Solving the NH Behavioral Health Workforce Crisis- 2025 Update

September 19, 2025

A Collaboration Among:

- Attendees of the July 31, 2024 and August 12, 2025 NH Behavioral Health Workforce Solution Sessions
- NH Behavioral Health Workforce Center at Dartmouth Health
- NH Community Behavioral Health Association

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Introduction

In 2024 New Hampshire leaders from all sectors sounded the alarm. Our behavioral healthcare workforce is simply not large enough to meet the needs of our state's residents. The 2024 report ***Solving the NH Behavioral Health Workforce Crisis*** provided diagnosis and a multi-sector strategy for leaders to follow. The report is publicly available at BHNH.org and contains nuanced and actionable solutions for government leaders, payers, healthcare provider organizations, law enforcement leaders, philanthropy leaders, and community organizations.

Workforce shortages in NH's behavioral healthcare sector have reached alarming levels and have stayed at these levels for nearly a decade. This means that many individuals in NH who need behavioral health support are not getting it despite heroic efforts from leaders in all sectors.

NH leaders have been actively trying to solve the behavioral health workforce crisis because they recognize the cascading societal risks that come with under-supported mental health and substance misuse challenges among NH residents including:

- Increasing deaths of despair from suicide and overdose
- Increasing hospitalizations and Emergency Department boarding
- Increasing behavioral problems at school and home, absenteeism, and school dropout
- Increasing levels of absenteeism from work and decreasing productivity while at work
- Increasing misuse of alcohol, drugs, and opioids
- Increasing levels of disability, unemployment, poverty, and uninsured
- Increasing incidents with law enforcement, arrests, court hearings, and incarcerations
- Decreasing lifespans (8.0 to 14.6 life years lost for men and 9.8 to 17.5 life years lost for women with serious mental illness)
- Long term impacts including Adverse Childhood Experiences, intergenerational trauma, and generational poverty

However, there are many bright spots in NH's quest to improve support for behavioral health statewide. To highlight just a few of the recent improvement programs, NH has launched promising multi-organizational initiatives including: NH Rapid Response and 9-8-8 for crisis care, Mission Zero to eliminate psychiatric boarding in emergency departments, System of Care for Children's Behavioral Health to provide wraparound support for children and families with behavioral health challenges, the NH Integrated Delivery Networks (IDNs) to integrate primary care and behavioral health, and the Certified Community Behavioral Health Center (CCBHC) program to bolster outpatient behavioral healthcare services.

Alongside these large-scale initiatives, NH's philanthropy community, our government leadership and staff, our healthcare organizations, our law enforcement leaders, and our community organizations have all committed significant time, effort, and funding to improve behavioral health across the state.

In August 2025, the *NH Behavioral Health Workforce Center at Dartmouth Health* and the *Community Behavioral Health Association* co-hosted the ***second annual NH Behavioral Health Solution Session***. Over 100 senior leaders representing diverse perspectives from multiple government agencies, healthcare providers, academic institutions, law enforcement and justice, philanthropy, public health,

peer support, workforce development, employment security, staff licensure, and community organizations came together in Plymouth. To begin the day, Deputy Commissioner at NH Employment Security Richard Lavers provided a detailed update on the NH behavioral health labor market. We then broke into a series of team exercises to think creatively and critically together across disciplines to move our thinking forward once more and to find new solutions.

The 2025 work builds upon previous progress and focuses on the practical actions NH leaders can take at each stage of a behavioral health (BH) worker's career pathway all the way from discovery of the field through to mastery. This work is applicable to a wide range of BH roles and the many different types of care settings where BH workers support individuals in need. The work is inclusive of those who serve individuals with mental health and/or substance misuse challenges.

Roles include but are not limited to:

- Paraprofessionals (e.g., Peer Support Specialists, Community Health Workers, Recovery Support Specialists, Navigators)
- Nurses and Advanced Practice Nurse Practitioners
- Case Managers and Supported Employment specialists
- Therapists
- Crisis Responders (Call center, mobile crisis, crisis stabilization)
- Psychiatrists / Doctors
- Administrative personnel (e.g., Leadership, Quality Improvement, Financial Management, IT)

Settings include but are not limited to:

- Crisis care settings such as:
    - Crisis call centers (e.g., 9-8-8, Access Point, Suicide hotlines)
    - Mobile crisis
    - Crisis stabilization centers
- Behavioral Healthcare settings including
    - Outpatient treatment clinics
    - BH clinics and practices
    - Community Mental Health Centers
    - Intensive Outpatient Programs (IOP)
    - Partial Hospitalization Programs (PHP)
    - Inpatient treatment hospitals
- Peer Support Agencies
- Primary Care settings with integrated behavioral health
- Schools / Educational institutions
- Law enforcement/Justice settings (e.g., Police-embedded BH professionals, County Court embedded BH professionals)
- Community settings (e.g., Libraries, afterschool programs, faith-based programs, sports programs, camps)

There are many leaders across NH working to solve our shared workforce crisis. We continue to learn a lot from one another, to discover breakthrough ideas both big and small, and to go to action where each one of us can make change happen. The following pages share the details of our work together.

Our shared 'Moon Shot'

"We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too."

-President John F. Kennedy address at Rice University, September 12, 1962.

Some would say that building our state's behavioral healthcare workforce isn't rocket science. But what if we treat it as if it is? We, as state leaders in the fields of healthcare, education, justice, and community support organizations, have already established that we are on this mission together. So, what if we take the collective strength of our loosely tethered, multi-sector coalition and formalize everything we know into a 'moon shot?' We already have much of what we need!

