



WELCOME to the

Public Safety & Behavioral Health Collaboration ECHO: Effective Crisis Responses in Your Community

Funding Statement

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Series Learning Objectives

1. Describe the roles, training, expectations, and legal and jurisdictional responsibilities of behavioral health providers and safety personnel (law enforcement, corrections officers, dispatchers, fire, and EMS) in responding to behavioral health crises.
2. Identify potential partners in Safety and/or Behavioral Health professions in their local communities, including pathways and structures that empower them to respond to behavioral health crises collaboratively as a team and provide longitudinal follow-up
3. Recognize signs of trauma and vicarious trauma in first responders and behavioral health providers, including strategies to support personal well-being and provide support to colleagues.

Series Sessions

Date	Session Title
10 June, 2026	First responder preparedness and roles in behavioral health crises
24 June, 2026	Behavioral health provider preparedness and roles in behavioral health crises
8 July, 2026	Vision for Behavioral Health Crisis Care – NH Rapid Response
22 July, 2026	Current State of Behavioral Health Crisis Response – Insights from three NH Regions
5 August, 2026	Continuing engagement to support people with recurrent crisis encounters
19 August, 2026	Trauma and vicarious trauma: caring for ourselves and colleagues
2 September, 2026	Community level actions and State/Federal resources to support coordinated responses

Today's Program

- Brief housekeeping
- Didactic: First responder preparedness and roles in behavioral health crises
  - Jeffrey Stewart, NRP, CAI, Ambulance Chief & Health Officer Brookline NH
  - Christopher M. Lewis, MBA - Lieutenant, NH Police Standards & Training
  - Susan L. Stearns, Executive Director, NAMI New Hampshire
- Case Presentation: Mark Belanger
- Discussion
- Summary
- Up Next





Core Training for Fire and EMS Personnel

-Jeffrey Stewart

Fire Fighters & Emergency Medical Services Personnel

Who are we and what do we bring?

The National Board of Fire Service Professional Qualifications (Pro Board)

Certification	Initial Training Hours	Continuing Education
Fire Fighter I	~213 hours	No National criteria – may be locally regulated
Fire Fighter II	~77 hours	No National criteria – may be locally regulated
Specialty Training	Various with specialty	No National criteria – may be locally regulated
Fire Officer I	~32 hours	No National criteria – may be locally regulated
Fire Officer II	~20 hours	No National criteria – may be locally regulated

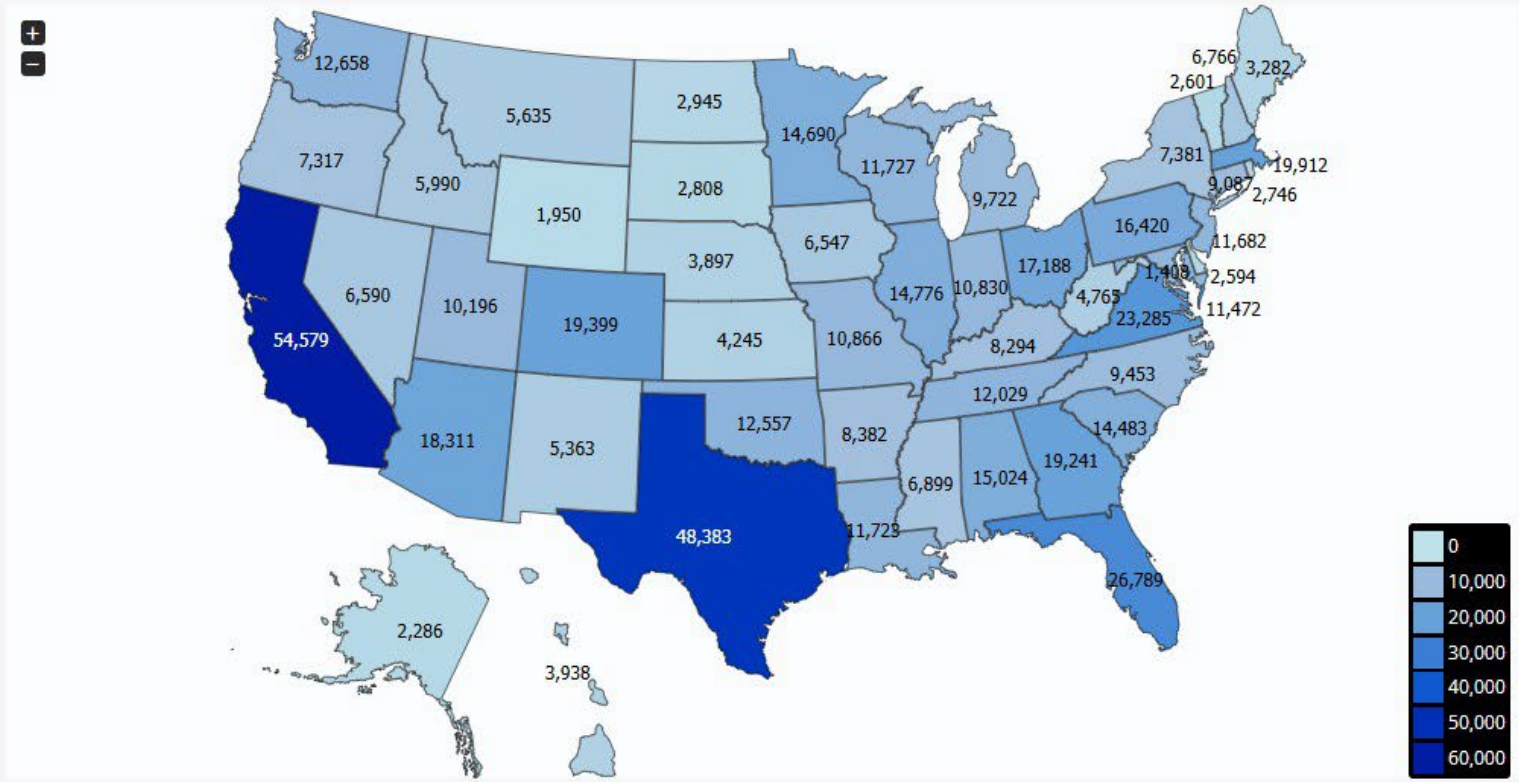
National Fire Protection Association (NFPA): Codes & Standards

The National Registry of Emergency Medical Technicians (NREMT)

Certification	Initial Training Hours	Continuing Education
Emergency Medical Responder (EMR)	~60 hours	16 hr. Q 2 yrs.
Emergency Medical Technician (EMT)	~120 hours	40 hr. Q 2 yrs.
Advanced EMT	~200 hours	50 hr. Q 2 yrs.
Paramedic (NRP)	~1,200 – 1,500 hours	60 hr. Q 2 yrs.

National Highway-Traffic Safety Administration's
Office of Emergency Medical Services: National Education Standards ++

Nationally Certified EMS Clinicians by State



Nationally Certified EMS Clinicians by Certification

EMR	EMT	AEMT	PARAMEDIC	TOTAL
17,009 (2.9%)	390,432 (66.7%)	30,155 (5.2%)	147,925 (25.3%)	585,521

Nationally Certified EMS Clinicians data updated daily

New Hampshire

- NH RSA Title VII: Public Safety & Welfare
  - Chapters 153 A & 154

- State Agency: Department of Safety
  - Division of Fire Standards and Training & Emergency Medical Services
    - Rules, Trainings, etc.

- **OTHER STATES or Territories – Check your Local Laws**

WHAT DO WE BRING?

FIRE SERVICES

- Authority for emergency scene control per NH State Law
- Authority to call in all kinds of resources if warranted – again through State Law and Rule
- Staffing assistance if needed
- Building or structural access skills if needed

EMERGENCY MEDICAL SERVICES

- Emergency Medical knowledge and skill sets based on certifications
- Ability to differentiate between Medical Emergency vs. Behavioral – Psych Emergency
- Emergency Treatment Options
- Transportation ability based on Protocols and agreements
  - SAFE – SECURED

THINGS TO REMEMBER:

- Both Fire Fighters and EMS Personnel
  - Receive some initial training on basic MH and SUD Crisis
  - Receive some initial training on self care for Physical and Mental Health
  - In NH – both may take the Crisis Intervention Training (CIT Program) – you will hear more about this later in this program

- EMS Personnel
  - Training on above increases as their certifications increase along with treatment options
  - Continuing education requirements have opportunities for more exposure to and awareness of both assessing and treating others as well as self-care

Collaboration Opportunities:

- MH and SUD trainings
  - Awareness level
    - This ECHO program
    - What is the MH & SUD Environment in your area?
    - Skill Sets & Community Resources
  - Assessment of and Treatment for
  - Self care all components are on the table

- **If you don’t ask…….Then you don’t know.**

References & Resources

- National Fire Academy: https://www.usfa.fema.gov/nfa/
- National Board of Fire Service Professional Qualifications (Pro Board): https://theproboard.org/
- NHTSA Office of EMS: https://www.ems.gov/
- National Registry of Emergency Medical Technicians: https://nremt.org/
- New Hampshire Fire Standards and Training & EMS: https://www.fstems.dos.nh.gov/

TAKE HOME POINT:

