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PROJECT NARRATIVE

PURPOSE AND NEED

The Plymouth State University (PSU) master's-level training programs for clinical mental health counselors, school counselors, and school psychologists are applying under a competing continuation for this HRSA grant to increase the number of well-trained, competent behavioral health workers in New Hampshire serving people across the lifespan--particularly children, adolescents, and transitional-aged youth who have developed a recognized behavioral health disorder or are at risk of doing so. PSU supports communities throughout the state and has a track record of serving New Hampshire's rural and underserved North Country and Lakes Region communities. In applying for this grant, PSU intends to leverage its interdisciplinary *integrated cluster* approach to education in which academic majors fluidly join with related fields. For example, school counseling, clinical mental health counseling and school psychology all train together in a shared core of classes. The mental health counseling and nursing programs work together in an interdisciplinary cluster through its simulated crisis/disaster training; counseling/nursing/physical therapy/and theater collaborate through the training and use of standardized patients; the school psychology, school counseling, social work, and theater programs collaborate on an annual summer children's theater production.

One notable result of these cluster collaborations is that the PSU programs applying for this grant are committed to interdisciplinary work which extends to external integration: fostering of the ongoing integration of behavioral and primary health care in the state. This integrated approach to care is still in its relatively early years in New Hampshire (NH), and while barriers such as a workforce shortage and technical issues have slowed the progress, the need to push forward is well understood by all.

The efforts supported by this grant will differ from our currently funded HRSA grant as its focus will be on supporting children, adolescents, and transitional-aged youth. More specifically, activities will include violence prevention and intervention, substance use prevention and intervention, telehealth training and supervision, and additional social-emotional evidence-based programming. As the grant application will detail, we will plan to recruit a more culturally diverse student body, faculty, and adjuncts, as well as train students for cultural competence. Another large focus will be to address the mental health impacts of COVID-19. Finally, we will provide information and resources to program candidates and matriculated students about loan repayment and employment opportunities to further support and increase the behavioral health workforce in the state.

BEHAVIORAL HEALTH NEEDS AND RISK FACTORS

Scope of Representation

According to data from the Census Bureau, NH's racial composition is 89.8% White, 4% Black, 3% Asian, 1.8% Hispanic, 1.8% mixed race with less than 1% in other categories. There exists much economic diversity in NH, with the southern tier bordering Massachusetts having more population density and wealth. The central and northern more rural parts of the state are sparsely populated, with no urban areas. The state as a whole has a median household income average of $76,768, while the three counties (Grafton, Sullivan, and Coos) that comprise the central and northern areas have averages of $63,389, $61,312, and $47,117 respectively.[1] Just

[1] United States Census Bureau QuickFacts, 2019. https://www.census.gov/quickfacts/fact/table/NH/INC110219

short of 8% of the population live below the poverty line; the largest demographic living in poverty are females ages 25 to 34.[2] Data are not available regarding the racial make-up of the behavioral health workforce in the state, but anecdotally, the workforce is largely White. Among current behavioral health students at PSU, 2.3% identify as Black, 1.2% identify as Asian, and 1.2% identify as Hispanic. Eighty-six percent of PSU behavioral health students identify as female.

Current Health Status Indicators: Incidence and Prevalence

Depression and Anxiety

In 2021, NH was identified as 28th in the country in regards to the rate of mental illness and prevalence. In its 2021 report, Mental Health America stated that 13% of youth aged 12-17 reported suffering from at least one major depressive episode in the past year.[3] In addition, the American Mental Health Counselors Association (AMHCA) is projecting that over 103 million American adults (about 40%) and between 8 million to 24 million children (aged 5-17 years old) will experience a negative mental/behavioral health condition and/or will develop a co-occurring substance use disorder in 2020 due to the unprecedented confluence of economic, social, and COVID-pandemic related stressors. During a similar time period in 2019, only 8.2% of adults reported symptoms indicative of an anxiety disorder and only 6.6% reported symptoms of depression. This data illustrates a rate of mental health prevalence that has more than tripled in the last year.[4]

Substance Use Disorder Incidence and Prevalence

In 2014, NH had one of the highest rates of substance use/misuse by youth and young adults in America and ranked 9th for youth binge drinking.[5] Drug overdose deaths – mainly involving synthetic opioids--have remained steady but high in NH between 2015-2018.[6] Twenty-five percent of adults in NH classified "drug abuse" as "the most pressing issue facing the state."[7] In 2017, New Hampshire had the 3rd highest death rate of fatal opioid overdoses of all US states. Further, "75% of NH people who inject drugs lack easy access to clean syringes and 67% have shared needles in the past 30 days."[8] Recognizing the need to codify harm reduction strategies, in 2017, NH passed SB234 permitting syringe exchange programs in the state.[9] In addition, NH ranks well above the national average regarding alcohol dependence and illicit drug use.[10]

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[2] Poverty by Age & Gender, 2019. https://datausa.io/profile/geo/new-hampshire#demographics
[3]Mental Health America, 2021. https://mhanational.org/issues/state-mental-health-america#Key
[4] AMHCA, 2020. Beyond a Perfect Storm
[5] New Hampshire's Substance Use Disorder Continuum of Care, 2016. https://www.dhhs.nh.gov/dcbcs/bdas/documents/coc-assests-gap.pdf
[6] National Institute on Drug Abuse, 2020. https://www.drugabuse.gov/download/21974/new-hampshire-opioid-involved-deaths-related-harms.pdf?v=366cc665343cef1c584ca4eda192930b
[7] New Hampshire's Substance Use Disorder Continuum of Care, 2016. https://www.dhhs.nh.gov/dcbcs/bdas/documents/coc-assests-gap.pdf
[8] NH Overdose Facts, 2019. https://mypages.unh.edu/sites/default/files/harmreductionproject/files/nh_drug_overdose_facts_6.13.19.pdf.
[9] NH Senate Bill 234, 2017. https://legiscan.com/NH/text/SB234/id/1491074
[10] Mental Health America, 2018. https://www.mhanational.org/issues/mental-health-america-prevalence-data-2018#:~:text=01%25%20of%20adults%20struggle%20with%20a%20mental%20health,Adult%20with%20Alcohol%20Dependence%20and%20Illicit%20Drugs%20Use