A moon shot requires a shared destination and we already defined that, borrowing from the mission statement of the NH Behavioral Health Workforce Center.

Shared mission – Shared purpose

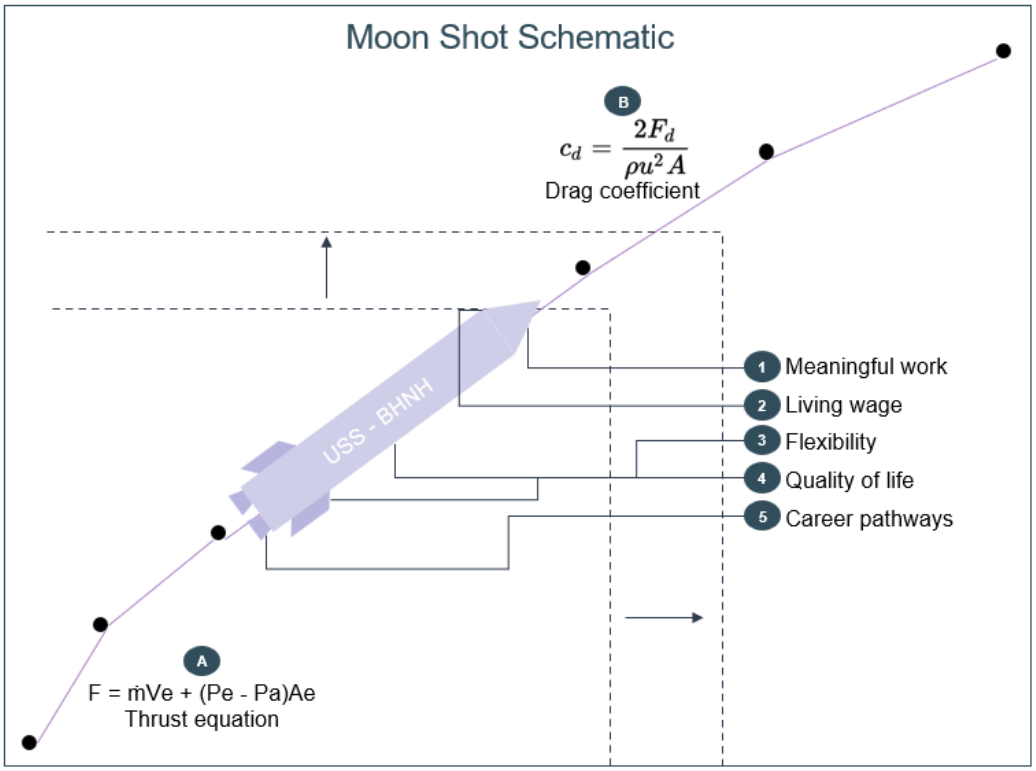
To make NH one of the best places in the country to train and practice behavioral health care!

A moon shot also requires a team to solve our workforce crisis. We have already realized that in NH, our 'moon shot team' will not be centralized under a single agency or leader, but will be distributed and led within the many hundreds of organizations and institutions that share in the mission and that have an invested stake in making this work. We recognize that NH has chosen a path that favors free enterprise where small state and county governments work in tandem with the for-profit and not-for-profit organizations in their communities and statewide. Therefore, our very large and dedicated 'moon shot team' is within every agency, institution, and organization. It is held together through shared purpose.

That is a lot of strength to build upon. But to date, it has not been enough to solve our workforce crisis. By many measures and predictions, our crisis is growing. So, what else do we need? A plan? We have a lot of plans. Actually, we have a lot of very good plans with breakthrough ideas, prioritized actions, and even some with assignments of sub-tasks. Maybe we can write a better plan this time. Or maybe we do something slightly different. Maybe we remind everyone from time to time that we are on the same team with a shared stake in not failing. Maybe we lay out the moon shot in detail and keep updating everyone on our progress. And maybe we trust that each organization, agency, institution, organization, and individual will pick up the parts of the plan that they can carry forward and bring to action.

The Secret to Flight - Core Components of a Healthy BH Career

Figure 1: Our shared 'moon shot'



We can celebrate that we have already discovered the secret to flight for our moon shot. We know from hard experience and from recent [post-pandemic] human resources research that a healthy career in behavioral health, or really any field, has the following components:

Meaningful Work: The daily work is challenging and feeds personal and professional sense of mission, purpose, and meaning.

Living Wage: The combined salary and benefits are sufficient for being able to live comfortably in a NH community proximate to work.

Flexibility: The work schedule affords some autonomy and is flexible enough to accommodate the needs of employees and their families. A portion of work may be performed remotely.

Quality of Life: The employees and their families get to live in safe, supportive communities proximate to the natural and cultural beauty that makes NH unique and attractive.

Career Pathways: Individuals have clear opportunities for lateral and upward growth within and beyond their organizations.