- **NOT ALL FIRE FIGHTERS ARE EMS STAFF**

AND…

- **NOT ALL EMS STAFF ARE FIRE FIGHTERS**





Core Training for Law Enforcement Personnel

-Chris Lewis





Advanced Training Options for Safety Personnel

-Susan Stearns

NAMI New Hampshire Training for First Responders

- Police Standards & Training Council
  - Academy Trainings - *Handling Calls Involving Persons with Mental Illness*
    - 16 Hours at Full-Time Police Academy
    - 8 Hours at Part-Time Police Academy
    - 16 Hours at Full-Time Corrections Academy
    - 8 Hours at Court Security Officer Academy
  - In-Service (Advanced) Trainings (since FY 22)
    - 40 Hours Crisis Intervention Team Training
    - 4 Hour Crisis Intervention Team Refresher Training

Crisis Intervention Team Training (Memphis Model)

- SAMHSA Mental Health Awareness Training Grant (2018) – 3 years
  - 40-Hour Crisis Intervention Team (CIT) trainings
    - Partnership with Department of Safety – NH State Police and Fire Academy
  - 8-Hour Mental Health First Aid (MHFA) for Public Safety
    - Part-time Fire/EMS

- Second SAMHSA Mental Health Awareness Training Grant (2021) – 5 years
  - CIT trainings for First Responders, including NHSP, local LE, Fire/EMS
  - MHFA for Public Safety – part-timers

Number CIT and MHAT Trainings 2019-2026

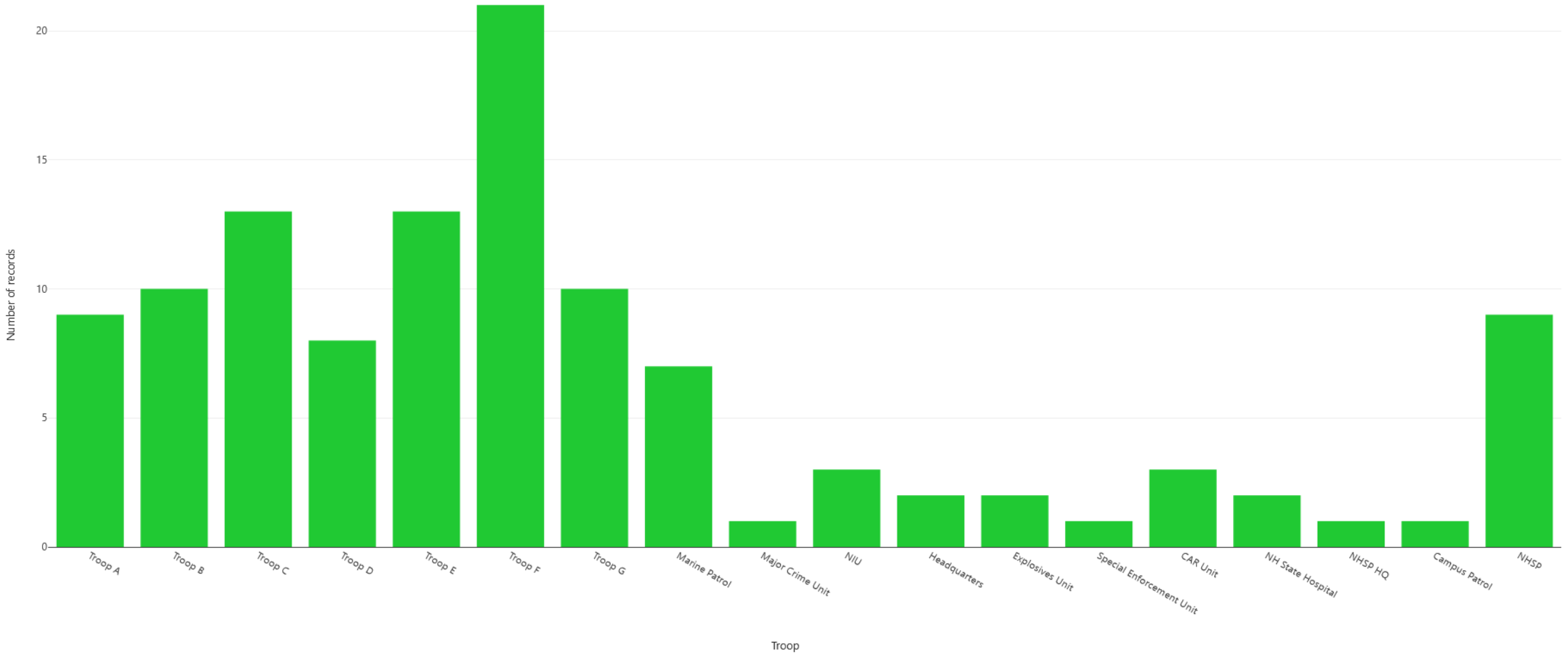
Training Type	Number of Trainings
CIT	56
MHFA	7

CIT and MHFA Trained Individuals

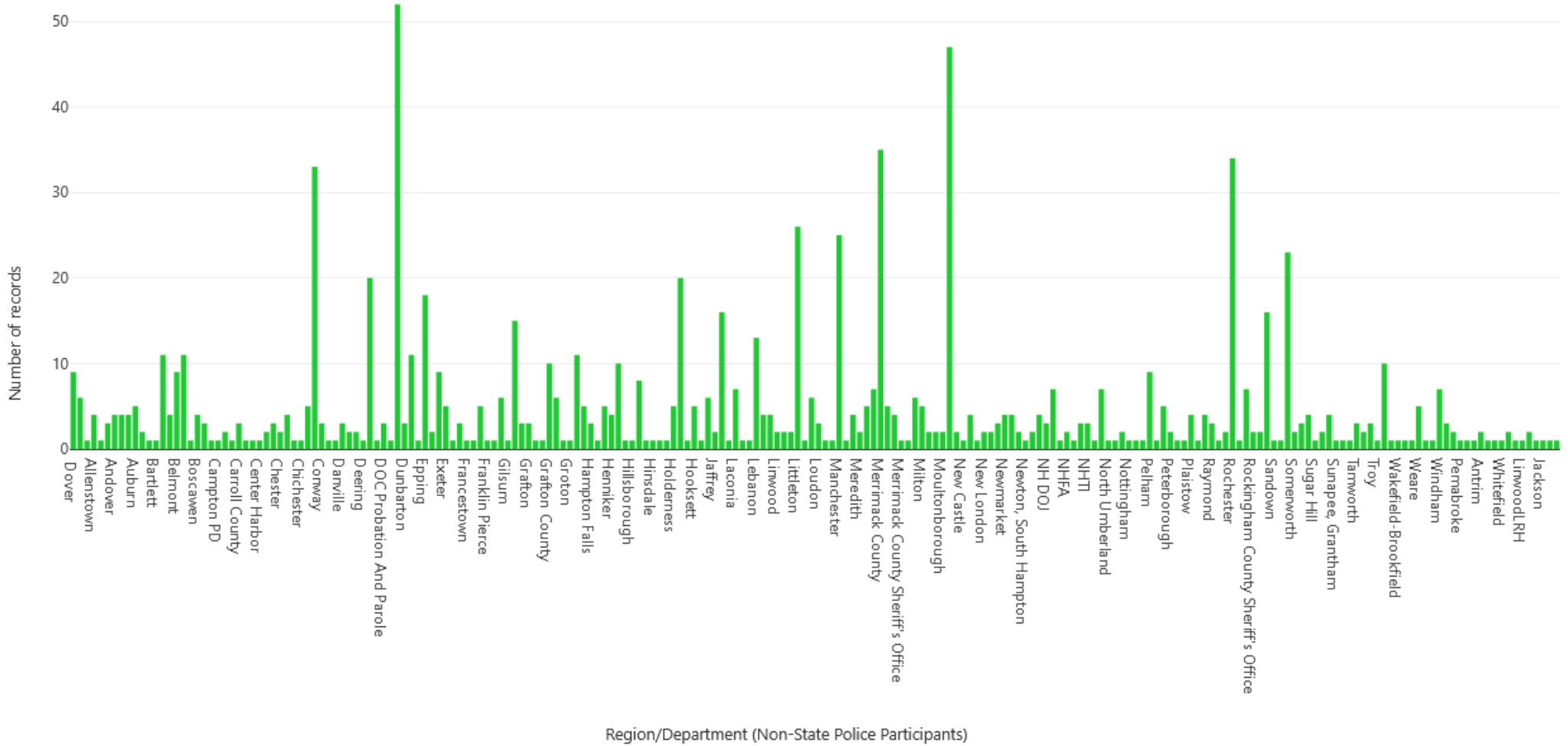
CIT Participant Type	Number Trained
Corrections	154
Fire/EMS	80
Local Law Enforcement	744
Sheriff	57
State Police	167
Other	58

MHFA Participant Type	Number Trained
Corrections	12
Fire/EMS	3
Local Law Enforcement	86
Other	65

NH State Police Trained in CIT by Troop/Division



Local Law Enforcement and First Responders Trained in CIT/MHFA by Town



Time for clarifying and discussion questions

First, do we have any clarifying questions?

