance – this can be a value statement
 - attn. to mental health is cost effective
- media needs to stop glamorizing drugs/alcohol. We normalize drugs, alcohol, violence, sexual abuse
 - need more “Silver Linings Playbook”

- demonstrate real condition of illness
- expand Medicaid – need financial resources
 - so need to advocate with policymakers
 - need coalitions and real stories by real people
 - you then create community and reduce “closeting”
- groups NAMI and New Futures should promote story-telling advocacy
 - Adapt “Dover Youth to Youth” in adults
 - Public service announcement – get it out there
 - Evidence-based knowledge
- duplicate what works
- need more housing and facilities

Concord Group E
Ed French

- Franklin Manc
- Not a focus on caregivers
- Want to stay current on issues
- Substance abuse direct and family avail of serv and beds iss
- Mental health issues in fam
- Ins. Issues
- Absence of connective treatment
- Not a lot outside of family for support
- Treatment not available – lack of supports
- Professional providers of support

Brainstorm: what do you notice? What is important to you?

Focus 1. Understanding the basics

- biological factors (physical and psych aspect to mental illness)
 - o people don't understand that it can be both
- lack of treatment options
- sub use disorder stats – staggering
- childhood trauma that continues for life
- 90% of those with need for treatment don't seek
- invisible
- sub abuse/alcohol huge problem
- absence of presc drug abuse in stats
- cost to community
 - o lost earnings/cost of treatment
- *Medicaid expansion will allow more access to treatment
- housing challenges

Focus 2. Stigma and other key challenges

- Believing someone w/MI is unpredictable
 - o maybe issue w/ employers
- root cause of MH issues
- lack of community
- influence of toxic stress that can influence MH
- bullying and stress need an outlet
 - o *(cyber-bullying → what does this do to stress levels → how is it relieved → IS IT?
- *cultural differences – huge challenge
 - o considered in treatment and support
- sub abuse → no stigma??
- Culture issues in terms of dealing w/MH issues
- Vets – suicide rates – not serving their MH needs

Focus 3. Populations for Unique Attention

- kids/children- suicide rates – MH stats
- homelessness and consequences to getting treatment
- lack of full service Vet hospital
- % of incarcerated have SA problems
- >90% of parole violations due to SA problems
- the # of people homeless, w/o jobs, on streets
- NH Suicide rate highest for elderly
 - o Why → what is the root cause
- 71% of women incarcerated have MI

Focus 4. Responses and Solutions

- 10 yr. plan → 5 yrs into and actually taken steps backward
- comm. Residential support – important need
- only 2 partial hospitalization services (not enough)
- emergency rooms have become MH centers
- Franklin Hosp – inpatient 10 bed MH
- Never hear about MH prevention
 - o Early intervention
- collaborative relationships needed between various providers including MH

Key Questions and Priorities:

- what are the key focus areas for further discussion?
- What should be the key areas to prioritize?
- What questions still need to be answered?
- Stigma – responses and solutions don't address this despite being a key
- Collaborative relationships needed among all providers including MH prof.
- Early intervention needed
 - o Working with family planning centers, schools, childcare, etc.
- More funding devoted to MI and SA prevention and treatment
- Co-occurring treatment MH + SA needed
- Catch it → more education –
- With intervention → treatment → expanded funding sources needed
- Prioritize allocation of funding
- Having appropriate provider serving needs
- Lack of training
- Gathering info on co-occurring MH + SA issues
- MH counselors need SA treatment trg.
- Lack of advocacy
- Why has NH gone from model to no longer being model in overall MH system (in a state of dysfunction) – why?
- Need to get away from quick fixes (just more beds)
- Cannot compel people to accept treatment

Community solutions and next steps:

- what are possible solutions?
- What should be done?

- Community Ed. Campaign
 - Address
 - 10 yr plan and status
 - items we highlighted tonight
 - stigma/cultural aspect – peer pressure and bullying
- Increased advocacy at all levels
 - By all stakeholders including those with MH and SA issues
 - Those with a story to share
- Collaboration –
 - Get all providers together rather than silos

FINAL PRIORITIES:

- key recommendations/findings
- specific questions
- top insights

- NH needs to spend \$
 - need to recognize intangible cost associated with not addressing the issues (MH + SA)
 - absences –
 - fund 10+5 yr plan

- community supports and services need to be restored
- a lot of people say the same things → what makes it happen

Concord Group F
Catherine O'Brian

1. Need to unbury issues of addiction
Need to access treatment
Finding the right treatment that works
Time needed
Diagnosis – younger ages
Frustration – why are we not moving forward
2. Stigma
 - Still a huge problem – addiction vs. other
 - Many negative connotations
 - Highlighted by media – news small %
 - o We hear negatives
 - Addiction and mental illness – different but intertwined
 - On addiction treatment – ambivalence
 - Science versus treatment
 - What does research show?
 - o More than biochemistry?
 - o What is effective research?
 - Illness

Treatment strategies

 - Lifelong, broad
 - Interventions
 - MI: AD separate but often co-occurring
3. No doubt youth are using younger and more
 - Easier to treat youth than adults
 - We need a clear voice –
 - o Speaking about these issues in terms public and legislators understand
 - Don't confuse terms –
 - From policy perspective –
 - o Need to clarify
 - Distinctions between MH + addiction issues
4. How to create policy – broad enough but specific enough
 - Relatively new concept – of alcoholism as disease
 - Important – awareness with legislators

 - NH has many orgs that care and have focus on populations identified –
 - Needs more coordination among groups

4. (cont.) Identify Common Goals

- CAPP – community action program
- Community public health network
 - o Coordinates ER responses
- Regions – urban vs. rural

- Distinctions – between physical and mental –
 - o Mental – we need more preventative – before becomes serious
- Can we identify in work place?
- How to identify – stigma?
- Conceptual shift
- Perception that you can't recover – old myths

Message = mental illness recovery is possible → very important

- Educating – everyone
- Teachers – “no one sees it in my son at school”
- Question on data –
- Stigma is a huge issues →
- Larger than data in report
- Impact of movies/media – “mentally ill people are dangerous”
 - o Pervasive – in US culture
- We have problems integrating “head” and body – mental and physical –
- Recent study → large number of people with mental illness are using drugs and alcohol to varying degrees
- What is evidence based practice of ??? diagnosis!
- Dartmouth College – model not fully used
- Even if there are \$ - do we have workforce that is trained and prepared –
- Are there tools – mental health fitness?
- Mental health assignments –
- Written programs –
- Lots of tools on internet (varying quality)
- Challenges → no simple cures
 - o Can't oversimplify –
- More primary care MD's are asking about mental health and emotions, making referrals

Highs and Lows

- Day to day changes
 - Sometimes psychiatrist or MD's may not see what caregivers are living with
 - Build-in incentives
 - o For clients, repeat ER for mental health
 - o Incentivize – wellness behavior
 - New program piloted → “In Shape”, whole-hearted approach, alternatives, yoga/acupuncture?
 - Can mental illness be “cured”?
 - No “cures” – you can “recover”
 - o A life-long process
 - Mental health field can learn from addiction field
 - Takes a lot of work – “a recovery model” – self-help
 - \$ = self-recovery doesn't necessarily cost more?
 - Moral choice?
 - \$600 day – NHH; average stay – for admission – 10 days
- Big Issue – Today more than 25 waiting for admission at NHH
- People in prison - for mental illness

- Don't need to re-invent the wheel
 - o System
- Research systems working in other states
- There was a plan in 2008 – we know it worked
- How do we get resources
- Dept. Justice lawsuit
- Why don't we value people who work in field of addiction and mental illness
- Why is it not worthy of our attention
- New films
- Time - anti-smoking campaign took time
- Values of our society and culture
- Taxes from alcohol

Priorities:

- Lack of systemic coordination - *one network? Comprehensive network
- Education – public awareness
- Work force – prof development
- Lack of psychiatrists
 - o Nurses, care workers
 - o pay rates (medical vs. mental health)
- different values youth today?

Surviving

- History BC – higher \$ - 1979
- *NH – opp → we are small enough to work together
- Clearing house – info, resources, building on service link
- Consumers also – *funding is siloed
- United Way – how \$ are doled out → overlap
- Identify gaps
- Same conversation 40 yrs!?
- The Mental Health plan (2008) versus substance abuse plan [Medicaid?]
- Bring these together
 - o Programs follow the \$
- MH + SA
- Different models and systems – beginning to converge
- *different levels of training
- Challenging to bring together

Missing –

1. Provide – one clearing house for both groups
 - Role for state?
 - Needs staffing
 - Resources current
 - Updated

Proactive vs. reactive – we've come a long time in 40 years!

- * a long-term vision*
1. One systemic network model that includes coordination between mental health and substance abuse

2. One clearinghouse building on service link
 - *staffed
 - *Updated – current
3. ** Education = \$ public awareness → treatment works, hope Campaign, STIGMA
4. Workforce development in mental health and addiction work
5. *Shift to pro-active approach
 - *look at autism campaigns that could include incentives
 - Can we serve all?
6. Resources → \$ state – federal – community
 - *Public Awareness Campaign → to find, work toward emotional wellness
 - Insurance → job coaches
 - MD's – primary care seeing mental illness increasing
 - Medical Marijuana – taxes?
 - Funding Sources
 - State, federal
 - Community – small, local, civic groups
 - Academic Diversity Opps?
 - Industry – needs incentive to participate
 - Med marijuana taxed?
 - Foundations – opportunities
 - Divide between rich and poor increasing
 - NAMI programs funded by pharmaceutical Cos.
 - Gates Foundation

Essential Conflict

- Private pay
- Code of ethics – to provide care to all
- Can we make choices between any groups?
- Triage?

Concord Group G
Gail Kennedy

What stood out

Focus 1. Understanding

- Second to last in nation for access to treatment
- Access to treatment but not always in crisis
- Not enough intensive SUD programs in state – 28 days too short
- When people are ready there are no beds – then they decide not “to be ready” or move on
- No timely access
- In ED’s, exacerbates their situation
- 2 treatment systems do not help – need to integrate (CMACS and SUDS are in conflict)
VERY BROKEN
- All talk no progress
- Co-occurring disorders frequent
- Lack of system integration – turn away even if laws are in place
- Data staggering – why is state not responding
- People don’t follow thru when appointments made – need to accommodate them when they are ready
- Way our system works doesn’t make sense: addiction is a “mental illness”, so they should be integrated
- ED’s not equipped to handle these cases “in, out” phenomenon driven by insurance companies
- Money drives the system
- Not the system drives the reimbursement – insurance companies rule
- Prevention impact with SUD is high but limited programs especially with kids
- No more school programs directed at education at SUD – all gone

Focus 2. Stigma

- *separating our MH from SUD creates stigma for both pop and professionals
- SUD is a moral issues – it’s personal choice influenced by environmental factors
- Other states look at SUD as a *public health issue
- Linked to how we train professionals
- Only now are we upgrading the requirements
- 2 fields have not kept up though on current trends
- Now some cross-training
- *language and “labels” keep up stigma
- *hard to change attitudes and beliefs
- Automatic “victim/prey” label in jails if you mention you have MI
- People will wait until established patient at CMHC until they disclose SUD
***SYSTEM PROMOTES DISHONESTLY which reinforces stigma**
- Kept out of jobs if you declare you have a MI even by people in the field
- *People don’t self-declare due to fear of repercussions and discrimination
- Suicide statistics were surprising
 - o Homicides show up, suicides do not

- *media and suicides – need to do educational reporting, promoting recovery – go after news story based on fear, salacious INFO
- Bigger question around discrimination against people who are different – culture, sexual preference, MI etc.
 - o how do we change society to be more accepting as has been done with cancer
- female inmates have trauma as well as MI and SUD. What not known is men have some experience and background (domestic violence and assault). Men taught not to report.
- **CONTINUUM OF CARE ACROSS LIFECYCLE**
- Kids in poverty are living in traumatic situations which will lead to MI/SUD potentially in the future

Focus 3.