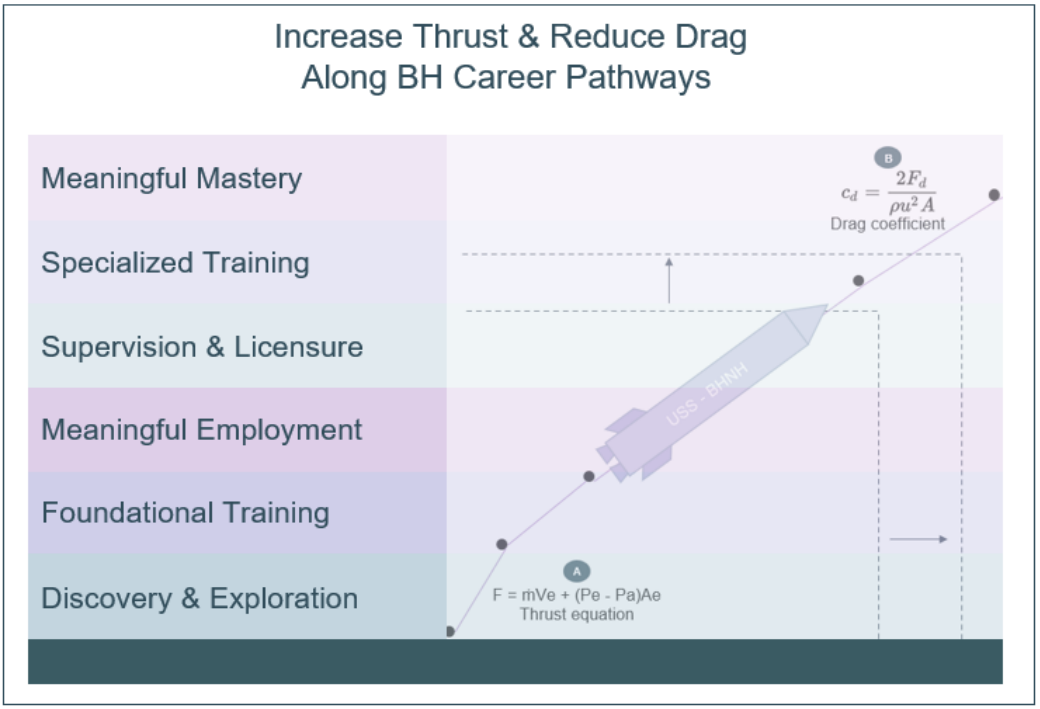
In a free labor market like we have in NH, lots of good things happen when these core components are in place. The careers attract prospective workers, educational institutions train and prepare them, organizations hire workers in line with demand for services, staff advance in their careers and stay aligned with their personal and professional missions.

But what if we are not seeing these good things happening and our workforce remains in a persistent state of crisis? This question was at the core of the 2025 BH Workforce Summit where participants spent much of the day identifying headwinds and tailwinds for each stage of a BH career pathway:

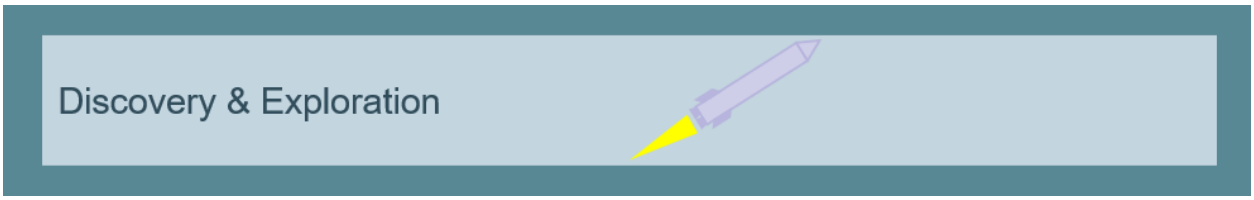
- Stage 1: Discovery and Exploration
- Stage 2: Foundational Training
- Stage 3: Meaningful Employment
- Stage 4: Supervision & Licensure / Certification
- Stage 5: Specialized Training
- Stage 6: Meaningful Mastery

To further stretch our moon-shot metaphor, there are critical conditions that either create *thrust* or create *drag*. Borrowing learning from those who study rocketry [which these authors did not], we know that there are hundreds of small factors that go into the magic of flight and that they are interrelated. To make our moon-shot work, our highly-distributed multi-disciplinary team has to come at the challenge from all perspectives and then work the problems together to amplify the factors of thrust and ameliorate the factors of drag.

Figure 2: Increase thrust and reduce drag at each stage of BH career pathways



Within these nuanced details lay our future work together. The following pages showcase many of the ideas from the August 2025 summit alongside earlier ideas gathered by the NH BH Workforce Center. We could not capture every idea in the room that day, or the ideas from all the other groups working on this problem, but that's not the point. This is continuous dynamic work that stands upon the shoulders of the leaders that have come before. These are the ideas we have together today and that will grow and change as we all do our work together. It is up to each and all of us to figure out which parts we can carry forward to ***increase thrust and reduce drag!***



Discovery & Exploration Stage

In this stage of the career path, individuals:

- Become aware of roles and careers in the behavioral health field
- Light their fires to serve others
- Find out about different behavioral health roles and care settings
- Figure out what preparation is needed
- Dig deeper to see if the role fits with strengths, aspirations, and professional identity

Ways to increase 'thrust' at this stage

❖ Work together to promote awareness building and to light the mission fires for new staff. Remember that we can focus some of our efforts inside NH but will have to also rely on migration given NH's near-term demography and low birth rate.

❖ Within the state, promote a wide range of BH careers and settings in schools at all grade levels. Integrate with curriculum like STEM was able to. Create a shared *Health Speakers Bureau* that can support awareness building campaigns on behalf of all BH organizations drawing on both clinicians and those with lived experience. Be inclusive of law enforcement, education, government, and community roles that require BH skill sets.

❖ Outside the state, promote NH as the best place to live, train, and practice BH care. Partner to create a *Chamber of Commerce model* that promotes on behalf of our institutions and employers.

❖ Highlight how NH leads in mobile crisis, justice/ law enforcement collaboration, peer support/ task sharing, integrated BH care, education, and community integration.

❖ Provide clear and detailed information about BH careers, their value to society, and what it takes to enter the field. Be transparent about training load, cost, funding availability (scholarship, Student Loan Repayment Program), and typical salary/benefits expectations.