For discussion

1. Fire, local Law Enforcement, State Police, a Crisis Team and two dispatchers are involved so far - Who is “on point” for the crisis response?
2. What are the strengths/assets of the responders on the scene?
3. Where are the safety risks for the person in crisis and the first responders?
4. What does the person in ‘crisis’ want or need?
5. How might the first responders proceed in a way that is both safe and that supports the emergent needs of the person in crisis?





Thank you!

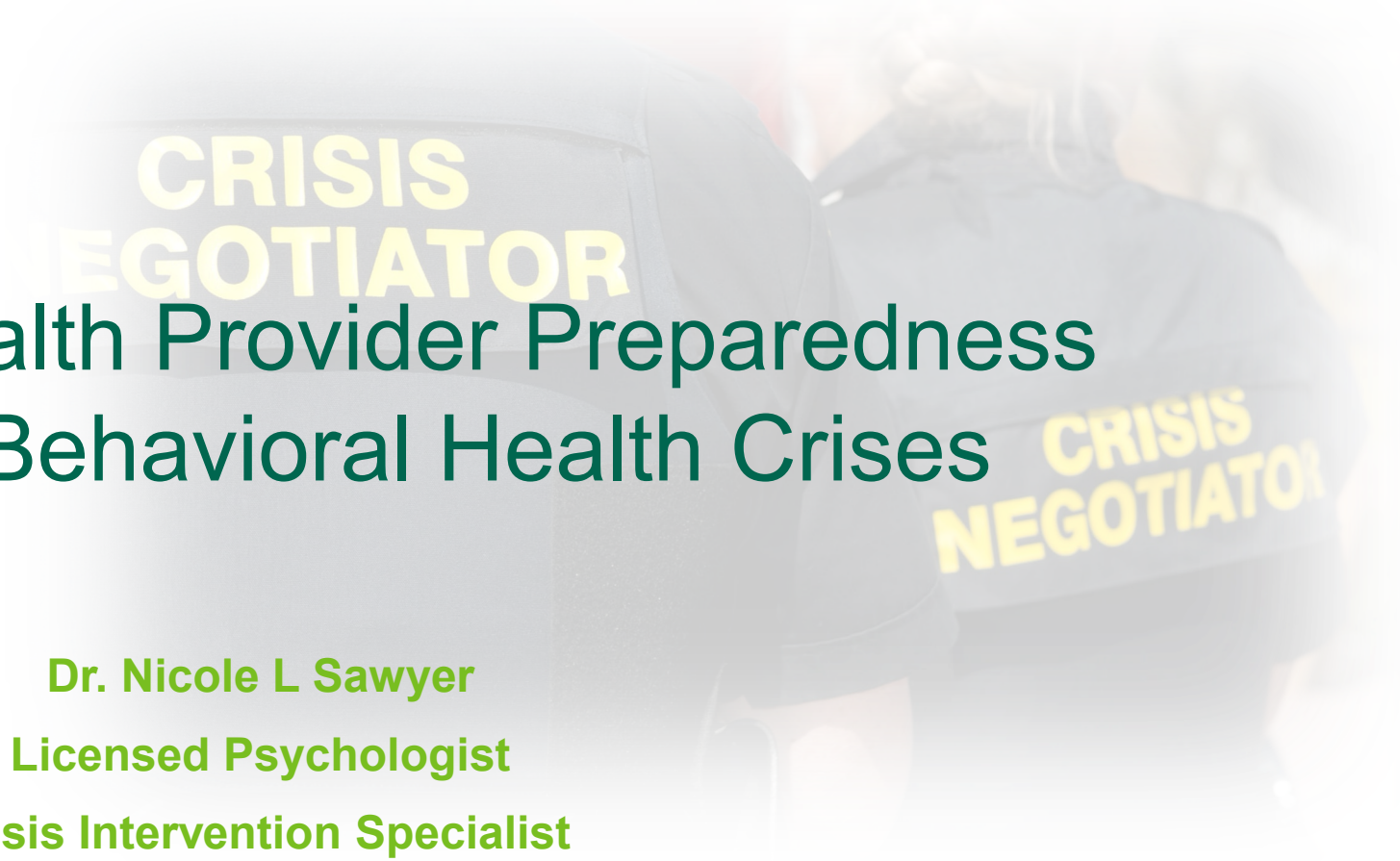
Dartmouth Health

Project ECHO®

WELCOME to the

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Session 2, Behavioral health provider preparedness and roles in behavioral health crises, June 24th, 2026



Behavioral Health Provider Preparedness & Roles in Behavioral Health Crises

Dr. Nicole L Sawyer

Licensed Psychologist

Crisis Intervention Specialist

Crisis Negotiation & Crisis Response:

- NH State Police along with several NH regional SWAT operations teams have incorporated at least one mental health professional (MHP*) into their Crisis Negotiation Unit/Team (CNU/CNT)
- No statute in NH that requires or regulates MHP support on law enforcement crisis teams
  - No regulations on roles, training, expectations of MHP
  - No regulations on legal and jurisdictional responsibilities
- Roles and expectations tend to be drawn from National Tactical Officers Association (NTOA) **Integration of Behavioral Health Advisors Standards and Best Practices for Crisis Negotiation Teams** recently updated in April 2026

*in NH we call them MHP, other places use BHA (behavioral health advisor)

Best Practices for MHPs on Crisis Teams:

Core principal: MHPs enhance CNT operations by providing real-time behavioral analysis, communication strategy support, and risk-informed consultation to negotiators and command, *without assuming a clinical or treatment role*.

GOAL: Preservation of life through communication and de-escalation

The MHP should be:

- A **licensed** mental health provider in NH (Psychologist, Social Worker, Counselor, etc.)
- **Culturally Competent** to collaborate directly with law enforcement operations
- Have **experience with intervention and/or assessment** of seriously disturbed individuals

Specific Training:

- Prior law-enforcement collaboration (CIT, CISM, mobile crisis, co-responder, hospital psychiatric emergency services/emergency departments (PES/ED).
  - CIT and CISM are widely available across NH and New England
  - Serving CISM teams is a great opportunity to build law enforcement collaboration experience
- Completion of an approved 40-hour Basic Crisis Negotiations course (or equivalent CNT-specific curriculum).
  - Typically, the FBI 40-hour course
- Training in suicidal/homicidal risk, threat assessment, trauma, substance use, and developmental disabilities
  - Typically achieved via professional licensure CE standards

Authority & Governance:

- The CNT/SWAT Commander has tactical/operational authority over the MHP during incidents.
- The MHP operates within professional ethics and licensure and will not independently direct police tactics or conduct clinical treatment while acting in the advisor role.
- The Negotiations Team Leader (NTL) synchronizes all MHP inputs with the negotiation strategy.



Roles & Responsibilities:

- Provide rapid behavioral assessment and working hypotheses about risk, motivation, stressors, and likely pathways to resolution.
- Advise on communication strategy (tone, pacing, hooks, triggers, time use), threats of suicide/violence, and stabilization tactics.
- Assist with third-party intermediary (TPI) selection, preparation, coaching, and risk-screening; draft/verbalize TPI scripts when appropriate.
- Support interviewer(s) for collateral contacts (family, providers, probation, etc.) and synthesize relevant information.
- Collaborate with Intel/Scribe to maintain a behavioral timeline; flag escalators/de-escalators.
- Participate in huddles/briefings; provide succinct recommendations (1–3 “most likely to help” actions).
- Post-incident: provide structured after-action insights.

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The REAL must is **TRUST:**

- At its core, the success of MHP collaboration depends 100% on the **trust** built between the Tactical Leadership, the Sworn Crisis Negotiators and the MHP.
  - **NO amount of training or expertise can overcome lack of trust**

- Attend and participate in quarterly and annual training events with CNT & tactical team
- Professional conduct with an ability to integrate into the culture
- Confident assertion while knowing your place on the team
- Willingness to accept responsibility for your role and respect the roles of others
- Belief in the mission
- *What happens in the NOC stays in the NOC*, no need for recognition


CRISIS
NEGOTIATOR





WELCOME to the

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Session 3, Vision for Behavioral Health Crisis Care – NH Rapid Response, July 8th, 2026

New Hampshire Rapid Response Overview

Brian C. Harvey, M.Ed., Clinical Planning & Review Specialist,
Bureau of Mental Health Services

AGENDA

- A Brief History of Rapid Response
- The NHRR Landscape
- 3 Key Take Aways

Division For Behavioral Health – Crisis Team



Brian C. Harvey, M.Ed.

- Clinical Planning & Review Specialist
- Bureau of Mental Health Services



Shannon Murano, M.S.

- Crisis Services Specialist
- Bureau of Mental Health Services



Mary Kate Russo, BS

- CME & Crisis Program Specialist
- Bureau for Children's Behavioral Health

New Hampshire Rapid Response

The Three Pillars



A Brief History of NH Rapid Response

NHRR System Design

- Available to children and adults
- Integrated mental health and substance use care
- Person-centered
- Recovery oriented including peer responders
- Trauma-informed
- Committed to Zero Suicide/Suicide Safer Care
- Upholds safety of individuals served & responders



A Brief History of NH Rapid Response

NH Background Drivers

- **DHHS 10-year mental health plan** calls for a centralized portal with a single source phone-based access point and calls for enhanced regional delivery of mental health services for children, youth, and adults
- **RSA – 167:3-1 requires** "That all children in the state under 21 years of age have access to mobile crisis response and stabilization services, that such services are available with a response time of no more than one hour…"
- **The Governor's Commission on Alcohol and Other Drugs** 2019-2021 Strategic Plan calls for a "one-stop shop" model to manage crisis calls and to create mobile crisis response teams
- **NH Children's System of Care (RSA 135:F and RSA 170:G)** requires statewide mobile crisis services for children and youth
- **National best practices** of Crisis Now and the transition of the National of the Suicide Prevention Lifeline to 9-8-8

A Brief History of NH Rapid Response

The Development of Mobile Crisis Teams in NH



Mobile teams are a key feature of NHRR.