Intimate Partner Violence and Youth Violence Prevalence

The most recent statewide statistics suggests that there were over 27,000 victims of domestic violence, sexual violence, and stalking in NH between 2017 and 2018.[11] At least one third of NH women and one-quarter of NH men report being victims of intimate partner violence, and more than half of women in NH have experienced sexual or physical assault in their lifetime. These rates are significantly higher than the national average of approximately 25%.[12] Among NH's high school aged children, 15% of female students report being a victim of sexual violence.[13] In a 2019 survey of high school students in the far North Country of NH, five percent of students 15-18 reported intimate partner violence.[14] Additionally, domestic and intimate partner violence has had a causal factor in over 90% of NH's homicides and suicides.[15] The NH counties reporting the highest rates of domestic violence are also the state's most rural and underserved.

According to the Center for Disease Control's Youth Risk Behavior Surveillance System's 2019 data, 23% of NH high school students reported they were bullied on school property, while 20% (the highest rate in the US) reported being cyberbullied. Almost 8% reported being involved in a physical altercation on school grounds while 6.4% reported being threatened or hurt with a weapon. Almost 7% say they skipped school during 2019 due to safety concerns. Finally, 18.4% seriously considered suicide with 7% reporting that they had made an attempt.[16]

An increase in virtual learning during the COVID-19 pandemic has led to greater levels of screen time and a higher probability that children and adolescents will engage in cyberbullying.[17] From 2007 to 2016, rates of cyberbullying in America doubled from 18% to 34%.[18] There has been an increase in cyberbullying or direct bullying toward Asian-Americans since the COVID outbreak, reinforcing the need for cultural diversity training.

Child Abuse

NH Division of Children Youth and Families (DCYF) receives over 20,000 reports of suspected child abuse and neglect and completes about 8,000 reports on these situations every year.[19] There has been a 30.6% increase in referrals from 2015 to 2019, a 21.7% increase in open assessments from 2015 to 2019, and a 28% increase in the number of children involved in these

[11] New Hampshire Coalition Against Domestic and Sexual Violence, 2018. https://www.nhcadsv.org/uploads/1/0/7/5/107511883/2018_nhcadsv_data.pdf.
[12] National Intimate Partner and Sexual Violence Survey: 2015 Data Brief, 2018. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf
[13] New Hampshire Sexual Risk Behaviors & Dating Violence, 2019. https://wisdom.dhhs.nh.gov/wisdom/#Topic_73DF2EC60AA741A2BE15D64028BAB05C_Anon
[14] New Hampshire Youth Risk Behavior Survey, 2019. https://www.dhhs.nh.gov/dphs/hsdm/documents/north-country-yrbs-results-2019.pdf
[15] Governor's Commission on Domestic and Sexual Violence, 2012. https://www.doj.nh.gov/criminal/victim-assistance/documents/domestic-violence-report-2012.pdf
[16] New Hampshire High School Youth Risk Behavior Survey, 2019. https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=NH
[17] Critical Need for Mental Health Services Amid COVID-19. https://nhcbha.org/another-reason-to-stress-about-stress-2-3-3-2-2-2-2-2-2-2-3/
[18] Cyberbullying Research Center, 2019. https://cyberbullying.org/summary-of-our-cyberbullying-research
[19] New Hampshire Division of Children Youth and Families. https://www.dhhs.nh.gov/dcyf/cps/index.htm

assessments from 2015 to 2019 – a total of over 30,000 NH children. These data means that approximately 12% of NH children are involved with DCYF due to allegations of abuse and neglect. The number of children who need alternative home placement due to abuse or neglect almost doubled between 2015 and 2019--from 982 to 1,779 children. In 2019, approximately 44.5% of DCYF assessments included substance use related risks.[20]

There is a higher risk for child abuse and neglect during the COVID-19 pandemic. Increased stress levels in parents, lack of usual social supports and childcare options, higher strain on social workers, and a lack of technology contribute to this increased risk.[21]

COVID-19 Behavioral Health Concerns

The effects of the COVID-19 pandemic on long-term mental health may take months to manifest and assess. Some of the most at-risk populations include the elderly, children and adolescents, those with chronic illness, and/or those with pre-existing mental health disorders or substance use disorders prior to the spread of COVID-19.[22] According to Mental Health America (MHA) data from January to September 2020, there has been a 93% increase in anxiety screenings and a 62% increase in depression screening when compared to 2019. Eight out of 10 people who completed the anxiety or the depression screening tools have symptoms categorized as moderate to severe, rates much higher than they were pre-COVID. Youths aged 11-17 years old are the most at-risk group, with the highest rates of moderate to severe symptoms of anxiety and depression--higher than any other age group. MHA reports 2020 has the highest rates of suicidal ideation and self-harm reported since they began their screening program in 2014 - these rates are highest among youth, especially those who are part of the LGBTQ+ community.[23]