- Veterans – surprising only state with no state facility (inpatient, etc.)
 - o FULL SERVICE
 - Youth: no research to treat early ages and to diagnose early in life
 - Youth should not be put with adults
-
- Lack of services to elderly in their homes (rides, etc.)
 - No telemedicine services to those in homes
 - Small towns trying to support but larger communities do not have the sense of community or an ability to pull together support, volunteer services
 - o Rely on social services – NO CAPACITY FOR MORE
 - People can “buy” services but if they don’t have money they are cut off
 - “Homeless” populations and MI/SUD are overlapping communities
 - Don’t segment the populations too much

Focus 4. Responses and Solutions

- Prevention – invest in it!
- Fear that education might cause the problem
- Harbour Homes – **holistic problem** – we need more of these in the state / **Across the state**
- More ACT learns
- Donut hole – need care for uninsured and ability CMHs to provide them
- Lack of services → declining e.g. women and children (only 1 program w/in the state)
- *More DRF /treatment/psych beds and detox
 - o Community hospitals or health centers
- After “homes” or care centers to help after leaving NHH or DRF
- Treatment and patient care should be seamless and communication between CMHC/NHH/PCP/EDs – all in system
 - o Needs to be excellent – no cracks!
- Providers and community must be interconnected regarding patient care

Key Questions and Priorities:

- Strategy: PSAS for education
- Indicators: ED #'s – when people go to jail beds and ER departments for help
- Need to spend money proactively – not reactively (put it up front not after the back)
- Evidence-based programs and treatment e.g. mental health
- Courts or community health programs

- Break down isolation/increase transportation to build the sense of community

Promote Volunteerism

Implications:

- Higher suicide, higher crime
- Business/economic dev't would be slow
- Public Policy: \$ZYM/DRF/ACR
- Need to change paradigm
 - o Follow patients, not \$
 - o No "boundaries" ???
 - Remove silos
 - o Early prevention

Priorities:

1. Ways to reduce/understand stigma
 - o Comprehensive and deeper analysis and approach to reduce stigma based on research – look at existing work – don't re-invent "the wheel"
 - o Look at attitudes/values that underlie stigma
 - o Peoples per
2. INTEGRATE TREATMENT
 - o (Evidence-based practice) and system of MI and SUD
3. How to re-direct money
 - o Use proactive/not reactive thinking
 - o Spend on "root" cause not symptom
 - o E.g. Lev low risk offenders stay in communities to keep home/family life more stable, keep jobs, etc.
 - Community based not jail based treatment

Community service and next steps

- Education – parenting support
 - o After care services
 - o Mentoring
 - o Community youth, after school programs
 - o Guardian Ad-lifers
- Pro social activities
 - o Health/fun family
- Work with police/fire department/first responders on how to deal with MI/SUD
- Community based psychiatrists
 - o Increase # across the state
- Youth/first responder mental health
 - o E.g. Dover suicide prevention in high school
- Return civility to our way of life
- NH Difference – include "WE CARE, WE SHARE"

FINAL, FINAL PRIORITIES

Common points or diverse points

APPRECIATING DIFFERENCES & REDUCE STIGMA

- Will go a long way to help change the way we look at MH and SUD

Keene Group A

Colin Lentz

Brainstorm

Focus 1. Understand the Basics

- Early intervention! (prevention)
- Creating accepting community in schools EARLY
- How do we break the cycle?
- Relation between mental health community and greater society
- Issues for traditional diagnosis model
 - o Funding is a huge issue (skews priorities)
- Mental health is a community issue

Focus 2. Stigma

- Public/community education about reality of mental health and special Ed. Individuals
- Difference between special Ed in public vs. private school
- Finances determine level and quality of care
- Lack of society support
 - o Easier to go to a bar than admit a mental health or substance abuse disorder
- Any difference marginalized a person as separate
- Self-esteem is reduced by cultural stigma (self-esteem is a major factor in treatment/recovery)
- Labels remove peoples' individuality
 - o People "become" their label
- Diagnosis is "symptom-reducing", not "asset-building"
- Diagnosis is a label, not an explanation
- Excess medication is a vicious cycle
- Lack of coordination for medication

Focus 3. Specific Populations

- Military culture (macho) doesn't support mental health for veterans
- Business focus (trickle-down) alienates mental health issues
- Mental health is not adequately considered under current economic and political cultures
- Beds in hospitals/houses + places to re-enter greater community
- Reality is swept under the rug
- Need major support for young children

Key Questions and Priorities

- The financing (who, how, etc.)
- Public education (e.g. New Futures)
 - o Advocates for mental health issues "Behavioral Health"
- Efficacy of state agencies (silos)
- Does our model work? Are there other models that would work better?

- More training for medical community and other professions that contact with individuals with mental health/substance abuse issues
- Private partnerships (funding)

Solutions and Priorities

- Media involvement
 - o Get the word out
 - o Dispel the myths
- Use multiple avenues to increase awareness and access to information + services
 - o Start awareness – building early in schools
- System/culture needs to become more pro-active (preventative) than reactive
- Reduce complexity in access process for treatment
- Funding for wellness-building (comprehensive) in schools
- Need incentive for funders
- Culture change!
 - o (trauma-informed perspective)
 - o (similar to “person-first” language)

Keene Group B
Jane LaPointe

Brainstorm

Focus 1. The Basics

- Nothing in this about peer support services
- Majority go without treatment or services
- We're being set against each other to keep us from doing anything national, together
- Mental health isn't necessarily visible external – like diabetes. Need to get to know a person – talk with them.
- 40 years without treatment – couldn't afford it
- People who make \$ allocations clearly don't value communities we serve – continuance of care, access to care – where are our priorities?
- We have data on the cost of MH or substance abuse issues
 - o Know they'll be unemployed, families suffer
- It's not just the one person – it's the family, etc. affected by lack of treatment
- Need more info on prevention to see the value/benefits that are possible – outcomes
 - o Prevention is first thing cut
- We spend trillions of \$ causing MH issues and pennies treating it
- Prevention → respite care vs. hospital
 - o More respite beds... Little → no cost to consumers
- Trauma, kids, witness, go through
 - o Can't put monetary value on human life
- Statistics fly in face of having pride in NH – NH advantage
 - o Decision makers in congress
- We're debating the expansion of Medicaid
 - o Do we help our neighbors or take care of ourselves
- I was denied service at local community mental health clinic since I don't have Medicaid
- Nothing in section on
 - o Peer support
 - o Internal stigmatization process that prevents people from reaching out

Focus 2. Stigma and other Key Challenges

(hard to do in room with all conversations)

- Want people to know that people who are “crazy” aren't violent
- I hope if I had a son like this, someone who see him, talk with him
- No mention of criminal justice – adds a whole levels layers of stigma
- How **media** and people use word “crazy”
 - o Impact of language on people – stigma
 - o What does it sound like to people with diagnosis
- People need to know people with mental health needs are out there – worldly, successful
- Because of stigma we don't put our job at risk by letting people know about our history
- Nothing about stigma of kids in foster care system and support they need

- More on kids
- Culture differences
 - o There is a lot of “isms” in the system
- Class-ism
- Stigma around violence
- Stats on suicide { important}
 - o NRA blaming gun violence and suicide on mental illness – blame it on the other
 - **Missing from info**
- Homeless people – off the street and into facility due to NH and substance issues
- Veterans – 2 died of suicide for every 1 killed in combat
 - o the need to escape
- Need more on kids
 - o not recognizing MH issues in children – children who bully
- Missing → trauma caused by people trying to get help in ER, community facilities
- Trauma, criminalization that happens when try to get help
- NH’s answer – go out of state – VT
- You shouldn’t have to go outside your community to get treatment you need
- Public transportation
- NH doesn’t care about its people accessing services
- No mention of peer support services
 - o Free
 - o Trauma-informed
- *peer-lead crisis/respice beds in NH – only 2 crisis/respice beds (need more)
- **Manadnock Area Peer Support Agency**
- Police take parental – permission
 - o Involuntary hospitalization
 - o Police listen to parents to get me into a facility
 - I’m an adult, taking care of myself
 - Not respected by law enforcement

Focus 3. Pops for Unique Attention

- Older adults self-medication for depression
 - o Leads to substance abuse
 - o More socially acceptable to drink than get help
- Shocking that we are only state without full service VA transportation
- Need peer support services for children /goth
 - o You’re not alone
- CHINS – cut – awful
- Keene youth services department – made 100’s of referrals
 - o Police no longer make referrals
 - o When there is time for intervention and prevention – re: juvenile justice
 - o No one wants to pay
- People don’t get referred
- No prevention
- Families, communities are huge resources

Services → from families, religious, social communities

- Lets support people in these decisions
- Support families proactively – before problems
- Strength supports already in place (before us vs. them)
- If supporting our families – prevention
- **Prevention? What does it mean?**
 - o before being brought to hospital
 - o is hospitalization prevention?
 - o Quick fix – send them to Concord vs. sitting down with family
 - o Prevention for whom?
- Taking – getting it out in open, discussable

Focus 4. Responses and Solutions

- Can't always be medication, must be more options

What works:

- Conversation like this – gathering community
- More services for every age group
 - o Affordable
 - o Accessible
- Why do we have to take people (all ages) out of families and communities for treatment?
- The things that “work” can be done within families when support is there
- Must address stigma and internalized stigmatization
- Supported housing – with case management
- Diagnosis drives the \$
 - o Can experience drive the service?
 - o Why is diagnosis necessary to get treatment?
- Peer support services – missing
 - o This is very medical model in this section
- “I don't let people bother me”
 - o Inner resilience
- Education for law enforcement – k spoke
 - o Take responsibility for trauma they've caused
- Invite people who have the diagnosis
 - o “experts” – to learn their experience
- VA Pamphlet - “If home looks like a battleground... it probably is”
- System – reverse classism – atrocities everywhere – intimate violence – “easier”

Key Questions/Solutions/Priorities

- **Stigma** – learn to walk away from it
 - o baby steps
 - o don't let it bother you
 - o “I'd be a good peer mentor on this”
- **Education** – of consumers, patients, providers (broadly defined), community
 - o Awareness of ???
 - o Person w/ MH issues don't ask for it, cause it, understand challenges in normal society
 - o There are people who are suffering and don't know it or options

- **Services and treatment**
 - Available
 - Don't depend on diagnosis
 - Free okay
- Innovative solutions won't come from people who created the system we have now
 - It will come from consumers not providers
 - Problem is the system not the people but we act like it's the people (easier to do)

 - I have more hope than I used to
 - Strengthen community, family
 - Access – transportation
 - We all have to be part of solution
 - Community – to recognize issue, to appreciate what people bring
 - Expertise of “consumers”
 - Dignity and respect for them
 - Our values are reflected in what we funded
 - Stay open-minded, reach out, find strength to find a place
 - ➔ Peer centered, facilitated groups
 - ➔ Find a fit for what you want
 - ➔ Learn how to recover from trauma
 - ➔ Voices group
 - ➔ Unity group
 - ➔ In shape
 - Consumer to consumer

 - Need emerging help
 - No one would help me
 - I asked for help and was given appointment in 3 weeks
 - Don't get care when need it
 - *If I had gotten the help and support I'm getting now as a kid, it would have been a different universe
 - We need to improve MH facilities and transportation access
 - Inconsistent, changing staffing creates gaps
 - Idea of hope
 - Personal responsibility
 - Education
 - Support vs. help at young age
 - Self-advocacy
 - Peer support from a young age
 - Guns – suicide in NH – NH gun shops care – committed to suicide prevention
- Listen to us – we are the people who know what looks – we are experts

Report Out

1. Peer Support – across ages, culture, races, types of life, economic groups,
 - Youth
 - Education
 - Transport/access

2. Hope – not learn, not stigma
3. **We** need to come together for solutions – will come from us
 - People, families, community, education, respect
4. Funding

Keene Group C
Hannah Peckham

Brainstorm:

1. Professional responses to SA and MH

- ➔ What's the procedure?
- ➔ Public response
- ➔ Crisis intervention training

*only 2 officers

- \$, small depts., JAIL – ME not NH
- police at elementary school
- Legislation vs. reality
- equitable/rational care

* stigma

- addiction as a terminal disease
- not seen as a disease
- teenagers – seriousness
- substances as MH cure/use
- cyclical MH + SA – interconnectedness
- *some people
- Resources ➔ corrections
 - Need to be at front end
 - *Prevention services
- “widened the net” re: police officers
- Country jail ➔ largest MH facility
- HIPPA laws ➔ privacy
 - What about parents?
 - Need to consider them
 - Treatment plan
 - Not always interpreted the same
 - Under 18 vs. over 18 – permission
- NAMI as disservice
- Policy
- Insurance industry and SA
- Look at this as resource
- Who can pay?
- Obamacare and MH coverage \$
- What are drivers of healthcare costs?
 - Small % MH
- Better communication w/ parents (or other close family members) for MH and SA on insurance parity
 - Parents did not know about statute?
- JUST LISTEN TO ME
- Laws
- Permanent recipients Of MH services
- Lacking resources, options, long-term care

- System vs. society, funding changes
- A place family can go to get resources
 - What do I do next?