❖ Support youth peer support programs. They have the dual mandate for helping youth while also exciting and preparing young people for a future career in behavioral health.

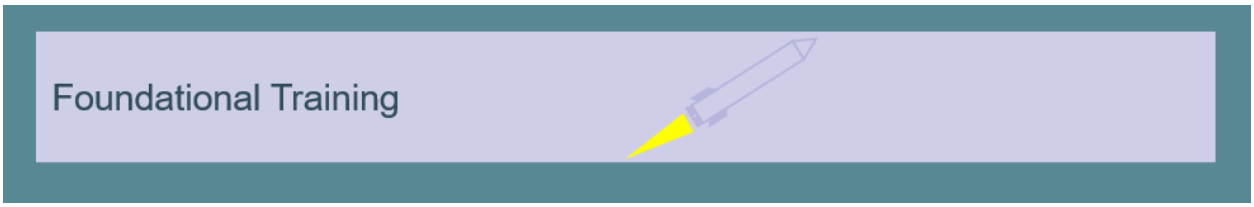
❖ Provide more exposure to the field through apprenticeship opportunities, shadowing, career days, and even camps. This includes featuring roles in career days at school, apprenticeship opportunities, and *Bring Your Parent/Friend to School or Work* events.

❖ Provide mentoring programs to encourage knowledge transfer to new and aspiring workers.

❖ Leverage the NH Area Health Education Centers (AHEC's), the NH BH Workforce Center website (www.bhnh.org), and existing Health Career Catalogs to help.

Sources of 'drag' at this stage and how to eliminate or reduce it

- There are not enough young people in NH to grow into the BH workforce. NH age demographics skew older and we have low birth rates. Draw on migration to supplement our workforce.
- Lack of awareness. Introduce BH careers early in schools and within proximate curricula (e.g., Nursing, Emergency Medicine, Physical Therapy).
- Role mystery due to privacy. Open BH up to shadowing so students may learn about the role directly. The privacy protections are surmountable.
- College cost/Student loan debt. Find creative ways to decrease cost of preparation. Transfer cost from the student to those who benefit. Utilize loan forgiveness and variants of the idea to exchange loan debt for a commitment to work in NH's BH workforce.
- Limited pipeline. Identify funding, resources, and shared infrastructure to build future workforce.
- Migration 'friction.' Remove barriers to domestic and lawful international migration such as training/ license/ certification reciprocity and work visas.
- Stigma. Continue efforts to destigmatize behavioral health struggles.
- Novelty of Peer Paraprofessional roles. Continue to demonstrate the value of paraprofessional roles, best practices for task shifting, and securing of funding to support these roles. Build pipeline of Peers in school alongside other clinical roles.
- Shortage of mental health career discussions. Talk openly about BH careers on social media.
- Challenging workplace cultures. Continue to build strong, supportive, mission-aligned work cultures to attract and retain talent.
- Shortage of community members trained. Provide community training in mental health first aid, Question-Persuade-Refer, and other basic skills courses that may be taught alongside CPR and First Aid.
- Shortage of volunteer workforce. Build and draw from volunteer programs such as medical reserve corps, 'candy stripers,' and AmeriCorps.
- Limited role models. Hold up role models in this field who are exciting people to look to for inspiration.
- Difficult to engage young workforce. Cater roles to younger workers who may be more likely to move geography for a rewarding role and way of life. Emphasize the benefit of work and/or internships in obtaining desired advanced education/training/employment.



Foundational Training Stage

In this stage of the career path, individuals:

- Become aware of education and training institutions and programs
- Determine how to pay for education and training
- Enroll in institutions and programs
- Select courses of study and classes
- Participate in classes and internships
- Adjust mid-stream (multiple times)
- Graduate and earn certificate / degree

Ways to increase 'thrust' at this stage

❖ Focus first on 'mission' rather than a specific job. Reinforce fulfilling a personal and professional mission by holding events and career days that draw on inspiring speakers from the field.

❖ Form and cultivate relationships among employers and training institutions to set up frictionless pathways from training to employment. Work together to make this a shared service for all like a *Chamber of Commerce* that sets aside interorganizational competition for workers in exchange for a more effective, less costly recruiting engine. Collaborate among education institutions and employers to attract students/staff to NH and the field. Co-develop student pipelines. This includes NH institutions, neighbor state institutions, remote programs, and beyond. Cultivate networks of school career counselors, admissions, career support, and alumni roles.

❖ Find creative ways to make education and training free or inexpensive. Look at models for 'free program tracks' like an entry level BH associates track. Fund and implement scholarships, tuition waivers, debt forgiveness, and stipends. Treat BH students like highly sought NCAA student athletes and make it work!

❖ Create attractive 'pathways' for learning that lead to attractive 'career pathways.' This includes lived experience and academic components and offering 'stackable' certificates and credentials.

❖ Cultivate relationships among learning institutions, PSAs, and employers to share information, learning, real-life shadow/ practice opportunities, and networks.

❖ Continue to encourage 'boundary crossing' across BH, law enforcement, and education.

❖ Add a BH track to existing Career and Technical Education (CTE) programs. (note: health track already exists)

❖ Draw on students that are participating in prevention and peer coaching roles in high school.

❖ Draw on practicing clinicians and peers to teach upcoming students.

❖ Draw sideways on students that are looking to switch educational programs and that have transferrable skills and lived experience.

❖ Build wellness and self-care into the curriculum so students receive long-term skills that sustain them.

❖ Share critical information among employers and educational institutions such as:

- Which institutions are preparing students for BH roles and exposing students to BH careers.
- Credit load and time to completion at each training institution.
- Health of the student pipeline (incoming, in-school, graduating) for each training institution.