In December 2019, before the COVID pandemic began, 26% of New Hampshire residents who texted the Crisis Text Line were experiencing anxiety/stress. By June 2020, three or four months after the pandemic began, that percentage was up to 39%. As of November 2020, the number had decreased to 25%. Of the texters in NH who were experiencing anxiety/stress, 36% also reported depression/sadness, 35% reported relationship problems, 20% reported thoughts of suicide, 18% reported struggling with isolation and loneliness, and 12% reported self-harm.[24]

GAPS IN BEHAVIORAL HEALTH SERVICES

Despite overwhelming need in most areas of NH, ongoing shortages of qualified professionals continue to comprehensively hamper prevention and intervention efforts. In 2018, more than 50 legislative bills were proposed to address health care shortages in the state, but most did not pass. Innovative models of care continue to be proposed by community stakeholders, but the fact is simple: NH simply does not have the necessary workforce to meet

[20] New Hampshire Division of Children Youth and Families Data Book, 2019. https://www.dhhs.nh.gov/dcyf/documents/data-book-2019.pdf
[21] Intimate Partner Violence and Child Abuse Considerations During COVID-19, 2020. https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf
[22] Critical Need for Mental Health Services Amid COVID-19. https://nhcbha.org/another-reason-to-stress-about-stress-2-3-3-2-2-2-2-2-2-2-3/
[23] COVID-19 and Mental Health: A Growing Crisis, 2021. https://mhanational.org/sites/default/files/Spotlight%202021%20-%20COVID-19%20and%20Mental%20Health.pdf
[24] Crisis Trends, 2020. https://crisistrends.org/

the health and behavioral health needs of its citizens.[25] As of 2019, NH had more than 200 clinician vacancies in Community Mental Health Centers, alone. Public schools continue experiencing critical shortages of counselors and school psychologists, as well.[26] The current ratio of students per school psychologist in NH is more than twice the recommended ratio.[27] Schools across NH recognize that students are requiring increasingly more social and emotional support, but the critical shortage of practitioners in the state limits their ability to address needs.

The cause of the workforce shortage in NH has been attributed to many reasons, but financial factors such as low salary/reimbursement rates, lack of loan repayment options, etc. are significant.[28] Based on a 5-year average and using Pell Grant eligibility criteria as the governing metric, approximately 66% of PSU school psychology and counseling students are considered financially disadvantaged. Despite Plymouth State University's competitive tuition rates, upon graduation, the average debt incurred by students is approximately $39,000. Based on the eligibility criteria, graduates of the Clinical Mental Health Counseling program will likely qualify for three of the four National Health Service Corps (NHSC) Loan Repayment Programs (LRP). Of the 54 NHSC approved sites in NH, the Clinical Mental Health Counseling program has preexisting relationships with 17; program faculty actively work to connect students with these organizations. Additionally, the three programs (School Counseling, School Psychology, and Clinical Mental Health Counseling) plan on hosting a yearly job fair for students and recent graduates. This job fair will highlight opportunities with NHSC sites in NH's more rural areas. The LRP opportunities will be integrated into recruitment literature and will be discussed with students as they progress through the program.

Large gaps have been identified in the areas of consistent substance use prevention for youth and young adults (both in community settings and in the schools), education of parents of children/youth who are using substances, and school policies that address early behavioral problems, risk factors, and substance use. NH has a great need for Master's Level Alcohol and Drug Counselors (MLADCs), Licensed Alcohol and Drug Counselors (LADCs), and other clinicians trained in co-occurring disorders and has a statewide shortage of these professionals.[29]

Inter-provider and interagency collaboration regarding substance use disorder was being impeded by NH's restrictive privileged communication law. This impediment was recently closed by amending the law to include exemptions that allow for the sharing of information as required by CFR 42 and HIPAA.[30]

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[25] New Hampshire Health Care Workforce Coalition, 2019. https://www.nhproviders.org/new-hampshire-health-care-workforce-coalition

[26] New Hampshire Department of Education Critical Shortage List, 2020. https://nhdoepm.atlassian.net/wiki/spaces/CHD/pages/347963415/Critical+Shortage+List

[27] Shortages in School Psychology: Challenges to Meeting the Growing Needs of US Students and Schools, 2017. https://www.nasponline.org/Documents/Resources%20and%20publications/Resources/School_Psychology_Shortage_2017.pdf

[28] A Plan to Ease Healthcare Workforce Shortage, 2019. https://www.nhbr.com/a-plan-to-ease-healthcare-workforce-shortage/).

[29] New Hampshire's Substance Use Disorder Continuum of Care, 2016. https://www.dhhs.nh.gov/dcbcs/bdas/documents/coc-assests-gap.pdf

[30] New Hampshire Revised Statute, Privileged Communications, 2019. http://www.gencourt.state.nh.us/rsa/html/XXX/330-A/330-A-32.htm

NEED FOR EVIDENCE-BASED BEHAVIORAL HEALTH WORKFORCE TRAINING

There continues to be a need for interdisciplinary, team-based care training in NH for school counselors, school psychologists, and clinical mental health counselors (CMHCs). Increasingly, CMHCs are being employed in integrated primary care sites. Lenz, Dell'Aquila, and Balkin conducted a metanalysis of 36 randomized controlled studies. Their results show better mental health outcomes for individuals treated in integrated primary care settings by behavioral health clinicians compared to treatment as usual. Just two of the four CMHC preparation programs in NH provide training in integrated primary care.[31]

The American School Counselor Association (ASCA) emphasizes the necessity of evidence-based interventions throughout their Ethical Standards for school counselors[32] and in their National Model.[33] Throughout every step of development, implementation, and evaluation of a comprehensive school counseling program, school counselors are ethically mandated to ensure the presence of evidence-based practices. This expectation illustrates the need for training in evidence-based practices in school settings.