Stigma: not just police, it's everyone including professionals

- Attitudes towards MH and SA
 - Biggest barrier to policy change
 - "the anonymous people"
 - AA "tentative anonymity"
- We have to TALK about these issues
 - Ex. AIDS

What can we do about it?
- *Veterans
 - PTSD – "drop the D"
 - Medicalized terms
 - "the government sent me"
 - *language "idiots"
- Language – needs to change
 - MH/illness is real
 - Verbal approach influences response
 - Mentors, unique populations
 - "I understand how you feel"
 - The power of vernacular
 - Respect to the individual → listen
 - "abuse" contributes to stigma
 - We need another term
- *What is the positive? ← recovery
 - Stigma, where do we focus?
- Choice vs. illness
- Validation of disease
- TALK about it
- Ex. CANCER
 - Discuss as an illness
 - Support w/ research
- Opportunities to change mindset

Ex. Rosa Parks, civil rights, gay rights

 - Value as a human being

→ This is who I am
- Media → negative representation

*Focus on recovery
- Statistics on positive
 - We don't see the positive contributions
- Gun violence
- John Winan's story
- "that's insane"
- *language
 - "so schizophrenic"
 - Inappropriate usage
 - Responsive usage

Solutions?

- Funding for whatever it may be
 - Must become a priority
 - Don't cut it if it works
 - Those in the field must care
- Statistics that are accurate
 - Lack of clarity and accessible info
- Parity – make it real/usable
- Prevention/early intervention
 - Funding was cut for these services
 - Much less expensive ← policymakers must know
 - + MH
 - *assessing who is at risk
- Housing solutions?
- *public health approach
 - Housing, education, jobs
 - Relates to prevention
 - Finding employment and employment services
 - Redefining “sick time”
 - Day plan
- *Change the conversation to Recovery from stigma/negatives
- Not funding full need, refocus on positives MH + S-use

Key Priorities/Issues:

- Parity, programs, and care
 - Insurance
 - Very big issue
 - How to make “systems of life” more accommodating
 - Public vs. private programs
- Reversing stigma → language
 - “Commit” – illegal sound (sin, criminal)
 - Education
 - In schools, educating public,
 - In the community vs. visible
- Legal resources to get help
 - How can we find them?
 - Where to look?
- Positives of prevention and recovery
- Overdoses
 - More deaths among young people/youth
 - Drug issues
 - Kids don't know about these drugs
 - Educate youth about drugs
 - Laws must keep up w/ changing drugs

Final priorities:

- *Funding
- *info and education
 - facts that represent reality
 - Call it what it is
 - Counteracting negatives
 - peer support needed
 - hear more from those
- Need to make it safe for people to be willing to say they have a disorder
 - MAKE IT OK
 - Same w/ addiction

 - People are afraid
 - *Coordination of care – effects everyone
 - h/c providers, primary physicians,
 - what to do
 - adequate numbers of providers
 - appropriate prescriptions/reminders
 - *do not just focus on prescription
 - working with the parents
 - Mental Health AND substance abuse disorders → together
 - Language
 - Co-occurrence of disorders
 - *lack of integrated treatment
- *HIPAA – cause of issues, age discrepancy
 - Involve parents and family in recovery process
 - *share positive stories on prevention and recovery
 - remember changes we have made
 - Ex.) Cancer, nicotine issues
 - 17 y.o. dealt w/ as adults
 - age, court system
 - = changes in access/services/treatment
 - want to see this changed ↑ 18
 - On parents insurance until 26
 - where is the parents' right?
 - Guardianship process
 - Start young
 - Lawmakers

Report Out:

1. Changing the conversation to hope and Recovery
 - Changing language, making it safe to speak out
 - Reducing stigma → education, retraining, first responders, law enforcement
 - How do we get to the stage of acceptance?
2. Changing the way we look at MH + SU services
 - Access ← need more resources for parents and family

- Who provides → retraining of responders
- 3. Funding and parity
 - Co-occurring disorders
 - Fund it if it works + keep funding it
 - Core services, insurance
 - o Housing, employment
 - MH + SU have equal standing

Keene Group D
Steven Boissoneau

Understanding basics/Stigma:

- Identify individual need
 < attention
- Find services/awareness
- Shortage services/resources

- *re-educate populations

- *educational understanding

- Misunderstanding
- People – power positions
- **Funding** – government, society/**public will**
- Respect – hope – compassion
- Treatment works

Stigma – Key Challenges

- Populations –
 - o Poverty class
 - Transportation
 - Employment
 - Services
- *Peer Group Benefits
 - o Youth
 - o Family
 - o Young adult
 - o Homeless
- Responses/solutions
 - o Housing
 - o Transportation
 - o Available services
 - o Parental support
 - o Early identification

Basic

- Well being
- Mental health minored
 ➔ Collaboration
- Coordination/holistic
- *isolation vs. cooperation
- Early identification of youth and teens
 - o Support for them and their families

- Integration of medical and mental health services and service providers (wellness recovery action plan)
 - *Consumer directed
 - o Individual and family centered
 - Change the way services are delivered
-

Community support and understanding

- Peer support
- Community engagement
- Small acts of involvement
- Community environment
- Positive values
- Funding – general challenge
- Medicaid expansion
- Alcohol fund 100% or more
- Peer support funding
- Local community funding
- Grant funding

Nashua Group A
Gail Taylor

Response to Data

- Shocking – 1st statewide conv.
- Nothing for kids
 - o No funding for prevention – where is tobacco settlement \$?
 - o Programs cut, no replacement
- II – vet suicide vs. killed in action
- Prevention a lot cheaper than treatment
- Treatment a lot cheaper than crisis
- How closely ties substance abuse and M. Illness
 - o Providers don't make cxn.
- Won't see treatment till clean
- Cnx – with criminal system
- No sucs for incarceration
- Judge Leary – advocate
 - o Nashua and Manch. Comm. Cxn program
- video game addiction – shuts off melatonin
- Subs. Abuse – a teachable issue
- Once cycle begun, continues unless intervention – consistent, reliable
- Stigma – huge – No comprehensive health edu. Curriculum. Know it is not an embarrassment.
- Self-medicating
- Stigma – Legislative level teachers
 - o Seen as a lifestyle choice, weakness
- Need education
- A “no-casserole” disease
- Addiction seen as choice
- Nation – we are so heavily medicated
- HIPPA – used as a stumbling block
 - o Facilities/providers use as a shield – don't inform family – needs guidelines
- Book – Pete Early “Crazy”
- Good for the patients confidentiality to be respected
- Caseloads are enormous – wait too long for appts.
- Paperwork – EMRs help, but forms
 - o Billing codes
 - o Medicaid paperwork – time vs. patient care
 - o Defense – for lawsuits
- Understanding the disorders
- Physician prescribed medication – to abusers
 - o Aderol, solexa – throw meds at amphetamines
 - o Narcotics – oxi, percocets
- NH – highest rate of marijuana abuse by 18 and under – since prevention \$ went away
 - o Highest youth alcohol
- Problem – not money issues, but priorities

- Shift problems – frugality
- CHINS – defunded 2011, a vol. governor initiated payback

Solutions

- Prevention funding – comm.-based prog.
- Realize it is a priority
- Needs to be integrated: continuum
 - o Mental health, substance
- families need more support
 - o NAMI – does good job – needs more funding
- Early prevention/intervention – could prevent
- Stigma – more info and edu. And awareness
 - o Community
 - o Legislature
 - o Teachers
- Establish mandates/parameters that define that need for help
- Educate – RA’s, etc. in college to recognize schools – need a mental health consultant
- Education – on how to center the mental health system
- Better choices – available based on personal strengths
- Pedi’s and primary care drs – more education know their expertise limits
- It takes patience – needs to be started early
- How to find the right providers – psychiatrist, counselor
- Need to know what makes a good counselor
 - o Research needed
- Legislature – Human services vs. reduce beer tax
- Profits from state liquor stores needs to be more than just 9%
- VA system treatment - a GI bill
 - o Assume trauma, don’t want for vets need
 - o Operational debriefs
- Motivational Interviewing and statement of change – continuing education
- More research – how to find and train therapists
- More tacking of outcomes
 - o Can be used for legislative funding
- More beds, programs
- Therapist go to home of patient and peer support
- Flexibility of treatment
- Lessen bureaucracy – more time for treatment
- FMLA – leave job for appts. – flexibility
- Have programs for prevention of recidivism
 - o Funding of success!!
- IMR – psyc – edu program teaches families about illness management and recovery
- Peer support linked w/ clinical, create a family atmosphere, social activities together
 - o It is community-based – where they live!
- shut down the programs that don’t work
- Replicate the programs that do work
- Mentoring programs – match those with illness to those not ill
- Mentoring for parents
- Need medical detox facilities – in patient

- Today go to ER and say suicidal
- Need more beds – i.e. Farnum Ctr
- Dan Petenza – replicate what he does
- Need someone in charge: judge, jails, mental health
 - So no decisions made – collaboration
- Trauma – informed sucs – treat trauma before it becomes substance abuse
 - Treat the root cause i.e. trauma, co-occurring disorders
- Integrating – the economy
- Mental Health Advocates – i.e. NAMI

Priorities

Categories

1. Funding
2. Treatment and Support for kids + families + adults + integrated care and wellness
 - 2a. Prevention Programs – pro-active
 - Correctional system
 - Research
 - Stigma
 - Marketing – public svcs announcements
 - Integrated care in wellness model
 - Advocacy
3. Education – teachers, students, legis, providers, community, vets, stigma (consistency)
 - Legislation

Nashua Group B
Paul Hebert

Focus 1. Understanding the Basics

- lots of similarity w/ 10-yr. mental health plan
- Need more comm. w/ DHHS and NH Listens (about 10 yr. plan)
- Combo of substance abuse and mental health – very prevalent in criminal justice system
- Be careful of terminology “brain disorder” is preferable to mental health
- People view brain disorders differently than other medical conditions
 - o Chronic, but treatable
- Children’s mental health is not mentioned in the discussion guide
- Catching issues early is important and often dismissed as “behavioral” problems
- We rank #1 for under age alcohol abuse
- Lots of inter-generational trends and family histories of brain disorders
- Addiction that starts young is with person for life – often w/ having to choose the least problematic substance to be addicted to (tobacco vs. alcohol)
- How did the system fall apart? (funding)
- Hospitals are ill-equipped to deal w/ acute issues (not dealt w/ the same was as acute medical condition e.g. cardiac)
- Geriatric and youth populations are underserved
- Attitudes and beliefs affect on ability to achieve outcomes → money isn’t the only reason and are the decision makers unduly influenced
- Hard for families to get good information about conditions
- Treatment resources are available based on what is “popular” for funding, not necessarily what is needed (pay or policy drives utilization)
- Chicken & egg w/ stigma & funding
- Sheer will and family commitment are important parts of the solution – can’t just rely on funding
- In crisis now – people need service & can’t get it
- Lack of funding for mental health causes bigger, more costly problems down the road. (e.g. incarceration)
- Resources aren’t there for kids w/ lots of brain disorders

Challenges:

- Funding system is hard to navigate
- Are we spending \$ in the right places (acute vs. prevention)
 - o Real society isn’t factored in
- Prevention is a hard sell, despite the evidence (\$1 now vs. \$7 later)
- Schools not necessarily in tune w/ early detection (parents/others need to be advocates)
- Treatment gap may drive costs later on
- Goal of substance use is to feel better not to get addicted
 - o Current Rx don’t do this
- Families left to deal w/ this on their own (different then “Medicaid” condition)
- Cultural differences are driven by how accessible the system is to the cultural group

- Need to address racism in order to reach our full potential
- History of oppression & racism impacts the reaction that people of different races and cultures have to “the system” & reaction to an individual
- Individual w/ brain disorders are stigmatized
 - African Americans are stigmatized, so there is a double stigmatization for some folks
- Stigma may be worse in NH than nationally (we are not a welcoming state). Lack of diversity makes us distrustful
- Stigma should be fixable – it is just about education
- Stigma is a double-edged sword
 - (people are self-stigmatized and don’t seek help)
- Everyone needs to be educated about this issue, not subsets of the population
- Brain disorders are not really like the way they are portrayed in the media
- Media reinforces stereotypes that are not accurate/representative
- Bullying of kids w/ brain disorders is worse than for other kids
 - Teachers don’t intervene
- Bullying is a focus now, but hard to legislate and enforce
 - Should focus on the victims and how to support them rather than on the bullies
- how to advocate for yourself is important

Responses and Solutions:

- CHINS – bill to offer voluntary CHINS
- Restorative Justice process
 - Have to make amends
- more opportunities to talk (like this)
- Forge common ground
- Brain disorders can be isolating (and self-isolating) → need for more community conversation and support
- More family support and support for families needed
- Schools don’t know how to deal with brain disorders and laws prevent disclosure, which limits the ability to form support groups

Key Questions: What needs to be done to prevent and respond?