- Role demand among employers.
- Information to promote matchmaking among candidate preparatory organizations and employers.

Sources of 'drag' at this stage and how to eliminate or reduce it

- Lack of awareness. Collaboratively promote educational programs and career pathways and NH generally.
- Enrollment. Reduce barriers to school admission and enrollment. Consider 'side doors' for BH students.
- Cost/affordability of school. Find creative ways to shift cost of school to those who benefit. Continuously work to improve the revenue and cost equation to bring more students in to the field. Be creative with stipends, offsets, scholarships, and affordable housing and childcare.
- Heavy class/credit load and graduation requirements. Re-evaluate role core competencies and re-calibrate curricula, class load, internship, and graduation requirements.
- Inconsistent standards across institutions and states. Seek consistent competency building to make it easier for students to shift sideways into a BH program or come in to a NH program from another geography.
- Privacy protections. Navigate patient privacy protections and permissions to allow more student interaction with the actual daily work of BH early in their training.

Meaningful Employment

Meaningful Employment Stage

In this stage of the career path, individuals:

- Become aware of current job openings in a variety of roles, clinical settings, and physical and/or remote locations
- Apply for and choose jobs based on a match between professional aspirations, personal/ family needs, and the role
- Onboard, train, and begin work – often under the supervision and licensure of other BH professionals
- Adjust mid-stream (multiple times) including changing roles, clinical settings, and/or employers

Ways to increase 'thrust' at this stage

❖ Focus on what we know works as mentioned earlier in this report: Meaningful Work, Living Wage, Flexibility, Quality of Life, Career Pathways. Find ways to celebrate mission, culture, and work environment.

❖ Be creative to balance the revenue and cost equation for prospective and current workers in our communities – particularly with student loan debt, affordable housing and affordable childcare.

❖ Remember that we can't grow our way out of this with just NH staff. Given our demographics we have to encourage migration to our state physically and through remote work. This requires building upon the natural beauty of NH and making our communities as attractive, safe, affordable, diverse, and culturally rich as we can. This requires lowering barriers to migration and reciprocity mechanisms.

❖ Form and cultivate relationships among employers and training/ feeder institutions to build clear bridges from training to employment. Work together to make this a shared service for all. Provide matchmaking assistance and guidance at the individual student level. Continue to follow and support students through the first job and beyond. Consider retired workers for mentoring and guidance.

❖ Provide staff with solid professional support and clinical supervision so they can learn their craft with excellent mentorship and guidance. A simple 'buddy' system, mentors, and formal supervision all help.

❖ Build workplace cultures that are motivating and engaging while offering opportunities for autonomy, responsibility taking, and professional growth. Be creative with scheduling, remote work, telehealth, and PTO to help staff maintain their personal health and 'batteries.' Make work spaces that are welcoming and supportive.

❖ Continue to implement 'task shifting.' This means cultivating and supporting a paraprofessional workforce, helping clinicians share the load with paraprofessionals in a safe and team-based way, and helping everyone work at 'the top of license.' It also means removing administrative and billing barriers.

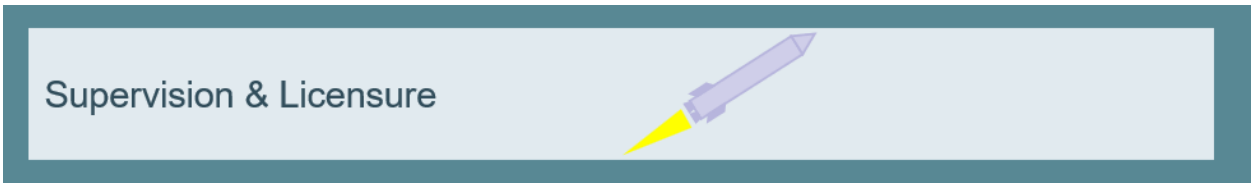
❖ Continue to advance the boundaries of BH with roles in law enforcement/justice and in education.

❖ Consider cultivating volunteers as part of the workforce. Include retirees as well as people looking to explore the field. Look to models like medical reserve corps, volunteer EMS, and wilderness first

responders. Lower the barriers to volunteering while providing appropriate volunteer training, management and supervision.

Sources of 'drag' at this stage and how to eliminate or reduce it

- The work is very challenging. Find ways to support staff as they navigate difficult client situations, maintain boundaries and personal batteries, engage with other professionals through peer supervision and communities of practice, and find ways to keep pursuing a difficult professional mission.
- Lack of living wage. Address the unbalanced equation between BH salaries/benefit packages and the cost of living in NH communities. Solve on both the revenue side (e.g., Competitive wages) and the cost reduction side (e.g., Loan relief, affordable housing, affordable childcare). Correct for recent inflationary pressures and stay ahead of this going forward.
- Charting burden. Conduct a 'back-to-front' investigation of charting burden among NH BH providers. Identify all of the low value information required through the billing and reporting systems built up over time by government agencies and payers and prune these out of contracts, billing procedures, and data collection systems. Identify all of the high value information and new ways to gather this information either passively (AI assisted charting) or through traditional charting forms. Completely clean up charting so that it returns to its intended functions and may be completed efficiently.
- Migration 'friction.' Remove barriers to domestic and international migration to NH. Consider the BH workforce of the state as a whole and encourage professional migration among service providers rather than competing among individual sites. Proactively and intentionally build career pathways and advancement-encouraging systems that transcend any single organization.
- Clinical Supervision. Continue to find ways to support staff with ample clinical supervision so they have back up for challenging situations and clients and so they can learn and grow through the early years of BH work. Recognize that supervision is a known bottle-neck and when we appropriately support and reimburse supervision capacity, it is a workforce multiplier.
- Barriers to applicants. Identify and remove remaining barriers for staff applying to jobs. Work through the complexities of hiring and supporting individuals with criminal backgrounds and history of substance misuse (see recover friendly workplace). Remove other unintended barriers such as forms that are unwelcoming to marginalized groups of potential applicants.