The National Association of School Psychologist's (NASP) most recent update of the school psychology practice model lists Research & Evidence-Based Practice as a core domain.[34] Given the significant social and emotional needs of students across NH, school psychologists are increasingly being called upon to implement evidence-based assessment and interventions. Thus, the need for evidence-based training is essential. One of our goals will be to implement better training in delivering evidence-based practice.

TECHNOLOGY INTEGRATION

Beginning in 2019-20, interns across all three programs began utilizing the online Time2Track platform for logging their field-placement hours. This enabled students and their respective programs to not only more efficiently and more accurately monitor progress, but also allowed for the tracking of important intervention characteristics. Examples of this data include: school psychology interns provided assessment and counseling interventions to K-12 students across the state; 69% of activities supported children diagnosed with ADHD, generalized anxiety, and/or mood disorders. CMHC interns spent 76.8% of their time providing individual counseling services to clients across NH, most of whom were diagnosed with an Adjustment Disorder, Anxiety Disorder, or Major Depressive Disorder (76.5%). School counseling interns spent the majority of their time (63.9%) meeting with students for individual counseling and consulting with school administrators, teachers, and families regarding social and emotional challenges faced within the school. Interns will continue utilizing this system and will expand data collection efforts to further assess demographic and intervention characteristics.

Beginning the 2021-2022 academic year, school psychology interns and practicum students will be trained in and supported with a year-long subscription to the Better Outcomes Now (BON) platform, which is an evidence-based progress monitoring tool designed for use during telehealth counseling.[35]

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[31] Journal of Mental Health Counseling Volume 40(3), 2018, pp 249-265
[32] ASCA Ethical Standards, 2016
[33] ASCA National Model, 2019. https://www.schoolcounselor.org/school-counselors-members/asca-national-model
[34] National Association of School Psychologists Domains of Practice, 2020. https://www.nasponline.org/standards-and-certification/nasp-2020-professional-standards-adopted/nasp-2020-domains-of-practice
[35] https://betteroutcomesnow.com/about-pcoms/evidence-based-practice/

Additionally, school psychology faculty are collaboratively involved with a multi-university project to develop a four-session supervision and ethics training curriculum that will be asynchronously provided to school psychologists free of charge. Plans are also underway this spring to pilot a 14-hour/seven-session online school counselor supervisor training as part of a nationwide study.

Since the start of the pandemic in March 2020, technology has been integrated into the Counseling Skills training course taken by students in all three programs. This has been implemented using Zoom for online lectures, both in the class as a whole and in breakout rooms for partnered skills practice. Further, students utilize TheraVue[36] by watching pre-recorded vignettes and responding with the required counseling skill being practiced. This allows not only for evaluation of individual skills, but also for more concentrated feedback. This technology also gives students the opportunity to practice specific clinical skills multiple times until mastery has been achieved.

BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

Current Capacity

According to Dartmouth-Hitchcock, "The majority of our clinics are using psychiatrically trained nurse practitioners and advanced practice nurses (53%) rather than psychiatrists (27%). Access to psychiatric expertise is critical not only to patient care, but also to the care and support of primary care clinicians in integrated behavioral health settings." Nine Dartmouth-Hitchcock clinics provide primary care and serve a large number of Medicaid patients for behavioral health.[37] Lakes Region Mental Health offers primary care services in its Laconia space with their partnership with HealthFirst Family Care Center and Mid-State Health Care.[38] Concord Hospital and Riverbend Community Mental Health Care have partnered to bring behavioral health clinicians into the emergency department as well as the hospital's primary care practices. Providers are working to improve health care in the greater Concord area while reducing costs, using an integrated system. "In an integrated system, primary care physicians play a key role in helping individuals understand how behavioral health is part of medical health." [39] Still, the number of integrated sites has remained small due to four primary barriers: 1. lack of a well-trained, competent behavioral health workforce; 2. limited training opportunities; 3. confusion over forging an integrated health practice; 4. challenging, disparate billing systems.[40] [41] [42] A

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[36] https://www.theravue.com/faq)

[37] Integration Care: Who Will Provide Integrated Care?, 2016. https://www.antioch.edu/new-england/wp-content/uploads/sites/6/2016/12/EFH-128-Integrated-Care-RPT-final.pdf

[38] The lakes Region mental Health Center, 2020. https://www.lrmhc.org/programs-and-services/children-family-services/

[39] Riverbend 2018 Annual Report, 2018. https://www.riverbendcmhc.org/wp-content/uploads/2019/03/2018-Annual-Report.pdf

[40]Integration Care: Who Will Provide Integrated Care?, 2016. https://www.antioch.edu/new-england/wp-content/uploads/sites/6/2016/12/EFH-128-Integrated-Care-RPT-final.pdf

[41] Integrating Behavioral Health and Primary Care in New Hampshire: A Path Forward to Sustainable Practice and Payment Transformation, 2016. https://www.citizenshealthinitiative.org/sites/default/files/media/NH%20Citizens%20Health%20Initiative%20White paper%20-%20Dec%202016.pdf

[42] Who will provide integrated care: Assessing the workforce for the integration of behavioral health and primary health care in New Hampshire, 2016. https://www.antioch.edu/new-england/wp-content/uploads/sites/6/2016/12/EFH-128-Integrated-Care-RPT-final.pdf

2016 study found that behavioral health clinicians and substance abuse counselors were both the most in-demand positions at integrated primary care sites and hardest to fill.[43]

Last year, a study of the state's 10 community mental health centers (CMHC) found that an 18.4% year-to-year turnover for staff was negatively impacting health outcomes for children and families and interfering with the center's ability to integrate care with other providers. Clients became frustrated by the turnover and dropped out of treatment or waited longer for treatment. In addition, the pressure to recruit and train new staff diverted limited resources away from integration pursuits. "The NH Behavioral Health Integration Learning Collaborative worked with provider and payer members to consider alternative payment models in order to create financial sustainability for integrated practice, including payments for medical and care management."[44]

For the reasons stated throughout this narrative, the University is well situated to use this grant funding to reduce the first three of those barriers.