- push for more home care is less institutional case (need more \$ for home care). Better supports. More parity w/ how natural Medicaid issues are being treated
- perception in general public need to be better informed. More media attention and better party w/ how Medicaid conditions are veined
- More support for Community Mental Health Centers
- Have to give better tools to schools and improve response to kids
- Implement the laws on reimbursement parity b/w mental health issues and medical issues
- No substitute for natural supports
 - Families, work, etc.
 - Businesses look at risk when considering job placement
- legislators need to allocate \$ for the 10 yr. plan
- Need a fundamental will/desire to achieve good outcomes. Look at model in France (best outcomes, 50% of cost)
- Early diagnosis provides best long-term outcomes. Need to focus here.

- More research into chemical roots of brain disorders
- Focus on kids, but not just in the schools
 - o Educate everyone about the issues
- media campaigns to educate when people will see them
- Media coverage of brain disorders to dispel stereotypes
- Educate pediatricians on screening for mental health issues
- State needs a way to recognize disorders that don't fit existing definitions
- Risk assessment approaches need to be evaluated
- Special/better supports for kids and elderly as they transition to adulthood (how do they deal with the new abilities/responsibilities)
- Need more expertise and experts in the field. (Not enough systemic capacity to handle the needs)
 - o Incentives for people to go into the fields (e.g. loan forgiveness)
- Teach people skills to advocate for themselves

Common Themes/Priorities:

→ Improve awareness

- educate across a wide range of people and constituencies

→ Prevention and early intervention

→ Natural supports and systemic supports (how to strengthen these and balance)

→ Increase staffing and available expertise

- licensing plays a role

→ Find a way to use NH culture as a positive when dealing w/ brain disorders

→ equity/parity of funding for brain disorders and physical disorders

**→ our focus was at 30,000 feet, not on specific disorders

**→ Advocacy efforts are important and shouldn't just be preaching to the choir

(***Group B priorities)

Nashua Group C
Sharon Cowen

Focus 1. Understanding the Basics

- mental illness/substance abuse often co-occur
 - o kids sometimes self-medicate/which do we address 1st (m. illness or substance abuse)
- don't see that other things are considered in background info – just because you have mental illness doesn't mean substance abuse – need a plan w/ accurate data
- treatment works but we have a gap = don't have enough facilities to treat population in state - \$ has decreased every year since 1989
- wrote a 10 yr. plan in 2008 – not implemented
 - o current governors more \$ in budget
- substance abuse and mental health are 2 different issues
- mental health literacy is important – what does each of us know about mental illness – the more I teach clients the better their conditions enable clients to teach others
- caregiver burden
- educated voters will change \$ for mental health
- educate families to bring help to individual
- addiction is chronic disease that has to be treated throughout life
- need concurrent and inclusive treatment of both
- treatment works – documented
 - o have evidence-based practices
 - o we know what works, not funding it
 - o educate voters and legislators
- trauma piece is missing from background info/need to be more sensitive to that
- NOT sufficient community support including housing, personal care assistant, DHHS is broken

Focus 2. Stigma and Challenges

- Bullying is a big problem and contributes to suicide
- Police departments need more training
- Stigma prevents people from seeking treatment and prevents funding
- Stigma results from people seeing effects of mental illness (assign blame/blame the victim)
- For every homicide in NH there are 9 suicides
- Stigma w/in provider community as well
 - o I treat both substance abuse and mental health because many providers wont.
 - o I talk about substance abuse/addiction as a medical issues
 - o Behaviors of clients often lead to stigma
 - o Can't treat mental health without treating substance abuse
- Need to keep people w/mental illness out of criminal justice system w/ treatment punishing and sending to jail don't get treatment
 - o Put in treatment programs - \$ maker
- fewer in-state mental health hospitals= more in incarceration – no treatment/supporting communities
 - o filling jails w/people who use drugs (move to focus #3)
- Child's relationship with supportive adult at early age 0 will prevent problems
 - o Kids having problems at earlier age

- When education personnel see home situation contributing perpetual trauma and stress until child leaves home then get access to abusing substances
- See couch hoppers – only constant is teachers
- multicultural piece – huge Latino, other foreign group pop that are underserved
 - cultural stigma – Latinos don't access services as much – use churches
 - family education important – need more translators
- Suicide section mind-blowing, 15-24 yr olds, suicide is second highest death

Focus 3. Populations for Unique Attention

- PTSD has drawn attention to brain disorders – raised awareness for vets
- Veterans – proper care of returning vets
- VA hospital in Manchester – integrated psychiatric care
- Criminal justice system
- Gender; identity issues – students and parents to help son or daughter, hard to find/refer the right person
- Older parents – dementia/Alzheimer's
- Lack of treatment for perpetrators of sexual abuse
- Mental health centers have limited resources for complex cases
- Homeless/housing/place to live is vital to recovery/lack of available housing for folks w/ mental health
- Mental health 1st aid – educate coaches
- Kids and youth

Focus 4. Responses and Solutions

- Paying Mental health providers better wages – turnover high – personal care providers, mental health providers
- Students incur debt when they go into these careers
- In home support – need consistent providers
- Disparity between public and privately paid providers
- Increase # of mental health professionals working w/ students full-time in schools during the school day/collaboration of school and other community resources
- Parents/family sessions/options available to use school facility, but using outside providers – sharing info when appropriate (private pay option not out of school budget)
- better general education info thru PTO's for parents – when parents hear their child has issues, reaction doesn't always help
- Breaking down barriers to getting treatment – Childcare, transportation, court issues
 - When treatment – person walks not knowing next step
- Need for residential treatment facilities for all ages (including youth) in NH – less restrictive environment – needs to be personalized
- Increase capacity for inpatient community residential facility w/ treatment in a timely manner
 - Temporary inpatient residential treatment at the local level
- Federally funded community mental health centers
 - more psychiatric health center
 - incentivize people to work in community mental health centers (psychiatrist and nurse practitioners)

- Legislative commitment and funding

What needs to be done to prevent/respond to mental illness/substance abuse:

- How severe challenges are – suicide numbers (sheer numbers)
- We know treatment works but don't fund treatment – don't move to recovery – therefore perpetuate illness
- Use alternative and complementary approaches to mental health treatment
- At state level, things get broken up into smaller pieces to respond to specific focuses from each group
 - o Need to educate all groups about what each is doing
- Community approaches to quality treatment – full wraparound and community of practice
- Reduction of bureaucracy
- Person-centered planning – individual treatment plan
 - o Not pre-determined treatment plan
- even at state level needs to be money-finding effort, grants, etc.
- structural, societal problems feed into mental illness
 - o should be addressed – homelessness, poverty
 - o infrastructure to respond to societal issues
- Improve mental health services that are accessible
- Move to managed care has been mismanaged
 - o Decision to do it and then implementation has been frightening
- 10 yr. plan – we have one – don't want to lose sight of it

Nashua Group D
Jeanne Dietsch

Focus 1. The Basics

- Childhood Trauma/Abuse
 - Cycle –
 - Family history
 - 1-5 adults – shocking
 - o experience
 - 2011 stats stand out
 - o assumer increase 2013
 - economic factor
 - o lack of jobs
 - o too much free time
 - o need for escape
 - negativity – healthy to discuss
 - *Attitudes and belief prevent seeking help
 - Afraid to talk about it
 - Everyone at risk
 - o Education is key
 - lack of compassion for fellow nurses w/ addiction
 - stigma
 - knowledge deficit
 - only disease for which you become scolded –
 - lack of compassion among service providers
-
- Stigma
 - Compassion
 - Education – of community
 - Family history
 - Pervasive issue 1-5
 - Economic factors
 - *lack of resources – huge
 - Cumulative stress unknown
 - Difficult to get people focused

Focus 2. Stigma

- Junior high devastating time for children
 - o Bullying
- pride in alcohol
- income for liquor
 - o doesn't support treatment
- limited facilities in NH

Focus 3. Populations

- shocking that more post 9/11 vets have taken own lives
- put \$ into treatment of nonviolent inmates

- shift costs to treatment
- early intervention
- 18-25 = peer pressure, diagnosed stat notable
 - are we getting better at IDing?
- Help populations understand costs
 - lack of awareness
 - lack of belief
- use of prescriptions part of “new norm”
- Children – schools overwhelmed
- Misconception about what is “safe” for underage drinking –
- Norms are skewed around acceptance
- Resources not sufficient for rehab

Focus 4.

- Need collective commitment to deal with it – fluctuations due to change in administration/legislators

Lack of resources

- insurance
- re-determination issues
- lack of access/availability
- limited facilities
- quality of staff
 - training in crisis management
 - interpersonal skills
 - knowledge of additional resources
- court diversion – drug courts
 - more prevalent programs
- more out-patient services
- transitional housing
 - access to C.O.C.
- transitional training

Family Issues and Norms

- need for schools to be more responsive to families
- school can't respond – not their role
- economy issues both ends
 - affluent/low-income – same struggles
- alcoholics in the home
- parents oblivious
- general norm
- Family/people desensitized
 - “only marijuana”
- Norms – more acceptance is use of drugs/alcohol
- Mentality pill culture
- Pills for everything
- Kids are smart, “sneaky”

- Lack of consequences that “matter”
 - o Effects of poverty
 - o Direct correlation
- parenting skills
 - o home remedies
- children’s medicine
 - o labeling not clear
- flavoring – attractive
- stigma
 - o media – promotes stereotypes
- non-professional diagnosis in press
- myths – violence blamed on mentally ill
- **strong positive messaging is needed**
- taboo to talk
 - o people don’t engage because they don’t know what to say
- people assume illnesses are “choices”
- campus programs, peer counseling ← solutions

Solutions

- peer counseling – adults and kids
- PSA
- Early prevention
- DARE program
- Beyond Influence
 - o Also coaches
- social skills in schools
- Nurse as population
 - o Peer support
 - o Mixed reviews/reports on alanon - “out of touch”
- build stronger structure for grassroots efforts
- collaboration between service providers
- planning board Edu
- comparative stats
 - o cost of treatment vs. cost of incarceration
- promote success stories
- “come out of the closet”
- Funding
 - o Programs – exist
 - o Underfunded
- Farnum Center/Keystone – moved from inner city
- Stigma – N.I.M.B.Y.
- Drug Courts – statewide
- “substance abuse”
- Need follow up after treatment, after prison
- Transportation to programs. Halfway houses, transitional housing isolated

Priorities

1. early prevention

- family/school/afterschool
- beyond influence
- PSA to remove/address stigma(s)
- PSA to create new norms
 - Talk about it

2. Transitional Supports

- halfway house
- vocational
- monitoring
- coaching
- community awareness education
- need liaison

3. Ongoing commitment

- state legislature
- courts
- employers
- medical community

4. Economic equation

- shift \$ from court/prison – to treatment and prevention

Nashua Group E
Betsy Houde

What do you Notice?