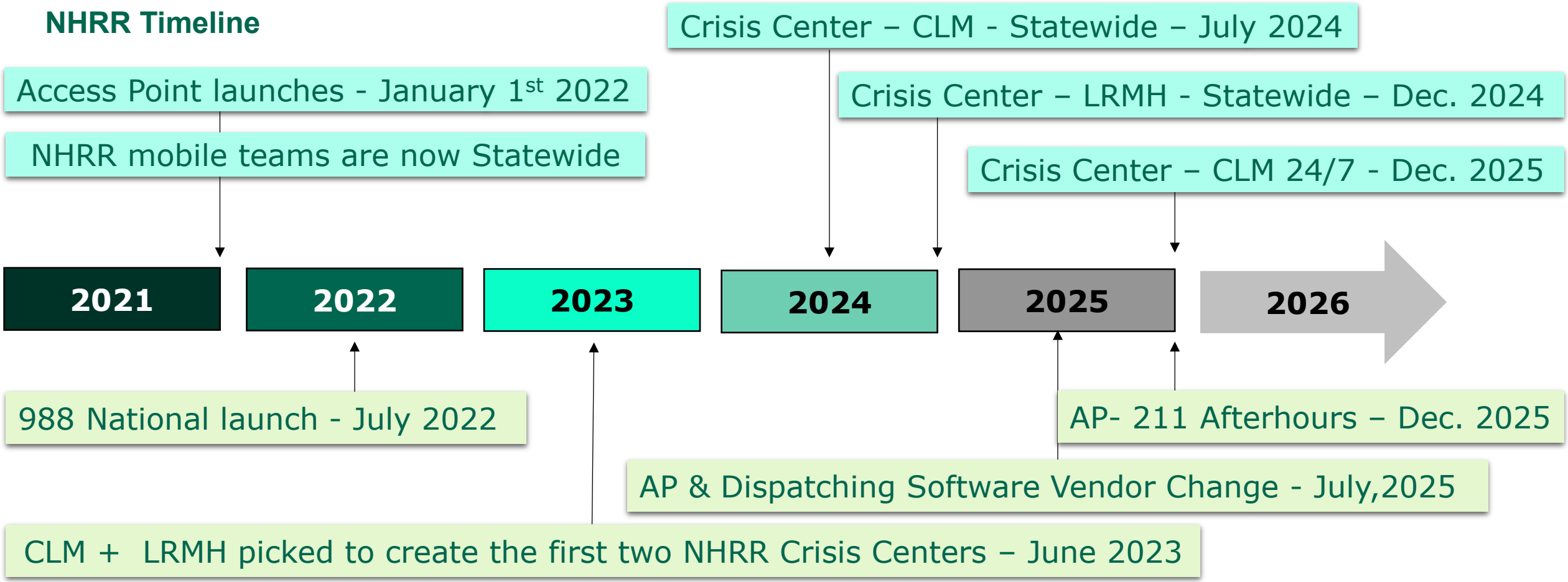
The first adult mental health mobile teams started with:

- Concord in 2015
- Manchester in 2017
- Nashua in 2020

NHRR mobile teams launches statewide on January 1st, 2022.

A Brief History of NH Rapid Response

NHRR Timeline



NH Rapid Response Landscape

Who contacts NHRR?

Schools frequently contact the Access Point for assistance in de-escalating students, finding them referrals, or requesting a deployment for that youth in crisis.

Families frequently call for assistance in support of a loved one in crisis. As we know they themselves may need help either navigating the system or minimizing the impact of the crisis on themselves.

First responders contact the Access Point for an individual in crisis in a secure setting such as a jail or in the community if the scene is clear or they are staying on site.



Many calls come to the Access Point from various providers from CMHCs to PCPs seeking supports for their clients in crisis.

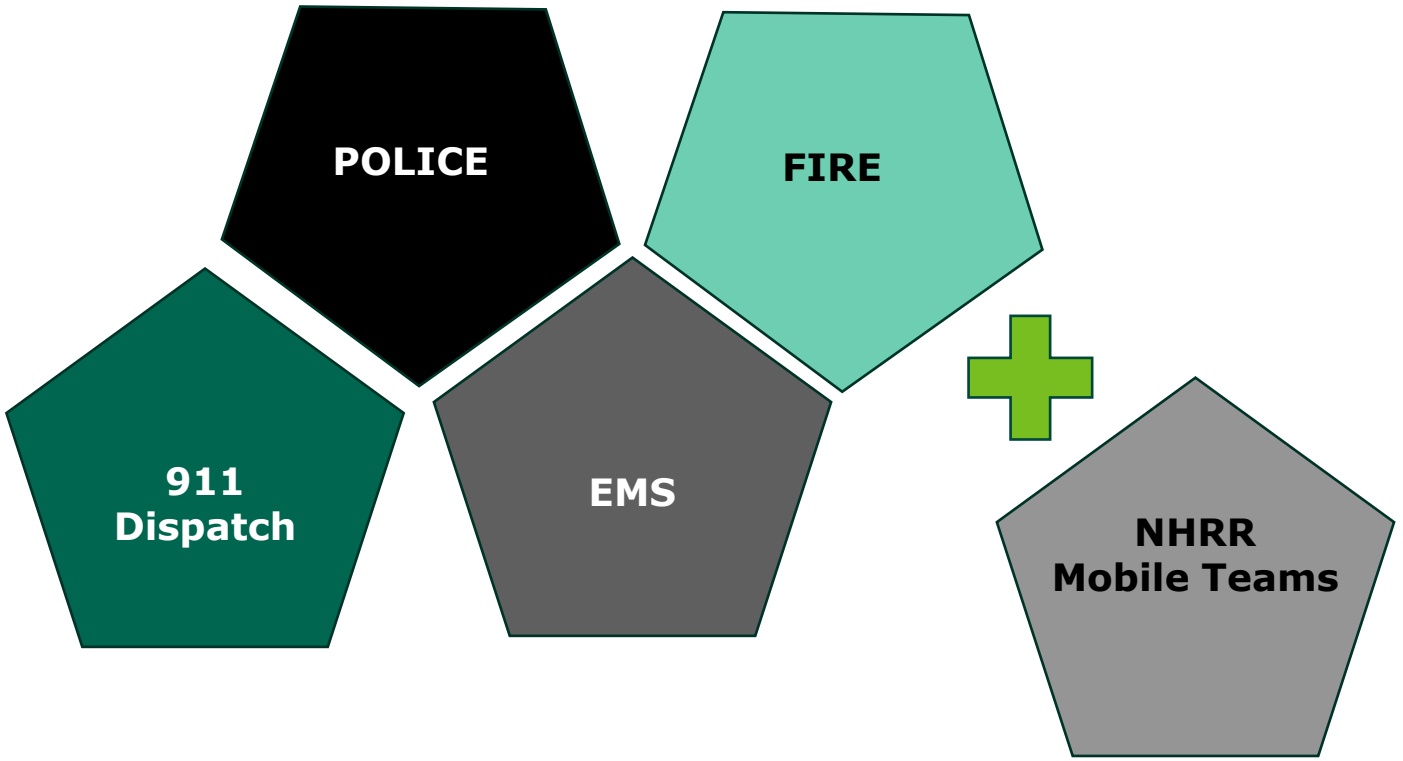
Regardless of age an individual can text, chat, or call the Access Point if they are in need of assistance.

NH Rapid Response Landscape

First Responders

Cultural Shift:

We are adding another type of First Responder**…** Can you imagine a time when police didn't exist?