Description of experiential training sites

Please refer to Attachment 4 for a detailed experiential training site description. Over the next 4 years, the three programs applying for this grant plan to place interns in 116 training sites across the state, 98% of which are interdisciplinary in focus. All but 12 of those sites are in rural areas. Health Professional Shortage Area (HPSA) scores range from 10-23 with 45 sites scoring 16 or above (areas of high need and high demand areas). We are requesting a funding preference for Qualification 1. Fifty percent of the school psychology graduates for Academic Years (AY) 2018-2019 and 2019-2020 are employed in medically underserved communities. See Attachment 12: Request for Funding Priority and/or Preference.

Plans for evidence-based trainings

Preparing mental health counselors, school counselors, and school psychologists to be practitioners utilizing evidence-based practice has long-been emphasized by all three training programs at PSU. Within each course, students are taught to think critically about the interventions they employ and to be informed consumers of research.

School psychology students will receive direct instruction and supervision regarding implementation of the evidence-based Partners for Change Outcome Management System (PCOMS).[45] At least one core faculty member will attend the Better Outcomes Now (BON) Training of Trainers conference held each spring in Florida. All school psychology students will then receive direct instruction regarding the implementation and use of PCOMS in their field placement sites. Each student will receive a subscription to the BON web application for data management and for use during supervision. Training will continue into students' internship year, during which they will be required to utilize the PCOMS measures. Each school

[43] Integrating Behavioral Health and Primary Care in New Hampshire: A Path Forward to Sustainable Practice and Payment Transformation, 2016. https://www.citizenshealthinitiative.org/sites/default/files/media/NH%20Citizens%20Health%20Initiative%20White paper%20-%20Dec%202016.pdf

[44] Integrating behavioral Health & Primary Care in New Hampshire: A Path Forward to Sustainable Practice & Payment Transformation, 2016.

[45] PCOMS-Evidence Based Practice. https://betteroutcomesnow.com/about-pcoms/evidence-based-practice/

psychology student will be required to utilize a single-subject case design approach to study the process and outcomes of at least one student they directly support.

Efforts are currently underway to establish a permanent training site for several school psychology and school counseling interns at two rural therapeutic/alternative schools. In collaboration with a community-based psychologist well-known for implementing evidence-based supports for at-risk children in schools and another training program, students placed in these schools would be trained in the *Healing the Self* model. This model is considered an evidence-based approach to reducing anger and violence in schools.[46] Research regarding the use of evidence-based outcome monitoring in school-based counseling will be conducted and published.

Innovative models of care

The NH Coalition Against Domestic and Sexual Violence serves as an umbrella organization providing guidance and support for 13 independent agencies in NH working to prevent and respond to domestic and sexual violence perpetrated against children, adolescents, and adults. In 2014, these agencies provided programming in 130 NH schools and youth-serving institutions.[47] Specific support provided by these agencies include provision of a 24 hour crisis hotline, emergency shelter, survivor support groups, educational programming, and court personnel. Despite these substantial efforts, the incidence of domestic and youth violence remains high in the state.

Given the significant mental health needs in NH, the NH Mental Health Care Access in Pediatrics (MCAP) Project is a relatively new endeavor undertaken by the NH Maternal Child Health Bureau to promote integration of behavioral health into pediatric primary care. This HRSA funded project currently seeks to implement the Extension for Community Healthcare Outcomes (ECHO) model, an evidence-based method of supporting providers.[48] Additionally, this project seeks to implement use of the Teleconsult Service Model (TSM). Finally, this project recently released a referral directory for primary care providers to assist in providing behavioral health treatment options.[49]

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[46] Reducing Anger and Violence in Schools: An Evidence-Based Approach, 2020.
[47] Primary Prevention of Domestic and Sexual Violence in New Hampshire, 2016. https://www.nhcadsv.org/uploads/1/0/7/5/107511883/primary_prevention_handout_4-2016.pdf
[48] Project ECHO, 2020. https://hsc.unm.edu/echo/
[49] Pediatric Mental Health Referrals: Guidance and Director for Pediatric Primary Care Providers in New Hampshire, 2020. https://www.nhpip.org/sites/default/files/user-uploads/NH%20MCAP%20Referral%20Directory.pdf

RESPONSE TO PROGRAM PURPOSE

(a) WORK PLAN (see Attachment 11)

(b) METHODOLOGY/APPROACH

A Systems of Care model is central to this project. These wrap around services provide clients a voice in the services provided to them and are in the forefront of NH's efforts to provide high quality care. In this grant, these supports will be inter-professional and interdisciplinary, thereby improving outcomes for people in NH, with a specific emphasis on supporting rural, low-income areas. The target populations are children, adolescents, transitional-aged youth, and individuals struggling with mental health and substance use issues. To accommodate trainees in clinical mental health, school counseling and school psychology, 116 training slots will be established. Eighteen new training slots will be created that focus on an interdisciplinary integrated care approach.