What's most important to you?

1. Understanding the Basics

- costs increase if MH/SA left untreated
- bullying consequences – victim + bullying
- Medicaid expansion critical for sustainability
- Treatment denied for SA @ MHC + Medicaid also denied → prison
- Inadequate budget to meet needs
- Violence in hoe not adequately assessed or addressed can lead to MH/SA
- Get MH/SA treatment together and include violence
- Nothing had improved in 20+ years
- Actually has gotten worse – ER bottle neck, etc.
- Quality of need doesn't allow for high quality services
- Inattention to prevention early on leads to more \$ services later
- NH is 2nd to last in nation for access to tax
- NH is 1st in nation for more underage drinking

2. Stigma and Other Key Challenges

- Stigma precludes people from sharing story that tax works and is needed
- Media portrayed is counterproductive
- "Politicians" use term "Mentally Ill" in Gun Safety argument, yet is data mismatched
- Stigma w/ general population interfere w/ access to tax
- "No casserole disease"
- suicide #'s under-counted due to crashes not accidents

3. Populations for Unique Attention

- Elders often overlooked – families not available, poverty, depression, = more need
- Seniors vulnerable, fixed-income
- Elders and older adults use masked → increased falls, etc. seen in ER's which stems from sub. Use not revealed
- Lack of Rx monitoring to ensure people taking proper meds and amounts
- Incarcerated - inadequate services for population
- Youth – growing pains vs. developing dependence
 - o Early education and testing
- Adults often became SA dependent from self-medicating
 - o Undiagnosed MH issues
- Veterans – lack of inpatient care, while O.P. services were doubled – only state w/out full-service V.A. facility
- Housing stabilizes everything. 8-10 yr. waiting list for safe, acceptable housing

4. Responses and Solutions

- Sounds better than it is in reality
- Access is one thing, lack of safe, quality housing is different –

- Lack of landlord willingness, etc./stigma
- Inadequate salaries impact workforce and doesn't equate to challenge of the work
- Promote cost saving/lives of prevention as savings in Tax costs
 - Why aren't we investing?!?
- Prevention saves lives + \$, why aren't we doing it?
- Capacity for inpatient beds and group homes for chronically mentally ill
- Greater # Assertive Community Treatment teams (watch jargon!)

Key Questions and Priorities

- more voluntary and involuntary inpatient MH/SA beds w/ seamless
- transition to community-based services
 - currently revolving door w/ ER and meds while waiting for bed and then discharged w/out long term care
- insufficient resources for MH + SA affordable assessment and tax
 - wind up in jails instead
 - more quality, EBP, and timeliness
- In NH, can't involuntarily commit someone for substance abuse – silos – MH you can!
- People incarcerated don't have enough services and doesn't often start until you're almost released. (Start at point of entry ideal)
- More early-intervention in schools
- Student assistance programs and peer supports
- Enhance K-12 health curriculum to include current info
- Promote Life of An Athlete – high school and younger
- Access to safe and affordable housing
 - Cornerstone of well-being
- Access to affordable SA/MH services
 - EBPs
 - Farnum ctr. has beds at \$8,000.00
- More training for officer, guards, and other w/in corrections system for more proactive understanding of SA/MH issues
 - Crime trumps need for services
- More community reintegration – jobs, etc./mentoring
- Mental Health courts showing + results –
 - Need to be expanded
 - Alternative sentencing
- Address long waiting list at MH centers –
 - 6 weeks → 3 month wait
- lack of O.P./inpatient psych providers for children/teens
 - and particularly that take Medicaid. Possibly due to low reimbursement?
 - Greater Medicaid reimbursement rates

Final Report Out

1. Build safe and affordable housing for all populations
 - children successful
 - reduce homelessness
 - those leaving corrections

- those w/ MH issues
 - promotes stability for employment retention
2. Fund effective prevention programming at earliest level
 - K-12 health curriculum
 - Student assistance counselors
 - Prenatal SA screening
 - Community programs i.e. Life of an Athlete
 3. Expand affordable, effective, timely screening, assessment and treatment and recovery services, both community-based and residential and inpatient beds
 - behavioral health
 4. Develop and **deliver!!** Training for corrections officials, educators, law enforcement... all those professionals that work with those struggling w/ SA + MH
 - plus the general public to address stigma

Plymouth Group A
Mollie Farnham

What do you notice: **Brainstorm**

Focus 1. The Basics

- underage drinking shocking
- NH had enviable MHC system 15 yrs ago
 - o Funding cuts have dismantled
 - o (broad base tax to support)
- Re-open beds!
- Address stigma; how to reach homeless? How to help those who refuse?
- HIPPA Regulations: Alternatives to commitment, re-evaluate systems to keep supports (family) intact and trusted, and informed. Family Driven Care
- Providers fear of lawsuits. Need provision to release info to prevent crisis
- More trained staff!! (fairly paid)
- Substance abuse; need more in-between community continuum of care (detox facilities, housing, support groups)
- Mental Health worker at homes; re-instate these services and funding, including conditional discharge

Focus 2. Stigma

- support families; dispel myths to public
- get recoverers integrated into rest of community. Assistance/network to re-connect
- educating employers
- most people recover and live healthy lives: With Treatment
- public health education on mental health and importance of treatment
- address issues of stigma with providers (Teach how to talk to family members.)
- local, high profile disclosure to illuminate prevalence
 - o 10 % of people have experiences

Focus 3. Unique Populations

- Spend \$ for tax and prevention; not incarceration
- Recreational marijuana use affect upon ppl with mental illness?
*Want answers: is it safe?
- **Opiates?**
- Effect on youth
- Need vets services here (closest hospital in White River, VT)
- NH an aging state; make plan for services for older adults (transportation, providers, meds!)
 - o Visiting elderly important
 - o (isolation an issues, basic needs)

Focus 4. Responses and Solutions

- Attract and retain mental health providers. Young career people.

- Address low-resource areas in state
- Education system in-state for MH profs. (Plymouth state; addiction training)
- Adequate services for parolees. (and follow-up)
- Improve MH courts to catch initial tax for people. Educate Law enforcement.
- Prevention
- Implement integrated services
- Educate families and services; point to help. How to navigate system?

Key Questions and Priorities

- \$ and resources
 “pay now or pay later”
 - o education
 - o advocacy
 - o qualified/well-trained professionals
 - o continuity of care: services; person/patient – centered
 - o more community treatment teams
 - o need facilities
 - hospital space
 - housing w/ supervision
 - clinics w/ supervision
 - o enhancing and utilizing what we have already

Communication

- HIPPA; providers encouraging staff to include families
- NAMI group/support groups} in this region; advertise, staff
- Educate and encourage policy makers to do something
- Educate general public and employers
 - o Facebook, twitter, exchange
 - o Use media to draw attention and dispel stigma
- providers not as afraid of being sued
- train law enforcement (to decrease stigma to treat people appropriately)
- *sensitivity training*
 - o by mental health care workers
 - o adapt best practices from other areas
- policymakers in NH; revisit 10 yrs ago
 - o what was working?
 - o Compare cost of tax then to now (including law enforcement, courts and jails, higher in crime)
 - o Was there more supervised housing in past?
- hearings with legislatures
 - o emphasis prevention
 - o testimonies from stakeholders
 - o appalling subs. Abuse stats in NH; too little tax
 - need services for all

Access

- make it real w/ services

- Parity; yet behav health treated as a specialty. Needs to be primary care (cover and conceptualized as primary care)
- “behavioral health is primary health”
- navigating the system
 - o simplify and help people navigate
 - o streamline; continuum of care
 - o more benefits specialists
- dept. of insurance
 - o make it easier, more clear
- transportation to/from services
- Single payer system
- Integrated primary care
 - o Payer sources all in one place
Information and services
- Need early detection, services for children
- Make info easier to get
 - o Ins. Benefits, (pre-auth) services, trained personnel, streamlined
 - o Medicaid now 3 for-profit
 - o *Companies? Is this smart?
 - o Go back to non-profit system*

Plymouth Group B
Bill Ploog

Focus 1. Basics

- *First in Nation in alcohol- surprise
- some of the worst stats we have the fewest resources to address them
- importance of recovery for H.S. dropouts
- Prevention at the smallest possible w/o thought of consequences

Focus 2. Stigma

- Stigma causes problems for those who need services –
 - o Stereotypes reinforce (the few who fit the stereotype reinforces...)
- public education is extremely necessary
- no disc/documentation of successful treatment
- no one tells their success story – desire for anonymity
- reverse “stigma” → moral superiority to others

Focus 3. Unique Pops

- they are vulnerable populations
- prisons make people worse; no follow up if they have issues
- drop off at the homeless shelters

Focus 4. Reponses and Solutions

- *need more \$ (NH has structural deficit)
- no political will in state to raise revenue
 - o the existing system cannot raise enough \$
 - o more to do w/ political will
- *need more case management follow through OR family/patient support specialists
 - o “continuity of care” for mental health issues

Key Questions and Priorities:

1. Challenge – Raising needed tax revenue
2. Challenge – raising public awareness of these issues
 - o impact of mental illness on communities
3. challenge – denial of mental illness w/in the family
4. strategies: addressing mental health issues in early life
5. challenge: mistreatment of mentally ill by medical professionals
6. strategy: importance of consistent support – importance of care
7. The programs are not accessed because: program is full; no transportation; requirements such as you must be homeless
 - o dentists not taking Medicaid
8. No program where they have family support (or no program)
9. Case manager/Comprehensive services are necessary especially for tough case – residential community

10. Priority: decrease waiting period at emergency rooms
11. Too few mental health treatment professionals and facilities and beds
12. No support after treatment; no in-between treatment for transitioning to the community
13. No housing available for late stage alcoholism (no wethouses)

Community Solutions

1. Comprehensive support – continuity of care
 - wrap around care
 - assertive community teams – intensive care
2. Don't Give Up!
3. Educating the public –
Examples of success – by those affected
 - “personal testimonials”
 - films e.g. in the schools
4. Caregiver support is needed

Key Questions

1. Talk to your legislators!
2. Art and Photography exhibits by mental/substance abuse
3. How can we be effective in talking to legislators? Talk about your life experiences.
4. Corrections facilities have become mental health facilities: work w/ judges to get offenders referred to programs – like a drug court

Plymouth Group C
Alan Robichaud

Brainstorming: understanding the Basics

- early impact of trauma
- Genetic factors
- Prejudices – cultural disrespect
 - o Language, at work
- low % being treated
- contradictory indicators NH-1; NH-last
- public perception is that we are doing much more in hospital beds
- system navigation is very different
- gaps in services causes long waits
- NH went from **worse to first** in MH
- Difference between physical; mental health
- ER with intervention is damaging
- Loss of core community services makes services thin
- Why such an increase in MH?
 - o Cuts in prevention in community
 - o Loss in infrastructure
 - Residential
 - Crisis
 - Voc. Program
 - o Population has doubled/less psych. Services
- long waits for Medicaid eligibility
- state eligibility for disability determination is 4 years
 - o nat'l it's 1 yr
- misunderstanding of how the system works
- mental health centers are forced to bill as a medical service yet there is no parity
- perception need vs. ability is distant

Stigma and other Challenges

- stigma itself
- people w/MI are violent

- Actually people w/ MI have higher rates of suicide
- Media exploits stigma (guns & MH)
- People w/ MH may not seek out services because of stigma
- Cultural expectation is that you pull yourself together
- Need a diagnosis before you can be served. No early intervention – “Labeling”
- People don't get visited in the psych ward
- Perceptions toward substance abuse
 - o Behavioral – vs. disease
 - o Disease is not a choice

Populations for Unique Attention

- large veteran #'s
- unemployment rate of veterans is much higher than the general population
- societal issues are great on all these populations
 - o veterans – re-integration (trauma)
- criminal justices stats re: incarceration
- incarcerated women rates are higher than men
- stigma x2
- start prevention at much younger age
- lack of support and follow-up after incarceration
- people w/MH issues and SA issues are warehoused in county facilities
- criminal justice = stigma
- more in mental health and drug courts; and veteran court