Supervision & Licensure Stage

In this stage of the career path, individuals:

- Advance in their career role
- Earn licensure and certification(s) based upon State Rules and Requirements of DHHS, the Office of Professional Licensure and Certification, and/or an external certification body
- Begin supervising other staff
- Adjust mid-stream (multiple times) including changing roles, clinical settings, and/or employers

Ways to increase 'thrust' at this stage

❖ Continue to create and cultivate meaningful supervisory relationships within organizations with intentional goal setting, protected time for co-reflection, easy to access backup for challenging situations, and clear guidance for professional growth.

❖ Collaborate among employers to remove the Supervision constraint through scale. Create a shared service model where senior employees may contribute to supervision time and junior employees may draw upon this support across institutions. This can help share scarce supervision time – especially in highly-specialized evidence-based practices or sub-populations.

❖ Continue to reduce barriers to Licensure and Supervision at DHHS and within the Office of Professional Licensure and Supervision. Conduct periodic review and elimination of barriers to licensure that offer no compelling value but that add burden to applicants.

❖ Given NH's reliance on migration to solve the BH workforce constraint, continue to work toward reciprocity with other states (particularly 'feeder states') and national standards bodies. Maintain 'waiver' mechanisms in the near term as state-to-state reciprocity improves.

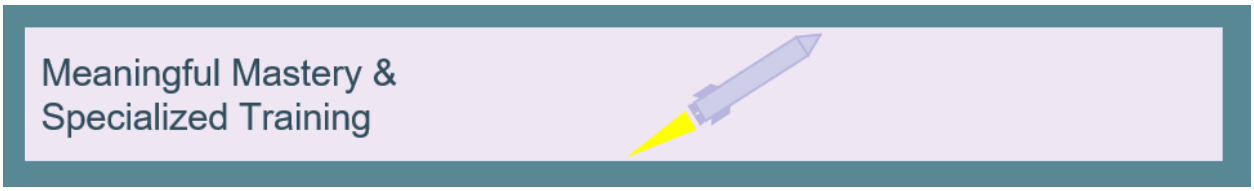
Sources of 'drag' at this stage and how to eliminate or reduce it

❖ Lack of standardized state requirements. Address reciprocity challenges with alignment to national standards, reciprocity arrangements, waivers.

❖ Supervisor preparation. Supervisors require a different set of skills so make sure to invest time and resources in training and professional development for our supervisors.

❖ Scarce time. Supervisors have many draws on their time. Supervision time is literally a 'force-multiplier' for the organization and needs to be protected. Adjust billing, scheduling, and productivity reporting to recognize the value of clinical supervision time.

❖ Scarcity of expertise. NH BH providers support individuals with many evidence-based practices, some of which are very specialized and that have scarce expert supervision. Solve for this constraint with shared supervisory support across provider organizations.



Meaningful Mastery & Specialized Training Stage

In this stage of the career path, individuals:

- Seek advanced training to become better in their roles and/or to specialize with a particular discipline, care setting, treatment methodology, and/or sub-population of individuals
- Advance again in their career role and exhibit mastery in the practice of Behavioral Healthcare
- Spend a significant portion of their work time coaching, training, supervising, and managing other staff
- Spend a portion of work time advancing scientific research in their field and/or teaching
- Earn advanced degree, licensure, certification
- Adjust mid-stream

Ways to increase 'thrust' at this stage

❖ Intentionally implement the elements of the *Academic Health Center* model throughout NH's BH system of care in concert with educational partners. Create the infrastructure, support, revenue models, and staffing models with the 3-part mission of serving individuals, training workforce, and advancing BH through research.

❖ Invest in training and professional growth infrastructure that focuses on advanced training, specialized EBPs, challenging sub-populations, and supervision. Formalize the BH roles within education and law enforcement. Draw on expertise within the workforce.

❖ Encourage lateral, upward, and diagonal advancement across organization lines. It is more important to grow an individual's career within and beyond the BH system than to retain a worker at a single organization. There should never be any 'glass ceilings' just lots of career pathways and options. Create reward/compensation mechanisms for organizations that cultivate early-career staff.

❖ Continue to lead in the treatment of mental health and substance misuse together as "behavioral health." Co-occurrence data supports this decision. The silo busting in funding, oversite, and delivery are all worthy.

❖ Continue to implement NH's 'System of Care' approach with crisis and non-crisis entry points, rapid level of care assessment, appropriate placement and referral, and staffing capacity balanced to need levels.

❖ Although this concept is included above, remember to continue to build out paraprofessional advancement paths alongside clinical pathways.

Sources of 'drag' at this stage and how to eliminate or reduce it

❖ Endurance. Leaders will need to support staff to sustain their sense of service over the long-term knowing that the work is persistently challenging. This requires leadership support with boundary setting, creative scheduling and time off/ hiatus options, and ample opportunities for role changes.

❖ Productivity and Billing models. Leaders will need to support their staff to find, attend, and pay for advanced training opportunities - to become contributors to the trainings as teachers and coaches – and to contribute to research. This requires realignment of productivity and billing models so that these constructs value activities associated with learning and advancement of the field.