NH Rapid Response Landscape

Deploying Mobile Teams

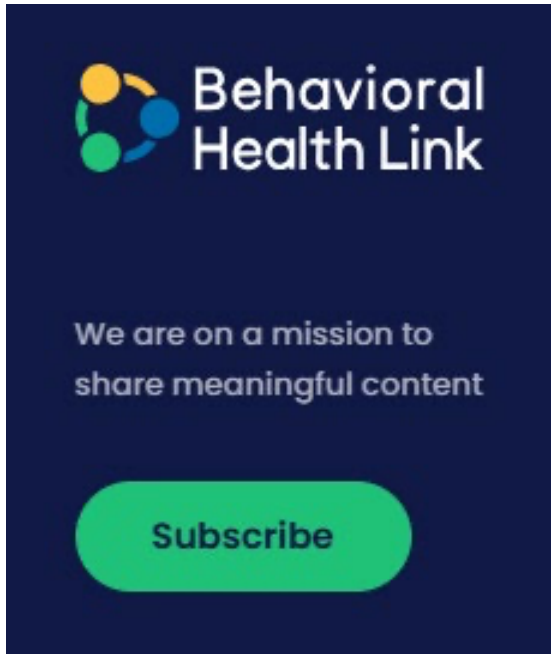


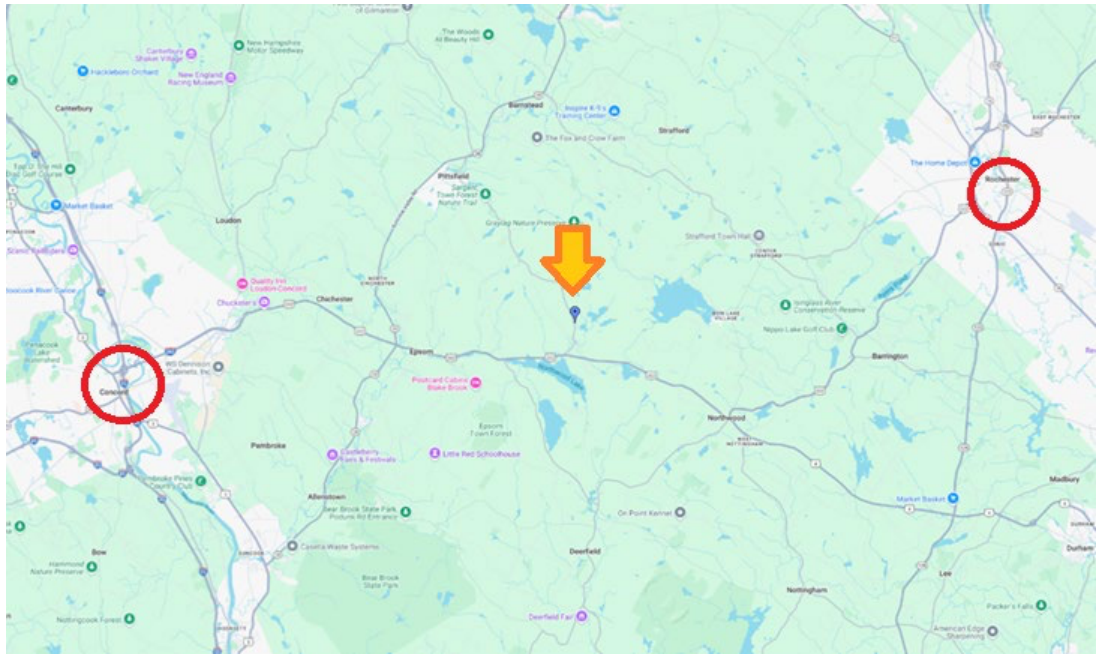
Cultural Shift:

In the past – Crisis were defined by specific criteria. Such as: suicidal ideation, homicidal ideation, psychosis. Now a crisis is anytime an individual's functioning, support system, and coping skills are overwhelmed.

NH Rapid Response Landscape

Dispatching





BHL is the new Dispatching Software for NHRR as of July 1st, 2025

Cultural Shift:

NHRR services (Mobile/Crisis Center) are available regardless of catchment area.

NHRR mobile Teams must accept a dispatch from the Access Point within 10 minutes.

The Access Point only dispatches within a 1 hour radius.

Someone To Talk To

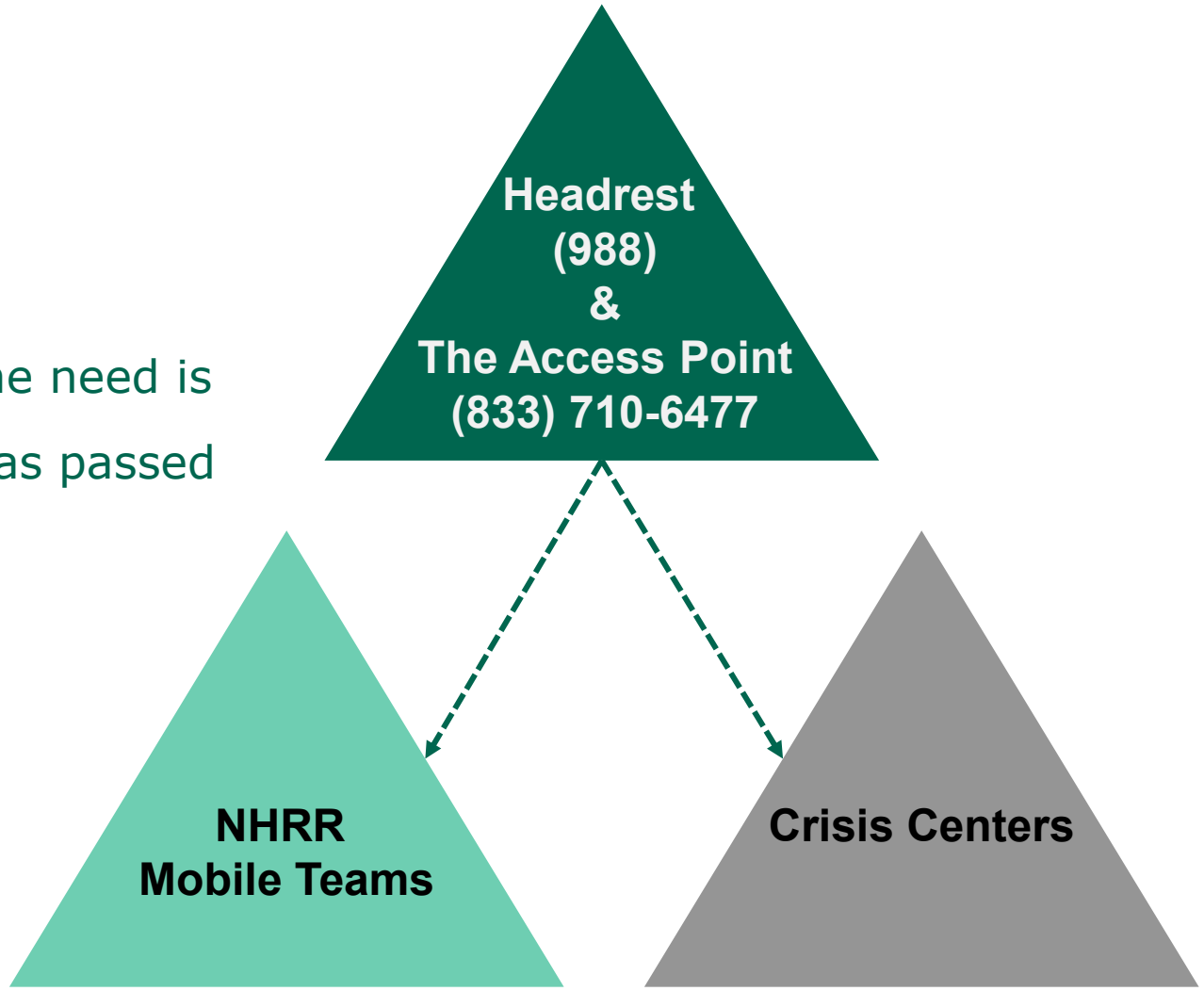
The First Pillar

Call Early, Call Often:

Someone will answer my call

A mobile team will dispatch to wherever the need is

I have a safer place to be until the crisis has passed



Someone To Talk To

The First Pillar

The Access Point

Call or Text (833) 710-6477

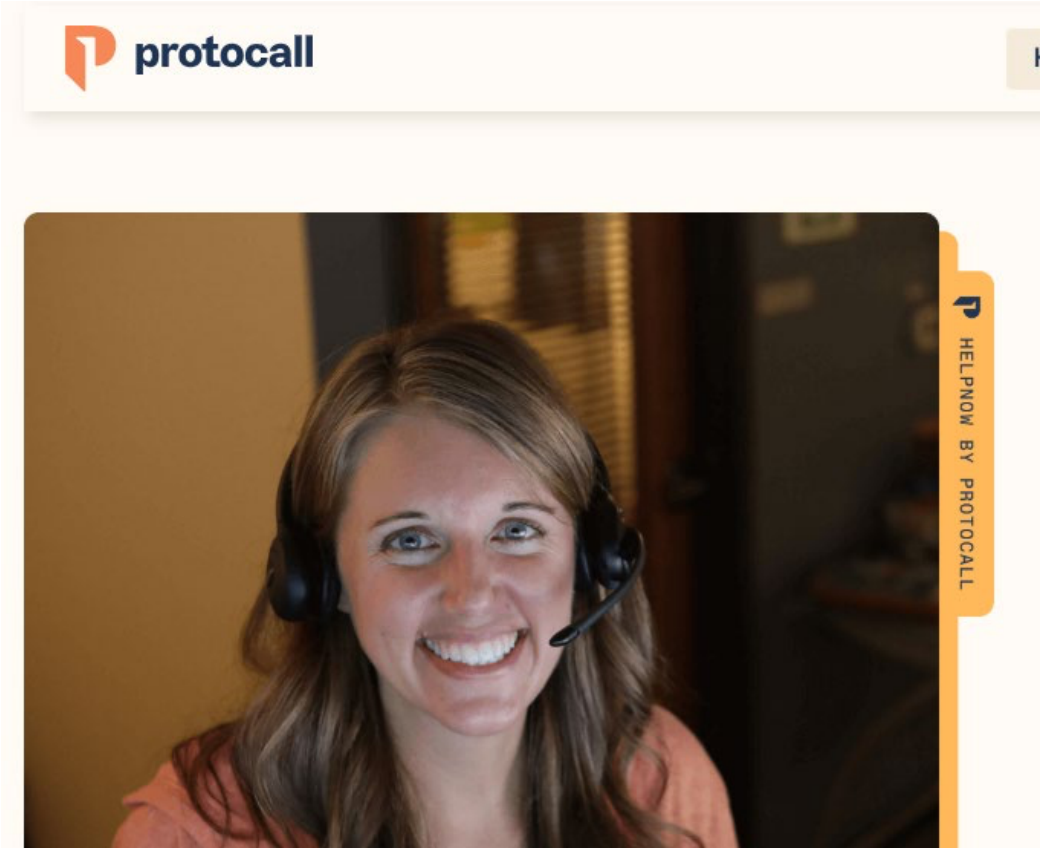
Chat is available at www.nh988.com

Can dispatch mobile teams or to crisis centers

VIRTUAL	TRAINED SPECIFIC TO NH	AVAILABLE FOR ALL

Someone To Talk To

The First Pillar



NHRR Access Point Vendor

- Protocall Services Inc.
- Operates in other markets (New Mexico)
- Over 350 crisis operators (Virtual).
- Specific workflows for NH.