We intend to recruit in two ways. First, we intend to recruit potential students with diverse backgrounds to the graduate program whose interests in diversity align with the counseling and school psychology program's mission of social justice and diversity. We will do this by recruiting at all NH universities. Second, during program candidate interviews we will share information about our annual student-led Diversity Institute with the purpose of recruiting student candidates who embrace a commitment to social justice and diversity. For the past 16 years, the counseling and school psychology students have hosted this event. The matriculated students who volunteer to lead the Diversity Institutes and those who attend will be representative of these ideals. Past Institutes have included a focus on the following populations: transgender, victims of human trafficking and sexual violence, understanding privilege, New Americans, religion/spirituality, and sexual orientation.

We plan to provide meaningful field placements for our interns. These new field placements will prioritize cultural and linguistic competency. We have identified eighteen new placements and when appropriate, have obtained informal agreement to be able to place interdisciplinary teams of interns there.

As discussed in the project narrative, we plan to develop evidence-based interprofessional training for faculty and students. At least one faculty will complete a train-the-trainers for an evidence-based program and lead the training for additional faculty members and students. We also plan to support faculty and students to attend trainings on evidence-based programs and tools as well as host workshops and trainings at our institution to support faculty, students and behavioral health professionals including site supervisors.

As a Competing Continuations BHWET 2017 grantee, Plymouth State University has experience in disbursing funds in an efficient manner. This includes spreading out the stipend disbursements throughout the course of their six- or twelve-month internship as well as utilizing direct deposit as requested.

During our BHWET 2017 grant initiatives, we worked closely with three other NH HRSA grantees to offer integrated behavioral health trainings to our students, site supervisors and behavioral health professionals throughout the state. We have already engaged in discussions of how we can work with other grant recipients in the future to offer specific trainings and have embedded these plans in our work plan (see Attachment 11, Goal 12).

The project and training components are connected to the public systems of health and behavioral health care in clinical mental health counseling, school counseling and school psychology. Currently, the principal investigator sits on the New Hampshire School Counseling Association's Executive Board, one co-principal investigator sits on the New Hampshire Board of Mental Health, and a second co-principal investigator has been a member of the statewide Behavioral Health Collaborative for the past nine years. As such, each investigator has worked to align the clinical mental health, school counseling and school psychology programs to meet the state's priorities related to the public systems of health and behavioral health care, particularly in rural, low-income and medically underserved communities. We plan to work with organizations within the three disciplines through ongoing collaboration with stakeholders in the seven NH Integrated Delivery Networks (IDNs). We will specifically place our interns at sites that support populations in these areas and will continue to build collaborative relationships with site supervisors and the organizations they represent.

Logic Model (see Attachment 9)

(c) RESOLUTION OF CHALLENGES

The scope of the program's goals and objectives is quite vast and, therefore, will require a great amount of support from those directly and indirectly involved in behavioral health, education, and the community. We will likely encounter several challenges with our workplan; however, we have also determined resolutions for each challenge. First, internship sites may display apprehension in continuing to offer telehealth services post pandemic, particularly in schools. To address this concern, we will include telehealth training into coursework for students as a viable option to traditional behavioral health services. Telehealth workshops and conferences will be offered to our students and behavioral health professionals, including our site supervisors. Telehealth supervision will also be a part of all supervision trainings we offer.

Our goal of promoting and implementing evidence-based programming and tools may require buy-in from site supervisors and behavioral health sites. By being training in evidence-based programming and tools, our interns will understand the importance of such practice and will be more likely to implement them as future professionals in the field. Interns can expose site supervisors to such practices, increasing the likelihood of supervisors adopting the programs and tools.

Another workplan challenge is addressing the mental health impacts of COVID-19 long after the pandemic is resolved. To address this challenge, we will continue to provide trainings based on current research about the impacts of the pandemic on human development and inequities, specifically on cognitive, social-emotional development, and academic performance of children, adolescents, and transitional-aged youth, as we anticipate there will be long-lasting impacts of the pandemic.

Undertaking substance misuse among children, adolescents and transitional-aged youth continues to be a challenge in our state. One approach we will take is to develop a prevention and intervention resource clearinghouse website accessible to all New Hampshire residents, as well as provide prevention programming to schools. We believe we can resolve this challenge by partnering with the State of New Hampshire's governor's office and stakeholders in the field of substance use prevention. For each workplan goal and objective, we have identified measures to gather data, such as surveys and program evaluations for each training and program we provide. This data will assist us in understanding the effectiveness of our efforts. We will also maintain a spreadsheet charting our weekly progress in meeting our goals and objectives for the duration of the award.

A challenge related to workforce development is the lower wages, particularly in rural, low-income areas for new behavioral health workers. This is exacerbated by the high debt associated with student loans and is often a deterrent for individuals interested in pursuing a degree in the behavioral health field. To address this challenge, we will provide information about loan repayment programs as part of our recruitment materials as well as throughout our program. Additionally, we will offer workshops about employment opportunities by partnering with local recruitment agencies and organizations. We have identified 16 sites which qualify for three loan repayment programs.

One challenge is the difficulty in recruiting a culturally diverse student population, as well as faculty and adjunct teachers. By focusing on areas of the state where there are more diverse populations, we will provide high schools, community colleges and four-year college programs with information about our counseling and school psychology programs. To address recruiting more diverse faculty and adjunct teachers, we will extend our outreach to fill such positions to professional listservs. Furthermore, we will engage directly with our internship partners and community partners throughout the state to recruit for positions. We will also consider offering some courses to be taught remotely in an effort to expand our adjunct teaching pool outside of the Plymouth area

In our experience some experiential training sites are limited in offering integrated, interprofessional behavioral health services, including technology implementation and trauma-informed care. To address this challenge, we plan to partner with other BHWET 2021 recipients to offer interdisciplinary integrative behavioral health trainings including supervision, telehealth and trauma-informed care. These trainings will be offered to our students, site supervisors, and behavioral health professionals throughout the state and nation to underscore the importance of universal integrated care.