Responses and solutions:

- integrate social structures/stop silos
- more \$\$\$
- connect MH & SA (co-occurring)
- parity w/ physical health
- more impact – how is the money being spent
- implement the “Plan”
- his is everybody’s plan
 - o healthy community, prosperity, safety, quality of life; “It’s the right thing to do”
- need an informed Public/Public leaders
- need to tell real stories
- Show me the budget and tell me your values
- Start with the kids (early intervention)
- Adopt other countries’ models

Key Issues:

- NH went from First to Worse
- Youth Services
- Reduce stigma
- Systems & structural change
- Co-occurring dx-treatment together
- More funding
- Parity w/ physical health
- Community engagement/everyone’s issues
- Relationship of MH & SA to poverty
- Social issues to create other issues
- Values

Key Questions and priorities:

- Generate Social capital
 - o Retired professor became re-engaged
 - o Community health worker
 - o Vis-à-vis – meals on wheels
- peer-lead services (self-help groups)
- **Early intervention – how to be a good community member**
 - o **Responsibility**
 - o **Respect**
- awareness of behavioral issues
- mentorships
 - o teachers
 - o parents
 - o community leaders
 - o elected officials
- **values – what do you want our communities to be?**
- **Develop “community” plan – model**
 - o **Annual report card**
 - **Relevant data**
 - **Local resources**
 - **Local people – stories**
 - **(social capital)**
- Language – understanding
- “Do Something!”
- Confront the fears of MH and SA
- Check out European systems
- Success of the whole is dependent on the success of each one
- Resources are being absorbed at a higher rate in treatment yet prevention is less costly and more productive
- MH, as under-resourced as it is; is better resourced than SA
- We’re changing a battleship; not a row boat
 - o Don’t be discouraged
- the community needs to step up and work in tandem with the “system”
- We need to value “people”. They need to be a priority.
- Change people’s attitude; then behaviors, then conditions change
- Policy also needs to/can change behavior (e.g. smoking)

Plymouth Group D
David Lamarre-Vincent

What did you notice? What is most important about the information?

- treatment 2nd last NH – Surprised
- shocking in NH \$ + last in treatment
- 20% 207,000 mental health
- Impact measured in cost \$
 - o Treatment early – late
- 2/3 w/out mental health treatment
- CMHC serving poor + limits
- Parents 75% of kids in foster care
- 1st in underage alcohol use

Focus 2. Stigma and Key Challenges

Notice? Important?

- 75% assault, domestic violence, under influence
- “queer” youth –
- trauma kid reversible
 - o caring adult
- Not getting early treatment
- Prevention, childhood treatment
 - o Leads to consequences
- 24% MH illness “dangerous”
- 39% unpredictable > isn’t this low?

Stigma

- Vets at home after combat
- 30% believe M ill can recover
 - o includes well and ill
 - o why do anything about it...
- Suicide and youth 2nd leading cause death
 - o Violent death ???/not silent

Part 2.

PSU - Suicide Prevention rant/more in every school

- education to decrease stigma/shame and to community as a whole
- stronger social welfare foundation
- more drug/MH courts in NH
- facilities treat co-occurrence/new paradigm facilities
 - o more providers
 - o VA?
- providers not able to handle #'s
 - o esp. with intense services
 - o no appropriate services to deal w/ age levels

- more family support
 - o GP home for families
 - o Tired/exhausted/parents need help w/ w/o MH issues themselves
 - o Too many
- Silos – NAMI/drug courts/MH Agency/DD area/DRC
 - o Hosp.
 - o Therefore end competition over shrinking \$
 - o Will managed care has potential
 - o Work in advocacy

Focus 3. Populations for Unique Attention

Vets/Youth/Older/Poor-Homeless/Criminal

- *correction our news institutions 75% D/A
 - o women 71% MI
- *50% of MI by age 14
 - o over lifetime
- *67-70% Youth JJsys + Mental Disorder
- *Homeless/Housing + MH – ADA8
- *Relationship of disability + poor
- *older in 20 yr doubles
- privatize corrections

Responses and Solutions

- *10 year 2008 - + now 2013
 - o solutions need will and funding
 - o w/ mandated care companies
- *Community Support hard to get housing w/ criminal record/MH
- *Misunderstood + nothing can do
 - o therefore lack of will imp. Public ed.
- *Health/Medical work with young adults
- *lack of child psychiatrists –
- *Mature system and strong family support with DD needed w/ MI families for support/Ed./advocate and diff. get guardian/us indep.
- *Business – clear messages a la tobacco

Part 3.

- collaboration
- whole village
- e.g. family resource center
- Community level agencies compete for \$
 - o Break down barriers
 - o See successful as aspiration not enemy

+ Mental Health court for adults

- pulls system together

County voted fund restorative justice

- Plymouth 13-17 Lebanon
- (Littleton/Haverhill stat up \$)
- ½ NH w/o juvenile diversion

Old CHINS gone/New CHINS?

NH H \$ COT – no weekend admits

- fewer beds
-

Do Advocacy

- more Ed./lots of ignorance/prejudices by leaders
- teachers/P.D./cont. Ed.
- State – letters to house/senate

A:

- More funding
- Existing funding – used more effectively/collaboratively

Near Future > Current opportunities

- E.g. “Youth Villages”
 - o Chicago program Vets and youth
 - look to existing successful programs
-

B:

- Common theme for mixed agencies
 - o E.g. whole village re children
 - o For shared action/service/collaboration
-

C:

- Education and Advocacy
 - o Indiv. – for consumer indiv/family (e.g. common release)

schools/jails/connect people
 - o + Group remedy misperceptions of leaders

Plymouth Group E
Paul Susca

Focus 1. Understanding Basics

- 20% of NH adults – Mental Health problems this year
- contributing factors: family history
 - o often function/result/product of Biol. factors and/or life experience
- P.10 graph: misleading; suggests faster turnover (quicker “core”?)
- Graph (p.10) and stats may be misleading
- There are not enough beds.
- **Big Picture: NH has a problem**
 - o Not enough understanding/discussion
- General population not aware unless direct experience
- Include stats on E.R. backup
- Stats on lack of providers should be here
- Cost of problem
- NH #1 underage alcohol abuse

Focus 2. Stigma and Key Challenges

- **Stigma** drives lack of public awareness and support for services
- Alcohol use has the least stigma
- Homeless who are alcohol abusers – lack of services
- Are there other conditions (cancer?) that provide lessons re overcoming stigma?
- Suicide: worrisome stats
- Importance of stigma should be emphasized
- PTSD & drug use among veterans could help w/ awareness/acceptance; reduce stigma
- Culture has made progress
- Many “webs” of stigma – goes beyond individual; affects support networks – stifles support
- **Culture of bullying** (←Leadership) supports further stigmatization
 - o Politicians, prof. athletes
- Need for civility in society
- Greater acceptance of other differences ...could be leveraged here (MH/SA)
- Blaming

Focus 3. Populations for Unique Attention

- Physically ill and disabled are another at-risk population
- Numbers of older adults needing services will grow
- Economic stress (increasing) among older adults → MH issues

Focus 4. Responses and Solutions

- “Addressing the Critical MH needs...” very valuable but has been ignored
- have creative ways to ensure access to MH services
- Young adults need ways to have social life w/out drugs
- Restoring self-esteem and connection to family
(related to stigma?) – Peer support?

- Need **moral will** to fund programs
Where's the \$?

Key Issues/ea. Person

- Homeless – need cold-weather shelter (overnight), day shelter, “wet house” (place where they can drink)
- **Stigma** and **money**. People in MH field need to talk to politicians
- **Community-based** care needed – would address statewide issues
 - o Needs to be **fully funded – centrally funded, locally run**
- Drug and mental health courts
- **Collaboration and coordination** of services
- Acceptance of gay rights could be mode re: stigma
 - o Does not have public cost
- Interconnectedness w/ other issues, esp. “Live Free or Die”
- Need to acknowledge **shared responsibility**
- Best – practices will vary place to place
- **Non-categorical care**
- **Housing first**

Community Solutions, Next Steps

- how will this conversation make a difference?
- Eventually it will be the right time
- Don't forget art! As example of new ways of dealing w/ MH and SA
- We miss a lot when we only focus on best practices.
- Continual need for awareness and education so more people know magnitude of problem
- Success stories and story-telling/art/media
- Town meeting as a venue for building awareness
- It's not just money – coordination; “collective impact”

Portsmouth Group A
ML Hannay

Key Topics → brainstorming

- only 10 community mental health centers serving 50,000
- MI + SA are both treatable
- NH ranks 49th for being able to access SA services
- 21 % with serious MI getting treatment
- 1st in nation for underage alcohol
- 3rd in nation for 12-20 drug use
- **Treatment works but not accessible****
- Huge gap in opportunity to access
- Education (impact missing)
- # of beds less in 2001
- 21 day wait
- treatment
- Mental health and SA affects family, jobs, etc.
 - o So little “basic information” out there

Stigma and other Key Challenges

- parents still blamed even after 18
 - o HIPPA prevents parents from knowing
- relapse ≠ failure
 - o is a setback
- 75% of parents of children in foster care have records of SA problems (a surprise to some)
- Stigma cause → victims of crime – not perpet.
- More vets since 911 have committed suicide than dies in combat
- Obituaries rarely ID suicide, addiction or MI
- Not mentioned: Stigma/myth that SA is a choice
 - o Fact: brain disease
- family stigma: isolating, MI + SA

Populations for unique attention

- NH the only state without full service vet facility
- Education needs to be a big player
- 14 age group highly vulnerable
- HIPPA prevents parents from knowing about their young adult, child w/MI
- **??** MI Assoc w/poverty
 - o that is myth and stigma
- we are all vulnerable
- vets with PTSD – counselor never been in combat

Group React/Finalize Key Topics to address and Discuss:

- NH stats = cone of shame
- Accessibility
 - o Inpatient/outpatient transition
- ID leverage points to impact change in NH
- Disparity b/w data + NH
- Stigma and ignorance
 - o It's a family disease
- treatment works
 - o longer the better
- Advocacy: casserole disease; lime green = limelight
- Veterans underserved in NH for MI+SA
- Schools and jails are places for finding what works, strategic interventions

Responses and solutions

- *more short term intervention, more mental health prof.
- criminal justice system in underutilized as treatment entry for SA
- education
- full service vet facilities
- determining right # of beds
- treat relapse not as a failure, treat it as a setback as in physical chronic diseases
- **more assisted living facilities for SA**
- providers need to focus more on – impact of relapse
- Early ID
- Make it a casserole illness
- Vets → counsel other vets

Priorities/Solutions/Actions

- more public dialogue
- use lottery commercial
- treatment mandated in sentence
- us vs. them → use bullying; model bystanders
- "Them is us"
- Glen Close
- Become involved w/ Gov't
- Easy Access – Small state → 7th in world, 3rd in Western Hem

Other Solutions:

Doctors – S-PERT → Access

Question re: SA/MI problem

- Education possible
- 60 day not 30 SA treatment minimum
- no detox coverage in some insurances

- impact of Medicare
- Invest in outpatient/transitional
- We must have a voice to make change
- Individuals with MI + SA must want help
- Advocate like those w/ developmental disabilities
- workforce retention at community mental health – pay more to retain

Specific Recommendations:

1.

- access – use small state to our advantage
- advocacy must be increased by us to state legislators/ reps
- unify stakeholders – consistent basic

2.