AP Program Manager:

Kara Washam
kara.washam@protocallservices.com
Program Manager, NH 988
855-404-5987

Someone To Talk To

The First Pillar



HEADREST
DAY AND NIGHT

Headrest Services Inc.

- Operates solely in New Hampshire
- 15 crisis operators.
- Specific workflows for NH.

Headrest Program Manager:

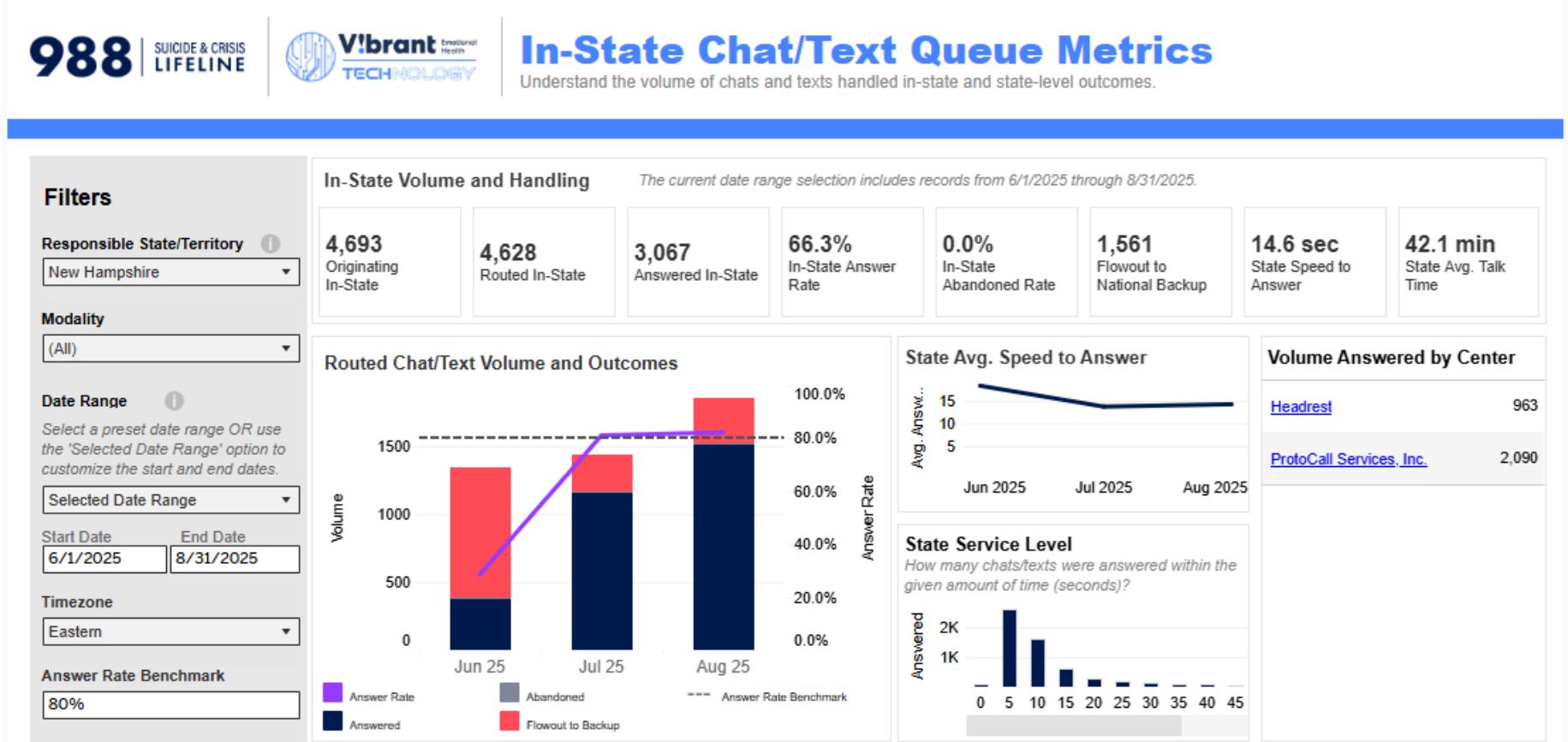
Al Carbonneau, Hotline Manager - Headrest, Inc

al.carbonneau@headrest.org

Office: 603-448-4872 press 1

Someone To Talk To

The First Pillar



Someone To Talk To

The First Pillar



Approx. 75% of the contacts at the Access Point are de-escalated by crisis operators and do not require any further intervention.



Referrals are made to:

- Peer Support Agencies
- 211
- The Doorways
- Partial Hospital Programs
- Private Practices
- PCP's
- And more…



If needed based on request, acuity, and availability a NHRR mobile team could be dispatched to the crisis or the individual could be referred to a Crisis Center.



Same day/Next day crisis appointments are also available at the CMHCs as well if clinically appropriate and/or preferred by the individual in crisis.



The NHRR Crisis Centers operated by Center for Life Management in Derry and Lakes Region Mental Health in Plymouth can take statewide referrals.

Someone To Respond

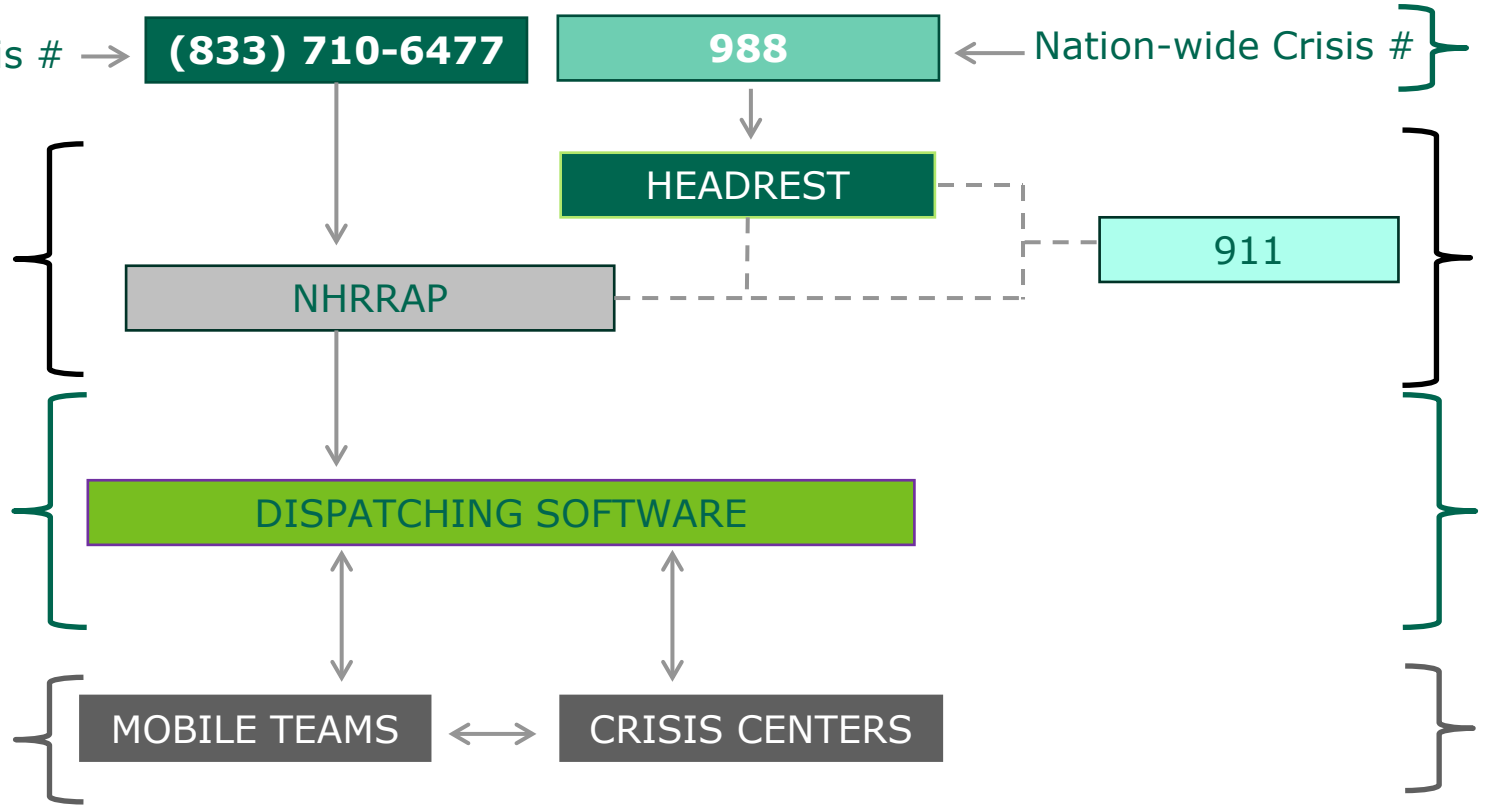
The Second Pillar

These #s will merge In the future

Sate-wide Crisis # → (833) 710-6477

988 ← Nation-wide Crisis #

Headrest & Protocall & 911 Have a Warm-Transfer Process for redirecting Behavioral health calls between them as needed.