Addressing youth violence and intimate partner violence is difficult particularly when the violence is less visible and the effects cause emotional distress to the victim versus physical harm. To address this obstacle, we have developed several objectives that provide training to our students, to children, adolescents, and transitional-aged youth, as well as parents and guardians, creating a wrap-around approach to prevention and intervention. Additionally, we intend to develop an expressive arts therapy curriculum that will offer our students further training to work with individuals who have experienced trauma. Our collaboration with behavioral health care

entities throughout the IDNs in NH will facilitate our outreach in this area.

To address the challenge of recruiting, supporting, and training internship supervisors, we will expand our supervision training options. In addition to our weekend-intensive training, we will include half-day trainings over several weeks and throughout each year. Delivery of the trainings will also vary as some will be offered in-person while others will be offered virtually allowing participants to choose an option that supports their needs. Additionally, we have included language in our student commitment letter that encourages students to continue to support the initiatives that the Counseling and School Psychology Programs and other partners in NH are working toward, even after they have completed their degree, including becoming site supervisors for future students.

IMPACT

(a) EVALUATION AND TECHNICAL SUPPORT CAPACITY

Performance Reporting Plan:

Dr. Robin Hausheer will assume primary responsibility for collecting the data on a weekly basis. The grant team including PIs, the grant support specialist, the grant student assistants, and staff from the Office of Sponsored Programs will assist with data collection. Weekly data are collected to evaluate progress toward each goal and objective as outlined in our work plan. Dr. Hausheer will work with the grant team to accomplish this task. Data will be aggregated using Excel spreadsheets and the Work Plan to create Performance Reports. A Performance Report will be submitted on an annual basis.

Progress reports will be submitted to HRSA annually. The Final Financial Report (FFR) will be uploaded by the Office of Sponsored Programs to the Electronic Handbooks system (EHBs) within 90 days following the end of the project period.

Through the duration of the four-year grant period, data about interns and their sites will be collected at the start of their internship experience and on a monthly basis and will include:

- Reports from supervisors regarding the progress of interns, including strengths and opportunities to improve performance.
- Ongoing assessment and reporting by interns about their supervisors, their site, their experiences and opportunities to practice their skills, and about the utility of working in an integrated care system.

Data about student interns will also be collected at the end of every term and include:

- Data based on the Student Personal and Professional Performance Rubric
- Site Supervisor Evaluation
- Attendance rates at meetings and other informational sessions, including those in the community
- Number of intern sites
- Number of integrated care sites
- Type of behavioral health professional interning at each site
- Number of available site supervisors
- Final student evaluation of sites
- Evaluation of fulfillment of requirements put forth by accreditation bodies, including the National Association of School Psychologists (NASP), Council for the Accreditation of

Counseling and Related Educational Programs (CACREP), and the NH Department of Education Standards for School Psychologists.

In accordance with grant requirements and because of our competing continuation with HRSA grants, we have a thorough understanding about the data to collect. To meet the grant requirements, the following data will be collected monthly:

- The number and types of field placements serving children, adolescents, and transitional-age persons
- The number and demographics of new students trained and the number who graduate during each year of the project
- The number of annual graduates
- The number of graduates who pursue careers serving at-risk children, adolescents, and adults
- The employment locations of graduates: does location qualify for rural, medically underserved, and/or National Health Service Corps loan repayment programs
- The number of inter-professional teams that were trained and the members of these teams
- The impact the training had on the population and community served (number of clients seen within setting, case note summaries/reports, teacher reports, parent reports)
- Efficacy of the program initiatives (evaluations completed by attendees and facilitators)

We believe that we have shown through our prior years' work on several BHWET grants (BHWET 2014, BHWET 2017, and BHWET Supplemental grant) that our grant team has the experience and expertise to carry out the necessary technical and data collection tasks required by HRSA. Please see Attachment 1: Bio sketches. We do not foresee any potential obstacles in implementing the program performance evaluation and meeting HRSA's performance measurement requirements. If we do experience any obstacles, we will use the Rapid Cycle Quality Improvement plan to make necessary adjustments. During our weekly scheduled grant meetings, we will use the Plan-Do-Study-Act (PDSA) Cycle in order to ensure continuous monitoring and project implementation are meeting the goals of the grant. Our PDSA Cycle follows the four-stage Rapid Cycle Quality Improvement (RCQI) plan, which will be used on a quarterly basis to make necessary adjustments.

We will recruit and place 29 interns each year of the grant for a total of 116 interns. Each intern will be required to complete a survey that addresses the following information as part of the internship experience and an alumni survey post-graduation:

- Type of experiential training opportunities offered in integrated, interprofessional settings including trauma-informed care to persons in high need and high demand areas
- Demographics of intern
- Employment in behavioral health setting serving persons in high need and high demand areas
- Employment at internship site
- Internship sites serving intimate partner violence and/or youth violence
- Internship sites' incorporation of culturally competent practices
- Partnerships with internship placements and job placements

- Inclusion of technology into internship training, including distance learning, telehealth services, trainings on digital health literacy
- Types of job placement services interns participated in and whether intern received employment opportunities as a result of these services

As part of our weekly data collection process the grant team will gather data about the number and types of trainings faculty and site supervisors participate in that are supported by the grant funding.

Our programs already collect alumni data one-year post-graduation; and we have been able to successfully do so through our strong relationships we build with our students prior to completing their programs. We enlist the services of our department graduate assistants to locate any alumni that we have lost track of in an effort to send out surveys and collect any data. As part of our survey for interns, we will include information about National Provider Identifiers.