- Increase public dialogue to lessen stigma, dispel myths, educate, make it a public issue, then is us
 - o Remove the shame
 - o E.g. mandatory subj PTA meetings
 - o Coping skills
- casserole disease and limelight
 - o be more public personally

3. Publicize disparity between data + NH stats

4. More inpatient, outpatient transition

5. Vets: educate public about treatment, stats

- Providers asking the right

6. When a provider/pharmacy gives out scripts, also give N.A. list

? National # for A.A. on all alcohol

7. Adequate access for continuum of care – see # 1

- inpatient, outpatient, transitional, housing

8. Mandate alcohol tax

- funds prevention
- + education
- + treatment
- cannot be diverted

9. Schools and jails primary places for prevention, intervention (strategic) and treatment

Portsmouth Group B
Bert Cohen

Understanding Basics:

1. political problem
 2. Funding is challenging
 - alcohol sales = generate fund
 3. legislators not making mental illness a priority
 4. Stigma – prevents people from standing up
 5. Advocacy is lacking
 - lack of understanding around advocacy
 6. Need for more state-wide participation – public/private
-
- alarming – lack of resources for vets
 - patients/clients – major challenges in advocating/identifying support – falls to families to assist
 - Financial/hardship ripples productivity across families
 - employers not making support a priority
 - educational system also lacking in providing support
 - lack of discretionary funds for mental health treatment
 - allocate \$ to people rather than specific programs
 - more understanding/education related to prevention
 - more prevention = less stigma
 - EAP – Employee Assistance Program – helpful outlet/resources
 - Instead of guardianship – parents need option to become part of care team
 - HIPPA – one place for someone to I.D. parents to be part of care team
 - Parents at mercy of children signing/not signing documents which enable/prevent access to children
 - solution – become part of health care team
 - emergency mental health centers for NH
 - NH needs more beds
 - Lacking residential beds/opportunities
 - Limited access to care → victimization, homelessness, poverty
 - Stigma – makes it hard to move residential into communities
 - how to overcome – education programs
 - great model for mental health – breast cancer
 - parent involvement – accessing information
 - young adults – talking to young adults
 - building connection – identity
 - build into health care curriculum
 - Exeter high – NAMI – student brought programs in to school – Sustainable
 - Early screening and implementation is missing
 - Not supported by healthcare system
 - Schools, parents lack training

- Parents/young adults need more access to information to help them start dialogue about mental health

Solution: merging mental/physical health – one stop shop

- have more mobile mental health first responders
- law enforcement collaboration – CIT from NAMI
- Mental health – first aid training

Challenges:

- Political
- Legislators not making MH a priority
- Patients can't advocate for themselves
- Lack of providers – attracting them to NH
- Lack of discretionary funds for treatment
- Early screening and identification is missing from healthcare
 - o Schools, homes
- Separation in treatment parity b/w brain (physical) and mental – as culture makes separation

Solutions:

- more legislative recognition of mental health challenges
 - strategy to praise political profile – when incident occur we need to take advantage of opportunity to raise issues
 - adopt a legislator – NAMI
 - address funding gap
- equip people with more tools and resources to be more effective advocates
- more public/private partnerships
- more resources dedicated to early prevention, identification, reducing stigma
- Emergency mental health centers
- 5MADD campaign – national scale campaigns
- Breast cancer campaign – best practice
- 1 More mobile mental health first responders
- 2 Emphasis on integrated/comprehensive care system

- ER's not equipped for mental health patients in NH – need to resolve this
- Public policy challenge – Medicaid expansion
- How Medicaid expansion is achieved is important
- Diagnosis determines – services/access
(brain vs. mental health) - more resources for physical (brain)

Portsmouth Group C
Gregg Spaulding

Focus 1. Understanding the Basics

- Treatment Gap
- Attitudes and beliefs impede ability to provide services
- Not comprehensive services
- Medicaid doesn't pay for services for(?) those not licensed MH practitioner
- Inability of family and person affected to recognize problem and get help

Focus 2. Stigma and Other key Challenges

- misperception that treatment doesn't work & that those w/ mental illness commit more crimes
- star(?) school system – take bullying data and do analysis and intervention policies
- help parent be the caring relationship that reduces the effects of trauma and stress

Focus 3. Populations for Unique Attention

- # of older adults doubling next 20 years
 - o not prepared to address their MH issues
- Veterans – Need MH/substance abuse facility in NH
- MH/young adults costs society if untreated or prevented...
- For example, 71% of incarcerated women have MI

Focus 4: Responses and Solutions

- Community MH workforce developed and trained
- Political – reframe MH issue solutions as an investment in society
- Successful access to care

Key Questions and Priorities:

- Execute/Implement existing 10-yr plan (no funding)
- **LIVE WELL & THEN DIE**

- reducing Stigma

- huge gap between planning and implementation

Treatment gap

- availability of services
- unrecognized affliction and ability to get help
- Destigmatize/prioritize & fund for treatment and prevention vs. consequences

- **#1 Destigmatize** by acknowledging it as a public health issues
- Define addiction as a mental illness and reject it as a moral choice
 - o Promote education and information
- classification roadblocks to care
 - o parity of mental/physical illness for access to care
- understand anyone's struggle is everyone's struggle

Group recommendations:

- reduce Stigma related to MH & SA
- Reframe issues to be a public health issue
- Treat MH & SA treatment as an investment
- Address existing treatment gaps
- Define addiction as an illness + reject it as a moral choice
- Promote education + info
- Raise level of compassion for the struggling
- Fund, Execute, & Implement NH 10-yr plan
- Change state motto to “Live Well Then Die”

Portsmouth Group D
Robin LeBlanc

Focus 1.

- 20% of Am. Seemed low (2nd par. Pg.8)
- II co-occurrence of subst. abuse and MH issues really imp.
 - o About 85%
- insufficient treatment of MI led directly to SA
- Multiple MI diagnoses increases SA
- NH 2nd to last in nation for MI treatment disheartening
- NH waiting list to get suboxone (treatment for heroin, limited # prescribers)
- Physicians aren't in position to provide full range of services needed
- Suboxone + methadone are big lies
 - o Enriches pharmaceutical companies
 - o Molecularly identical to heroin
 - o Drug replacement therapy doesn't work
 - o Either clean or not

Stigma – big disconnect between people seeking help and for people knowing someone needs help

- important for people to know MI
- more likely victim than perp of violence
- media plays up small %, perpetuates myth
- assumption that someone who commits mass murder would have to be mentally ill
- stigma keep many w/MI from testifying or even speaking to policy makers – very powerful if do
- magnifies if multiple issues
- lack of solid fact-based info

Populations:

- Dad was Korean war vet w/ undiagnosed PTSD. Alcoholic
- Husband air Nat'l guard – feels military stigma of seeking treatment for PTSD could make it mandatory to attend NAMI presentation
- Fire and Police missing from list
- MI shows up a lot by 14. Best if treated early
- 1 of 8 hs students have diagnosable SA problem, schools not equipped to handle
 - o SAMSHA
- NH doesn't have good treatment for SA, esp. for youth
- When released from prison w/ no support, ended up back – get food + shelter. Even though community friends tried provide support
- NH nat'l leader for work in prisons to prevent recidivism. Not continued out in community.
- Dad vet of WWII – always in rage
- Before died told granddaughter his own story – not his own children

Responses and solutions

- need more resources for prevention
- Provide PTSD services to veterans even long after military service over
- Compulsive behavior is shame-based
 - o Low self-esteem
 - o Guilt
- being addicted isn't about the particular substance. It's about what's going on inside
- Learn more about disease concept
- Brain changes when addicted
- Prevention is hard because can't predict

What needs to be done:

- III Funding – for prevention
 - o Restore legislated % of alcohol tax to Gov Commission
 - o Pay now or pay later
 - o Stigma reduces funding
- II stigma reduction on multiple levels
 - o Und. Role of domestic violence as cause
 - o Availability of services
 - o Better information about avail. Of services
- II more community conversations (better together)
 - o Honesty
 - o Open-mindedness
 - o Willingness
 - o Caring
 - o Love
- Draw policy makers into conversation
 - o Get \$ out of politics so politics neutral
- help people und. The value/potential of each person
- stand up together – connect grass roots to grass tops
- promising practices
- law enforcement; schools }can't solve
- engage business – they can change culture – declare “this is a substance-free culture” can branch out to home
- Create culture where “recovery is cool”
- Champion prevention
 - o Intervention
 - o Treatment
- Need solid strategies before society invests
- Recovery from MI
 - o Just hear bad stories
- People don't want to pay taxes
- Families of people w/ dev. Disabilities are a powerful force. Storytelling is effective. Worth time to organize NH residents
- Recruit people by asking, “are these issues of concern to you?”

Specific Recommendations:

- address the big picture (holistic, comprehensive approach)
 - o while keeping in mind the distinct needs of different diagnoses
- empower those who care to become a lobbying/political force
- Get facilitator training through NAMI and/or NH Listens

How to de-stigmatize:

1. Education on all levels
 - telling/sharing personal stories
2. Figure out strategies to de-stigmatize in special populations, e.g. youth, vets
3. Normalize – since 1 in 5 people have MI, then you probably know someone
4. Funding needed for all aspects make case for cost of not funding

Portsmouth Group E
Maria Sillari

Basics:

- NH 2nd to last for SA txt
 - o 1st underage alc use
 - o lack of resources
 - o 20% deaths → addiction
- NH Hosp. admissions charts
 - o Large decrease in # of beds
 - o ? discharged too early?
- M'aid expansion w/d
 - o More txt to # 8,000
- Untxt'd MI + SA = more \$\$
- 2/3 MI + 90% SA not txt'd
- NOT included in data – kids starting to use drugs and alcohol
- Unfunded mandates in the CMHCs – Are ppl getting services they need?
- Missing info → difficult to put together staff dev't and retention opps in the CMHCs – zero \$; zero time
- 8 mil adults w/ co-occurring disorders
- Staff retention → difficult and complex population
- In 10 years it's gotten worse
- Some things we aren't doing
- STIGMA

Stigma and Challenges:

- post 9-11 vets taking lives > # killed in action
- NH 1 homicide = ~ 9 suicides (suspect more), 9 **confirmed**
 - o In CMHC – suspect another 40% deaths → suicides
- 75% DV → attackers under influ of alc/drugs
- Ages 15-24 – suicide second leading cause of death
 - o ? relation to bullying and social media
- MI (txt'd) more likely to be victims of violence
- School approaches to address bullying don't get at the culture at the root of (social media)
 - o Cosial media – big, overwhelming
 - Not enough data available on the impact/correlation
 - Needs to be part of school culture
- begin to talk about illness + health, not mental illness
- Separation between medical and MH health
 - we txt diabetes, why not MI?
- work – MI on record can impact job

Populations:

- NH – only state w/out full service VA facility
- 56% state prisoners – mental illness
 - o est'd 71% of women
- ACCESS

- Importance of txt/intervention at first incidence of schizophrenia
- Lack of sub. Abuse txt services
- Not avail even when you're ready for help
 - Short term
 - Or expensive
- female vets, prisoners – mental illness, high #'s overall for females
- Anticipated growth of elders w/ co-occurring
 - SIGNIFICANT
- NEED FOR STABLE HOUSING – TRULY IMPT
- ? Accuracy of correlation between poverty and mental illness

Reponses and Solutions + Priorities

- NH HAS A PLAN that has been effectively ignored
 - START HERE
 - seemed hopeful
 - \$ decreased since written in 2008
- Drug and Alc – 6% is supposed to be dedicated to prev. and txt. → 1/5th actually is
- Speak repeatedly w/ legislators, not just about budget time
- STIGMA – no one blames the developmentally disabled – many blame the mentally ill or substance abuser
- PREVENTION – return on investment not immediate
 - not patient to wait for outcome/impact
- PUBLIC EDUCATION & AWARENESS
- IS ANYONE LOOKING AT WHAT'S WORKING WELL?
- SUB ABUSE PREV + MH PROMOTION – Strafford County
 - This is working
 - **COORDINATED SCHOOL HEALTH**
 - Results: less sub abuse, more accessing services, less depression
 - Less \$ - starts in kindergarten
- FUNDING MECHANISMS aren't flexible
 - REDISTRIBUTION
 - \$Need \$Need \$Need**
- FOCUS ON MEANINGFUL OUTCOMES
 - STATE EVIDENCE BASED PRACTICE
- BUT MEASURES #S, FIDELITY to program w/out looking at outcomes
- HARD TO GET HELP – Where do you start?
- “Didn't meet criteria for admissions” (Hosp)
- Need to hear more from people experiencing it
- MORE EDUCATION AROUND + SUPPORT FOR TRANSITIONS
 - i.e. txt → rtn to school
 - i.e. 21 yrs →
 - TRANSITION TRAINING – Need for, training, \$ for
 - Txt → work
 - Incarceration → release
- NEED MANY NON-INTIMIDATING ACCESS POINTS TO CARE/SERVICES/community supports
- *WORKING: De-escalation program for POLICE

(community connection; educ) (CAP?)