Optional Breakout: CCBHC, a window of opportunity for BH workforce

In NH, the Community Mental Health Centers play a seminal role in developing the state's BH workforce. Our 10 CMHCs and their satellites are in every region of the state and they are charged in statute with supporting the behavioral health needs of adults diagnosed with Severe Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) and Children with Serious Emotional Disturbance (SED). CMHCs provide care in the 'safest least restrictive setting' and they have historically been the key to de-institutionalizing mental health care. In NH we herald our CMHCs for literally emptying mental health hospitals like NH hospital and for doing the challenging daily work of supporting people in their communities.

NH's CMHCs and their BH teams provide evidence-based services including Assertive Community Treatment, Cognitive Behavioral Therapy, Supported Employment, Child and Parent Psychotherapy, and many others that help individuals to function and thrive in their communities. At the same time, CMHCs train and supervise the staff that can carry this work forward. CMHCs are the critical supervised training ground for early career behavioral health workers.

On the financial side, NH CMHCs have been underfunded in the recent past, meaning their revenues have not kept pace with the costs to provide required services. This is most evident in below-market staff wages (a CMHC's largest operational expense) and in the related staff vacancy and turnover rates tracked every month by CBHA. In NH, leaders use the CMHCs staff vacancy and turnover data as a 'canary in the coal mine' indicator of BH workforce distress and the reports show persistent workforce distress.

In January 2025 two of our urban/suburban CMHCs, Greater Nashua Community Health and Mental Health Center of Greater Manchester, began operating under a new certification and a new payment model. In July 2025 the first of our rural CMHCs, West Central Behavioral Health, joined them. The model is called *Certified Community Behavioral Health Center or CCBHC* and is supported federally by the Center for Medicare and Medicaid Services (CMS) and by the Substance Abuse and Mental Health Administration (SAMHSA). To be certified a CMHC must provide a suite of evidence-based treatments to fidelity and align staff capacity to meet the behavioral health needs of the local community as determined through periodic needs assessment. Certified centers enter into a new reimbursement model with the state and the Medicaid Managed Care Organizations (MCOs) called Prospective Payment System 3 or PPS-3. This is a simple daily rate.

Now every payment reform brings with it benefits and challenges. PPS-3 is particularly fit for purpose for improving NH's BH services and rebuilding a workforce that is critically understaffed. Since the 2001 Institute of Medicine (IOM) *Crossing the Quality Chasm* report[1], CMS and many commercial healthcare payers and MCOs have introduced new payment methodologies to support healthcare. All payment reforms attempt to balance 2 things: *care quality and cost containment*.

[1] Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press. https://doi.org/10.17226/10027.

Healthcare quality has been defined by the IOM for nearly a quarter century as care that is *Safe, Timely, Efficient, Effective, Equitable, and Patient-Centered or STEEEP.*

Safe: Ensuring patient safety means preventing harm from the care intended to help them. This includes minimizing medical errors, infections, and other adverse events.

Timely: Reducing waiting times for appointments, tests, and treatment is crucial for both patient well-being and effective care delivery. Delays can lead to negative health outcomes and increased patient anxiety.

Effective: Providing care that is based on scientific evidence and is likely to benefit the patient is essential. This involves making sure treatments are appropriate and delivered by qualified professionals.

Efficient: Avoiding waste of resources (staff time, supplies, equipment, and money) is important for both cost-effectiveness and optimal patient care. Efficiency also includes streamlining processes to reduce unnecessary steps.

Equitable: Providing the same quality of care to all patients regardless of their race, ethnicity, socioeconomic status, or other personal characteristics is another important aspect of high-quality care.

Patient-Centered: This involves respecting the patient's preferences, values, and cultural background when making decisions about their care. It also means actively involving patients in their own healthcare journey.

Cost containment works in tandem with healthcare quality to ensure that a society pays an appropriate amount for the healthcare of its people. Cost containment methodologies use incentives and counter-incentives to balance 3 things, *underuse, misuse, and overuse*. Underuse occurs when necessary care is not provided, misuse is when care is provided incorrectly, and overuse involves providing care that is more likely to cause harm than good. The IOM defines these terms as follows:

Underuse: This refers to the failure to provide a service when it would benefit the patient. For example, not prescribing an antibiotic for a bacterial infection or not offering preventative screenings. Underuse can lead to worsened health outcomes, increased disease progression, and higher overall costs in the long run due to complications and delayed treatment. From the patient's perspective, underutilization can also occur when they don't accept or engage in recommended healthcare.

Misuse: Misuse occurs when the wrong treatment or service is provided, or when a treatment is administered improperly. This includes prescribing the wrong medication or dosage, or performing a procedure incorrectly. Misuse can lead to adverse events, complications, and increased costs associated with correcting the error or managing complications.

Overuse: Overuse happens when medical services are provided that are unlikely to benefit the patient and may even cause harm. This includes unnecessary testing, procedures, or medications. Overuse is a significant problem because it exposes patients to potential risks, increases healthcare costs, and diverts resources from more effective treatments. A common

example is the overuse of antibiotics for viral infections, which contributes to antibiotic resistance.[2]

The following figure describes the magnitude of need for cost containment of underuse, misuse, and overuse. It goes on to qualify the fitness of PPS-3 to provide appropriate payment incentives.