The dispatching software sends time sensitive crisis info to the mobile teams or crisis centers from the AP.

The mobile teams & crisis centers can transfer crisis info to one another through dispatching software

NHRRAP Dispatch Levels

Safety Levels from AP to Rapid Response Mobile Responders

PILOT VERSION

New Hampshire Rapid Response Access Point

Level	Description	Criteria	Rapid Response Action
B	**NHRR Team Alone** Access Point will recommend that the NHRR Team deploys independently with any combination of trained responders, to any statewide location, in support of individuals in behavioral health crisis where no safety issues have been identified based on the Department approved risk rating levels.	Most typical community settings (home, public place, businesses). No significant safety concerns have been identified. Locations may be where the environment is under professional control and has professionals on scene (e.g. schools, residential facilities, nursing homes, etc.) OR the environment may be outside professional control, and therefore an element of caution is advised in responding.	NH Rapid Response Teams may respond in any configuration based on their discretion without law enforcement, using typical safety measures. NHRR Teams may deploy as: • A solo master's level clinician: • A pair of responders one of whom is a mater's level clinician; • A solo rapid responder with access to a master's level clinician via video; • A pair of responders with access to a master's level clinician via video; • A multidisciplinary team as part of a crisis center.
C	**NHRR Team with Law Enforcement** Access Point will recommend that the NHRR Team co-deploy when there is serious risk of harm to an individual or others and/or when a care setting is not safe. NHRR team co-deploys encounter with law enforcement in the background or following behind but on scene, or in the lead - immediately available to intervene if needed.	• Very High risk for Suicide: (Able to maintain safety until team arrives) • Moderate risk for Harm to Others (Ideation only) • Individual exhibits affective instability, impaired judgment, altered perceptions of reality, impulsivity, and/or functional impairment • Recent history of aggression • ~~Weapons are indicated as being part of a plan and/or on site; means elimination was pursued; no imminent danger to self or others; no intent.~~ • Dangerous pets are present and have not been secured or removed from the premises. • In situations where abusive individuals are present. • Environmental hazards are present • Situations in which no information was able to be obtained.	*If Law Enforcement is requesting a dispatch: NH Rapid Response team coordinates with law enforcement directly. AND/OR NHRR Teams may choose to not involve law enforcement at their discretion and following professional judgement (please follow your own internal policies and procedures).* ***NHRR Teams are responsible for coordinating with Law Enforcement and for determining how to co-deploy safely.*** Step 1.) Connect with the 911 system if delaying care pending co-deployment with LE would place the individual in jeopardy of escalation that may result in harm to self or others. If Law Enforcement is not immediately available to support, RR Teams may wait and stage pending LE availability. Step 2.) If 911 is unable to assist the individual in crisis – take steps to ensure the individual in crisis gets care by alternative means.

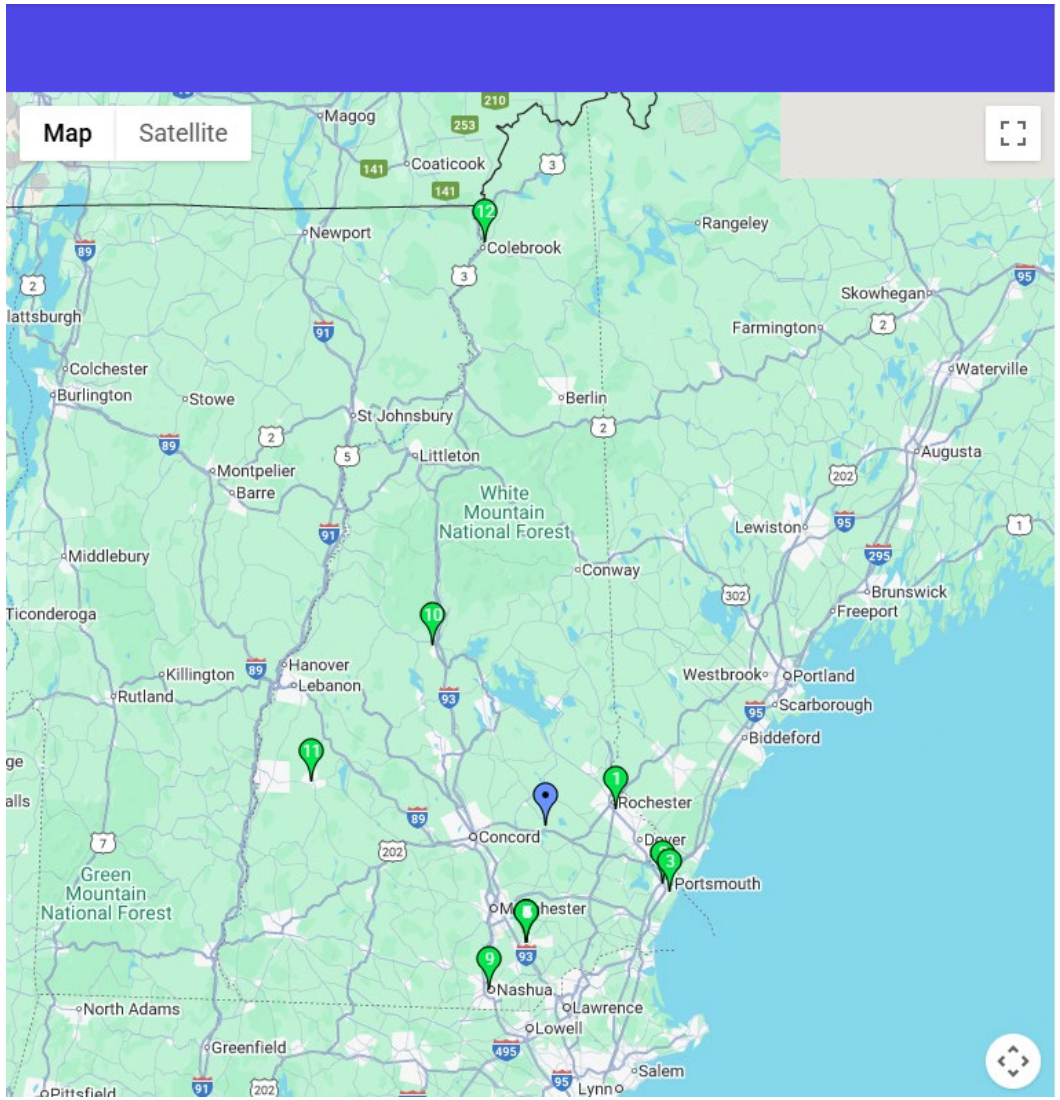
PILOT 03/30/2026.