- *SAMSA's "MH FIRST AID" program – Educ and awareness Campaign for community
- CONVERSATIONS ARE great start - want to see something come out of this - MOMENTUM
- MH/SA – considered part of health – NORMALIZE
- Youth to Youth, TEEN INSTITUTE – Valuable programs
- ? HOW TO IMPACT systems change? = seat belts, smoking
- START W/ THE MESSAGE TO CREATE CULTURE SHIFT
- CONTINUE "SBIRT" DEVELOPMENT + MOMENTUM – VERY POSITIVE
- HLTH HOMES ++
- PMP - ++ - ACCESS TO A PERSON'S MEDICATION HISTORY
- Create Statewide initiative to provide transparent data
- NEED "Wellness Umbrella" – access to services
 - not just 1 but many – nutrition, etc.
- DEBUNK THE MYTHS
- Continuity of care and more communication between providers
- CHOICE
- HELP PEOPLE COME OUT OF ISOLATION – NOT BEING ISOLATED IS PART OF RECOVERY
- It's WORKING – HEALTHY CHOICES, HEALTHY CHANGES
 - Out of Monadnock CMHC

Portsmouth Group F
Robin Albert

What did you notice?

Part 1.

- Numbers are staggering
- Cost to state of NH – {stats are staggering and eye-opening
- % of population
- 1st in nation youth alcohol
- 2nd to last people in need of substance abuse treatment

→ important: **continuum**

- understanding “we-them” counteracts stigmatization to understand the continuum
 - **We see people in crisis –**
 - o **People in recovery are “mixed in”**
 - o **We don’t “see” people flourishing in recovery**
 - Sense of shame that NH is **failing people re: providing beds and treatment**
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- **Neg. attitudes can = discrimination**
 - Discrimination is part of many diseases
 - Language and the way we speak can change how ???
 - Person is not the disease
 - “Relapse is anticipated” shows how difficult this is and need to cont. treatment
 - family history – important concept

Part 2.

- 75% of domestic violence stat
 - o not surprising but traumatic
- work: many people flourish in workplace and succeed despite issues and co-workers don’t know
- **stigma = invisibility**
- BULLYING – talked about in a different way. SUICIDE ISSUES/understanding of tie to mental health
 - o “on-line” increase of issues
- disheartening to hear people relate mental illness to violence
- confusing when you relate stats re: domestic violence
- sexual orientation issues resonate
- Stigma may lead to individuals “hanging” w/ “wrong” crowd/high risk crowd
 - o They are more forgiving
- **Positive note:** trauma in children can be reversed

Part 3. Populations

→ Criminal Justice System – we should be doing more and earlier

SHOCKING STATS

- Prevention and mental health

- Promotion – raising awareness re: importance of mental health issues is so important
- Surprising stat: 10% of pop is veterans
 - Sounds like a lot
- Reaction to youth – how we treat youth – divert from crim. Justice system

- Economic issues effect what happens
- **“Vicious Cycles”**
- So many issues getting treatment
 - “system” challenges
- How can people without support get help when it’s so hard even if you have support
- Drastic effect on state as population ages

Part 4.

- Look at how MA addresses mental health and SA
 - Much better and funded

- There is a plan – it needs to be funded
- Can’t do everything w/ Gov’t
 - There will never be enough \$
 - WHAT can we do in communities and families - Obamacare – how will it effect mental health services?
- Capacity will be tested

Key Questions:

- Public Policy – **CUTS**
 - Cutting residential stay and halfway house
 - Program cuts – multiple offenders } negative effects, more repeat offenders
 - *positive – some funds to start treatment
 - Less relapse when residential programs were longer
-

Indicators: Challenges w/ access

- fighting the system
- lack of knowledge from medical professionals
- lack of treatment guidance
- **NEED TO EDUCATE MEDICAL community**

- Lack of services, beds
- **SCALE of problem – LACK of capacity**

Solutions:

*Importance of NH Medicaid expansion

*Prevention needs more funding

- effective prevention
- cross issue – preventing violence in families

*Alcohol prevention ed like Dover youth to youth

- What can we do about corrections facilities? Decriminalizing?
- Need for option in crisis
 - o Before and after emergency rooms
- “Designated receiving facilities”
- More peer recovery programs
- New paradigm shift needed regarding that mental health is complex continuum –
- Prevention and treatment are complex and also on a continuum
- **Public education is vital
- \$\$ is needed and will not be the only answer
- Gov’t and private needed together
- Both human and economic workforce issues

Prevent:

- Identify problems early
- More education for general public
- Bring issues out of the shadows
- Schools, teachers, parents, Drs.
 - o consistent reporting to the public
- NH needs to address increasing diversity in our state and providers understanding as well –
 - o Social service providers need ed. re: diversity
- Need positive ways to talk about how to help people thrive

Good Strategy: Supporting community health centers and community mental health centers

Next Steps: A strategy –

- Take one small component of the larger issue – address w/ proven program success.
 - o Will generate impact – success breeds success

Another Strategy –

- STAND UP & ADVOCATE
- DO NEED BIG PLAN (as well as starting w/ small component)
- We’re not going to “fix” this problem – it needs to be continually addressed
- It’s not a “war to be won”
- Must break myths and stigmas
- Need super public education about how this effects us all
- Need to examine both private and public systems
- Prevention – focus on early identification of issues
 - o Highlight prevention on youth
- EDUCATION around language, respect, continuum

Portsmouth Group G
Nancy Lehoux

Focus 1. The Basics

- MH + Sub. Use – occur together – or MH is catalyst for use
- Treat MH to prevent use to self-medicate
- prescription drug use up
- Over prescribed?
- Stats about adults – needs stats on youth
- Clarify perception and reality
- Better screening – listen to our youth
- Provider training

Focus 2. Stigma and other Challenges

- really need improved public education
- broader training for more people
- need more understanding of behaviors of MH issues
- Need to publicize that there is recovery and rehabilitation
- People w/MH issues can re-join work and society with continued support
- Family is the support and advocate – they need support too
- Use of mentors can be beneficial. To both child and family
- Everyone in family is affected by family members MH issues
- We need to address family

Focus 3. Populations

- social isolation of older people
- productive activity for populations that have meaning
- create a senior workforce to be mentors
- 17-year olds in the adult justice system
- poverty impacts MH – no access to service – vicious cycle

Focus 4. Responses

- Restoring capacity is a tremendous benefit
- More services needed all over state
- Fund community-based services
- Those w/ MH issues don't belong on the streets or in our jails – they deserve a facility that serves
- More crisis beds in all communities
- Capacity not using
- Red tape

Report Out/Major Ideas

- MH reframe in a public way
 - o To dispel myths and misperception to more community support for serv & supports

- intervention early leads to positive re-introduction into society and prevents escalation/deterioration (e.g. jail, homelessness, poverty, long hospitalization)
- Fund and support opportunities for meaningful productive activities, employment, etc.
- More/Improved community-based services and support
 - reduces social and econ. Cost

Portsmouth Group H
Susan Dewhirst

Focus 1. Understanding the Basics

- Incredibly high # of people w/ subs abuse w/out treatment = 90%
- Not many programs to treat for both
 - o Mental health and substance abuse
 - o Lack of integrated services
- High # of co-occurring disorders – clear that it is a biological issue
 - o Striking statistic
- Negative attitudes – by people generally at these issues
- Access – back challenges (barriers) – transportation, childcare
- Social support needed for recovery
 - o Not offered and not funded
- #'s of people who cannot afford healthcare and thus no access
→ the ways we pay or not pay for these services – ex. a heart attack would get \$\$ support
- suicide is the only way to get these services
 - o not just the threat
 - o immediately endanger to yourself for someone else

Access – and then there are no beds available

- Emergency rooms don't treat MH + SA issues
- Shocking how ill-prepared to provide services for a state this size
- Medicaid – something very concrete can be done
- Lack of capacity
 - o *This wasn't always the case in NH → agencies and services did exist
- we're going backwards
- attitudinal?
- partisan politics?
- Funding?
- de-institutionalize w/ no halfway houses
- We didn't go backwards – we went nowhere
- We've doubled our population while service costs higher
- What is available after NH hospital?
 - o Peer support
 - o State peer support
 - o Respite
- Not included – how do these stats play into prison populations

Focus 2. Stigma and Other Key Challenges

- NH – rates of teen suicides higher than national average
- Stigma is a political issue →
 - o Lack of understanding and empathy
 - o No political will to make a difference
- Mentality of “pull yourself up by your boot straps”
- Is Live Free or Die/suck it up make the – let's talk and help yourself – attitude more prevalent?
- Stigma – denial to accept resp. as a state – which leads to isolation of ind./families
- Education

- Lack of Knowledge
- Everybody needs to talk about it...
- The \$\$ are not there
- What happens in schools?
 - o Schools can be a microcosm of what happens in the broader society
 - o Start w/ changes in the schools
- School – social skills education
 - o Huge lack of trained personnel in the schools
- Academics and the matriculation are the focus →
 - o Not \$ have band width for social skills
- If we're looking for a place to make changes
 - o Universal Screening – can happen in the schools
- Mental Health
 - o Frameworks – watch your mouth, bullying and good models of how to get it into schools

Focus 3. Populations for Unique Attention

- Different populations of those w/ mental illness
 - o Level of functioning
 - o Stages of treatment
 - o Age } all being lumped together
 - o Vets
 - o Multiple services

Absurd: to treat someone w/ heart attack in the asthma ward of a treatment center

- Matching people w/ correct peer group
- Dual Diagnosis
- Aging pop more concern – not being
 - o Addressed – caregiver support
 - o Quality
 - o Function well and independently
- Stigma – perception of how family members are being treated
- Fewer mental health hospitals
- Profits drive this
- Criminal Justice – system – glad it's being recognized
- Rec'd book: "Crazy" by Early
- NH – more alcohol and drug – struck at how we rank
 - o What about early intervention
 - o Kids self-medicating
 - o High tolerance for substance abuse
- Durham – edu. Pop – resources are available but not the will to address it – we survived it but things have changes
- Housing – Safe and decent –
 - w/out this how can you make good decisions about safe partners, jobs and persuing care
- single males
- adolescent males
- ? Marijuana big trigger for NH issues
 - o lowers IQ

Focus 4. Responses and Solutions

- What stands out is what's missing
(untapped) *Schools!
→ can be very effective
 - o children's behavioral health plans

→ Integrate the rec'd w/ these rec'd – we need to reach the whole spectrum

→ Endowment for health – has the info

untapped – *Religious instit. – use as a mechanism to dispel myths

Change the way we fund

- kids who grow up in poverty have higher MH and SA issues
- missing – peer recovery
 - o evidence based programs
 - o annual report

Solutions:

1. ID + treatment
 2. Crisis Capacity treatment
 3. Post-Crisis Recovery
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Housing First! – Big nat'l movement – nat'l stable housing then bring services to where people live

Vocational Rehab – being productive is therapeutic

Age Pop Program

Making your comm. police have training community response.

- training in Roch. – crisis intervention teams
- Mental Health Costs
- More receptive to help vs. prison

TRAINING

- Training and Awareness to people who are dealing w/ these pop.
 - Need to retain staff and people are trained and then leave, big impact on clients
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- What does our society value?
 - o We need to shift funding
 - o State and fed
 - Recent tragedies may help –
 - o Need national spokespeople
 - Resolve

Insights and Solutions:

*Mental Illness – very broad category – they victimize + be victimized

Re-message how we talk about this

*High stat of NH → New England Attitude in our state → leading to denial and/or stigma

Insight and Solutions:

- *We group all issues together – need
 - o Importance of having consumers as part of the policy decisions and understanding the voids

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- *Role of Schools – training and resources – early ID

 - *Universal (early) screening – many indicators
 - o As they grow and develop – then there is a history
 - o Cont. to care
-

- *Co-occurring disorders

- *Family support – understanding
 - o Decrease stigma, denial

- ***Societal Shift** – family
 - o Schools
 - o Screening
 - o Language shift
 - o Stigma

- *aging population in NH → huge issues
- *early 20's – ID + get into treatment