(b) PROJECT SUSTAINABILITY

Together we will explore options for securing funding to support interns as they complete their internships. We will generate a list of these options and a plan to pursue them. We will demonstrate the positive impact of our interns and encourage schools, community health centers, and hospitals to find ways to provide some support. For example, they could pay school-based interns substitute teacher rates. Due to the critical shortage of school psychologists in NH, we will work with the Department of Education to provide school psychology interns with an alternative credential which would allow them to be hired by school districts to complete their internships with pay. We will partner with other mental health organizations to find funding.

We will demonstrate the positive impact of providing training for supervisors as a method of increasing the behavioral workforce to provide expert supervision. As a result of this four-year project, we will have hard data demonstrating the overall importance and positive impact. We will provide this data to the University and demonstrate the enrollment increase and encourage them to provide financial support to sustain this effort.

For schools using the Aperture Education Social-Emotional Learning Program, we will support their transition to independent data analysis to advocate for self-sustaining funding. Additionally, we plan to offer schools and behavioral health professionals opportunities to develop grant-writing skills so they can acquire funding for their future projects.

DISSEMINATION OF OUTCOMES

Faculty and interns will be encouraged to submit papers for presentations at local and national professional conferences. The model for supervisory training, inter-professional training, integrated health care, and parent training will be made available for professional conferences and publication. Some information will be shared via the NH Children's Behavioral Health Collaborative on its website and at state conferences. Regional meetings with stakeholders will be convened to share information and explore and develop new collaborations across the State. All of the data and information will be shared in university courses including school psychology, counseling, educational leadership, and psychology. Faculty and students will continue to work together to develop integrated cluster projects to disseminate information.

ORGANIZATIONAL INFORMATION, RESOURCES, AND CAPABILITIES

PROJECT ORGANIZATION CHART (see Attachment 3)

Plymouth State University is a visionary institution at the hub of an ever-growing creative community where students, faculty, staff, and alumni are actively transforming themselves and the region. We develop ideas and solutions for a connected world and produce society's global leaders within interdisciplinary integrated clusters, open labs, and partnerships and through innovative and experiential learning. The programs seek to prepare professionals who are engaged in the ongoing processes of increased self-awareness and enhanced interpersonal effectiveness. A commitment to social justice is promoted through an emphasis on honoring and recognizing the diversity that exists within society and through the development of skills necessary to implement interventions aimed at the positive transformation of people and systems. The programs envision a world where there is less social injustice and more compassion, human rights, and human dignity.

The programs are part of the University's Health & Human Enrichment cluster which is dedicated to developing the knowledge, skills, and dispositions needed to effectively work with children, adults, families, and organizations across a wide variety of settings. Practices are promoted that are grounded in current research, holistically focused, developmentally appropriate, and culturally competent.

The programs support seven full-time faculty, all of who are active and respected in their specialized fields of study. The Project Director will dedicate 25 percent of her time during the academic year and 1.5 months during each summer over the duration of the grant. The programs also draw on the expertise and experience of a number of adjunct faculty members, many of whom are current or former professionals working in NH and the greater New England region.

The curriculum of the programs in clinical mental health counseling, school counseling, and school psychology emphasize evidence-based practice and interventions that are transformative in the lives of the culturally diverse clients with whom they work. These programs include an intensive pre-internship practicum and six- and twelve-month internships, which provide students with hands-on experience working with clients of all types. During the course of their internship, master's-level students receive direct supervision from site supervisors, who are professionals working in the student's area of interest. Students are also required to meet on a weekly basis with program faculty and other interning students to discuss the successes and challenges of the week.

The majority of school counseling and school psychology students select a public school as their internship site. Clinical mental health counseling students often choose to intern at community mental health centers and Federally Qualified Health Centers. Currently, the programs have agreements with approximately 180 internship sites dispersed throughout NH. These sites offer students intensive, hands- on experience, directly working with children, adolescents, transitional-age youth, adults, at risk persons, and families. Students also gain realistic knowledge about where their site fits in the larger Systems of Care and how current

professionals are working with other resources and agencies to provide the most effective interventions in the lives of young people.

The programs collaborate with a number of state and local organizations and agencies that support the mission and vision of the programs. One such organization is Lakes Region Mental Health (LRMH), a local mental health care and crisis center with several locations. LRMH is a leading provider of internship positions for clinical mental health students and employs a large number of graduates from that program. The programs strengthen this relationship by providing professional development opportunities for individuals employed at LRMH.

The programs are currently working with the NH Children's Behavioral Health Collaborative which developed the NH Children's Behavioral Health Core Competencies. The goal of these competencies is to provide mental health professionals across the state with tools and knowledge to provide the best services to their clients in a climate of care that is uniquely New Hampshire. These competencies focus particularly on working with children, adolescents, at risk and transitional-age youth as this population has traditionally been subject to neglect and lack of funding on the part of NH State mental health agencies. The Competencies emphasize a clinical methodology that is client (youth) driven and that continuously involves the family of the client, as this is essential to creating a robust unique and profound system of care for each individual.

Plymouth State University’s counseling and school psychology programs were awarded two BHWET 2014 grants totaling $2.2M, a BHWET 2017 grant ($2M), and the Supplement ($400,000). The principal investigators have met all federal reporting requirements and have been fully supported by Plymouth State University’s administration and Office of Sponsored Programs.

Plymouth State University's Counselor Education and School Psychology programs lead the state and region in the education of mental health professionals. The programs emphasize their commitment to training culturally competent behavioral health professionals who effectively implement personal and systemic evidence-based interventions using an inter-professional System of Care.