	Magnitude of Need in NH BH Healthcare	Fitness of CCBHC & PPS-3
Underuse	Very high need. There is consensus through *Mission zero, DHHS Roadmap, 10-year mental health plan, etc.* to reduce treatment of BH acute events in Emergency Room and Hospital settings and instead focus on engaging individuals in preventive screening, community-based care, and BH emergency care through NH Rapid Response.	+CCBHC encourages centers to match service levels to the actual needs of their communities. +PPS-3 encourages utilization of BH Outpatient Services at visit frequency defined in EBPs.
Misuse	Medium need: Misuse risks are well managed through training, clinical supervision, and fidelity review. The critical need in NH is appropriate funding to support enough capacity for clinical supervision.	+CCBHC encourages centers to provide EBPs to fidelity to prevent misuse. +PPS-3 appropriately reimburses supervision, training, and quality improvement functions to prevent/reduce misuse.
Overuse	Low need: Though overuse of Emergency Services is a concern, overuse of outpatient services in CMHCs is not a concern nor priority in NH. Remember historically CMHCs replaced expensive and restrictive inpatient care. Support to keep individuals in community is critical.	+CCBHC encourages centers to match service levels and needs of their communities. +PPS-3 encourages utilization of BH Outpatient Services at visit frequency defined in EBPs.

NH is in early days of CCBHC implementation and DHHS, the initial CCBHCs, and the MCOs are learning quickly and adjusting the program structure and details to improve the program every month. The remaining 7 CMHCs are watching the initial rollout closely before cautiously engaging.

In its first 6 months 3 big struggles have challenged the implementation of the program but there are ways to solve for each and all the engaged leaders are working through these challenges right now:

Sufficient Medicaid Funding: The proverbial 'elephant in the room' among the CMHCs and all behavioral health providers, is whether there will be sufficient federal funds to support investment in and operation of CCBHCs. Medicaid match funds have been difficult to maintain through the State bi-annual budget process in Spring 2025. The federal budget bill has significantly reduced Medicaid funds and implemented intentional barriers to enrollment, both of which significantly reduce available funds for CCBHC and BH care generally.

[2] Institute of Medicine (US) National Roundtable on Health Care Quality; Donaldson MS, editor. Statement on Quality of Care. Washington (DC): National Academies Press (US); 1998. The Urgent Need to Improve Health Care Quality: Consensus Statement. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223995/

A transitional period of unfairness among CMHCs and then raise all boats: The structure of CCBHC financing provides a one-time opening for NH's CMHCs to re-align service provision, staffing, wages, and operating expenses to the needs of each community. Since the program is rolling out in waves, the first 3 CCBHCs have access to an appropriate amount of revenue to match their community needs and staffing costs. In the short run this creates a period where there is some risk of staff migration to the CCBHCs since their wage and benefits packages can be more attractive. In the mid-term this can go away if the initial CCBHC program rollout succeeds, if the non-CCBHC centers see value in joining the program, and if they become Certified themselves and raise their wage and benefits packages.

'In with the new - keep the old:' With the positive intent of easing transition, the program has ushered in a new Payment Methodology, PPS-3, without ushering out the last 2 payment methodologies, Capitation and Fee-For-Service. The original intent for PPS-3 was to encourage a simple daily rate with low administrative burden. This means that a fixed rate is to be paid for each individual that engages with the CCBHC on a given day and that the CCBHC will provide the appropriate services based on client needs and the evidence-based practices defined in their treatment plans. PPS-3 has a separate rate for crisis since crisis costs can vary widely from outpatient costs, especially in rural regions. The "prospective" part of PPS means that DHHS and the MCOs pay the CCBHCs in advance of expenses which brings predictable revenue stability to the CCBHCs, encourages hiring in line with community need, and reduces CCBHC reliance on expensive credit/working capital.

Moving forward, it is sufficiency of Medicaid funding which is most critical. NH government leaders are on the cusp of breaking through the BH Workforce Crisis with the need-aligned revenue that CCBHC brings to the most vulnerable part of our healthcare delivery system. With more Medicaid revenue certainty, the state government and its contracted MCOs will be able to clear out the last remaining misaligned cost containment mechanisms and administrative barriers to payment.

Specifically, it will benefit NH significantly to quickly complete the full transition to the PPS-3 payment methodology. The interim practices of shadow billing fee for services (FFS) and of reconciling capitation-based prospective payments with PPS-3 payments are currently bringing little incremental value while causing a lot of burden. These stacked payment models are exponentially multiplying the complexity of accounting offices in CCBHCs, challenging the reimbursement systems and processes of MCOs, requiring error-prone workarounds in Electronic Health Record and billing systems, and challenging Boards of Directors to provide appropriate oversight. And most importantly, holding on to the old payment models is canceling out the market incentives of PPS-3 in a time where NH needs to be focusing on the 'underutilization' issue and keeping individuals in community rather than in expensive emergency rooms and inpatient units. This is the precise target for 'Mission Zero.'

CCBHC brings a lot of promise for solving the workforce crisis in the Community Mental Health Centers. Since CMHCs are the gateway and training ground for much of NH's BH workforce, the improvements we make here can amplify workforce sufficiency through the entire system of care. NH DHHS and the first 3 CCBHCs have done the hard work of clearing a new path for the state and now it is up to all of us to support, improve, and expand the best parts of this program.

In Conclusion

The NH Behavioral Health workforce is still in crisis. All of the easy solutions have been tried and exhausted. We know the components that will encourage staff to enter and remain within our critical BH workforce: Meaningful work; Living wage; Flexibility; Quality of Life; and, Career Pathways. Our next chapter is a shared 'moon-shot.' We are held together through a shared mission. We have our work cut out for us to bring action to hundreds of ideas for how to increase thrust and reduce drag for staff who are making their way through their career discovery, training, and mastery.

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Report Authorship

This report was written by the team at the NH Behavioral Health Workforce Center at Dartmouth Health. Mark Belanger, MBA, was the lead author with support from Barbara Dieckman, MBA, MS, Julie Balaban, MD, and Jacqueline Pogue, MA, MPH.