Someone To Respond

The Second Pillar

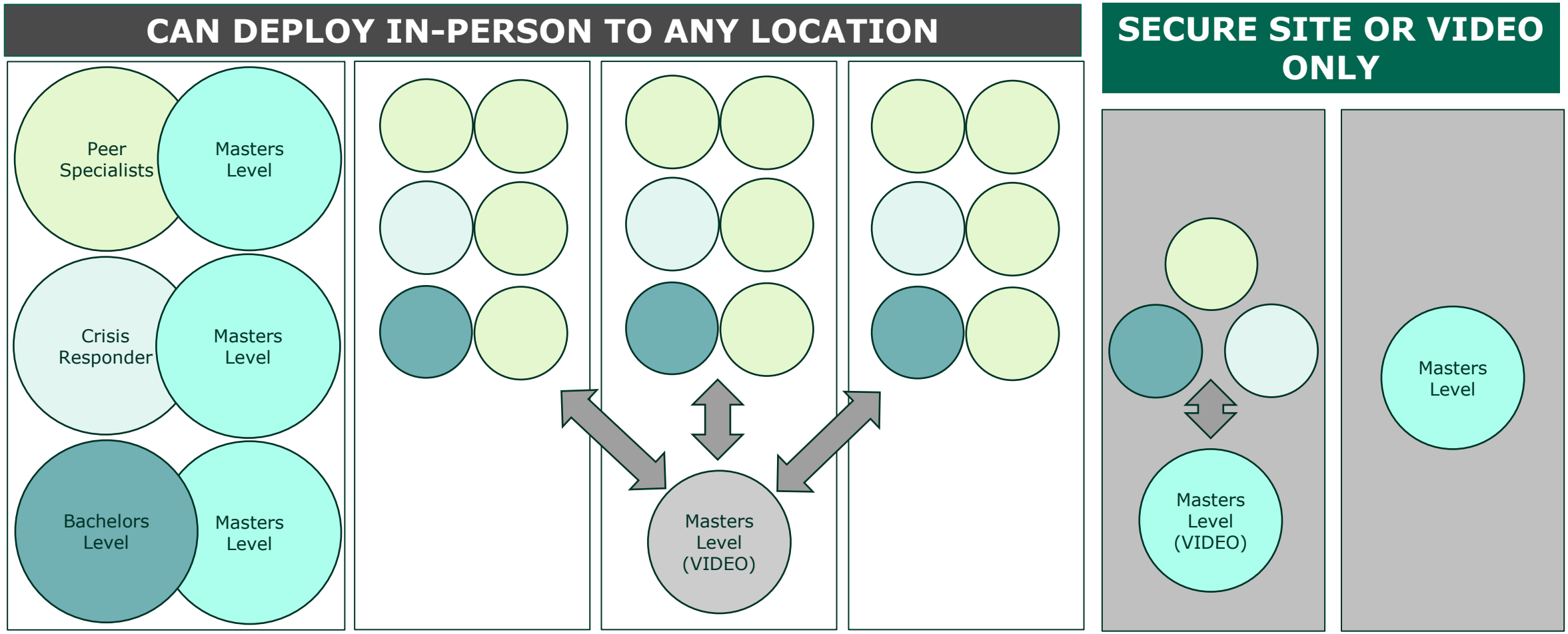
Rapid Response Teams across the state can respond in any of the three ways:

- In-person by a deployment to a community location
- By video assessment
- Or, in the office by a Same-day/Next-day appointment scheduled by the Access



Someone To Respond

The Second Pillar



A Safer Place To Be

Crisis Centers - Locations

SOMEWHERE TO GO LEVELS 1.1 -1.5

1.1	Peer Supported Stabilization
Crisis services for Somewhere to Go at Level 1.1 include a peer forward model that can support individuals with de-escalation and stabilization services for up to 23:59 and may include non-clinician therapeutic behavioral services as defined in the He-Ms.	
1.2	Functional Support Services - Stabilization
Would include all services provided by peers at Level 1.1 with the addition of FSS and Case Management services without the presence of psychotherapeutic services.	
1.3	+ Clinician Supported Stabilization
Crisis services for Somewhere to Go at Level 1.2 may include any of the services from Level 1.1 but shall include psychotherapeutic services as defined in the He-Ms.	
1.4	+ Medical Supported Stabilization
Crisis services for Somewhere to Go at Level 1.3 may include any of the services from Level 1.1,1.2 but shall include allied health professionals up to and including a DEA licensed provider.	
1.5	+ Medical Stabilization
Gold Standard – Crisis Now model – All previous levels plus full medical coverage (physical/psychiatric) on site.	

Crisis Centers currently operate within these three levels

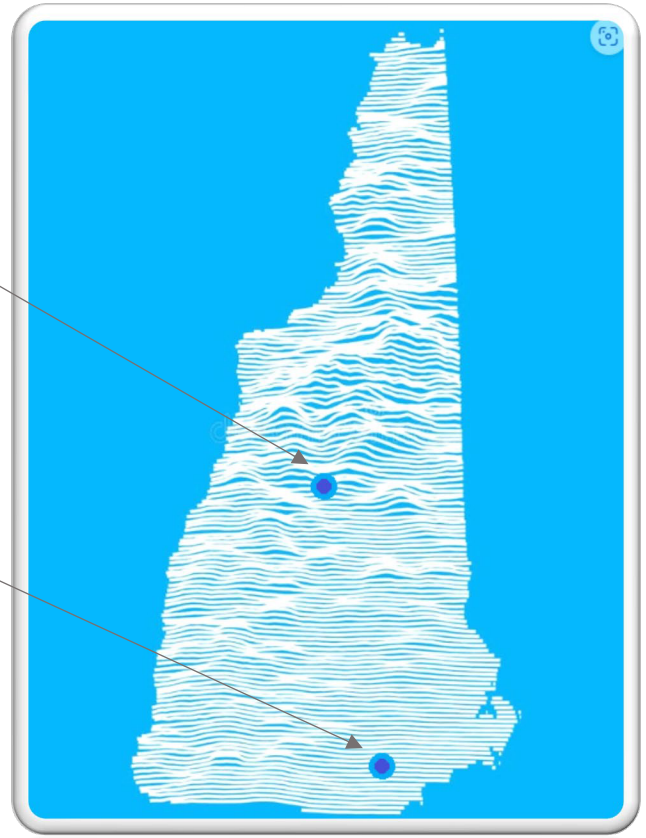
Future plans to include medical

A Safer Place To Be

Crisis Centers - Locations

Crisis Center - Plymouth

Crisis Center – (Derry)



Plymouth – Peer Forward
1.1 Model
Varying Hours

Derry – Peer Forward
1.3 Model (Clinical Support)
24/7
Early 2027 Level 1.4 (Medical Support)

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A Safer Place To Be

Crisis Centers - Locations



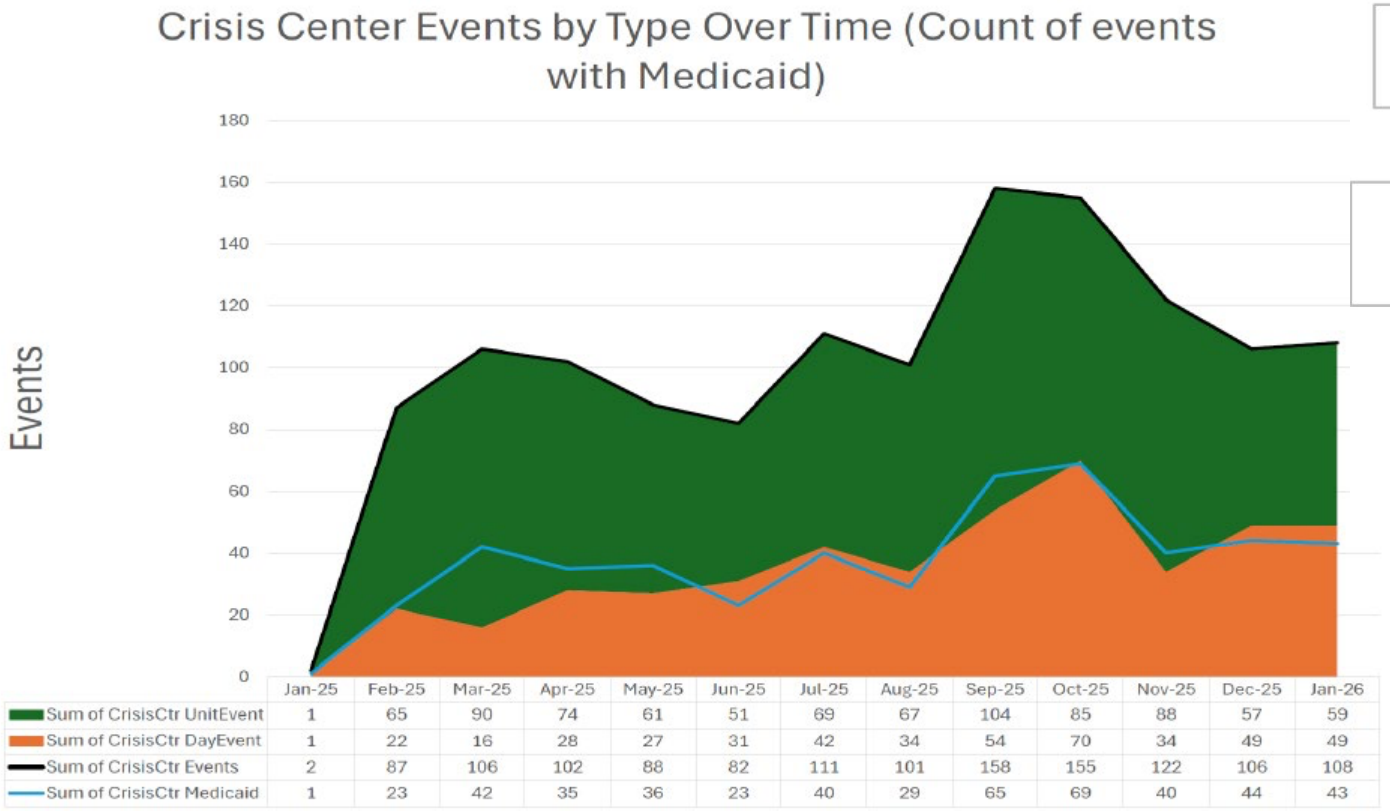
Crisis Center - Derry

Location:	10 Tsienneto Rd. Derry
Hours:	24 hours 7 Days a Week
Ages:	Any Age
Staff:	15
Positions:	Clinicians (4) Case Manager (1) Peers (10)
Services:	Observation Screening/assessment, Case management Nursing/medication

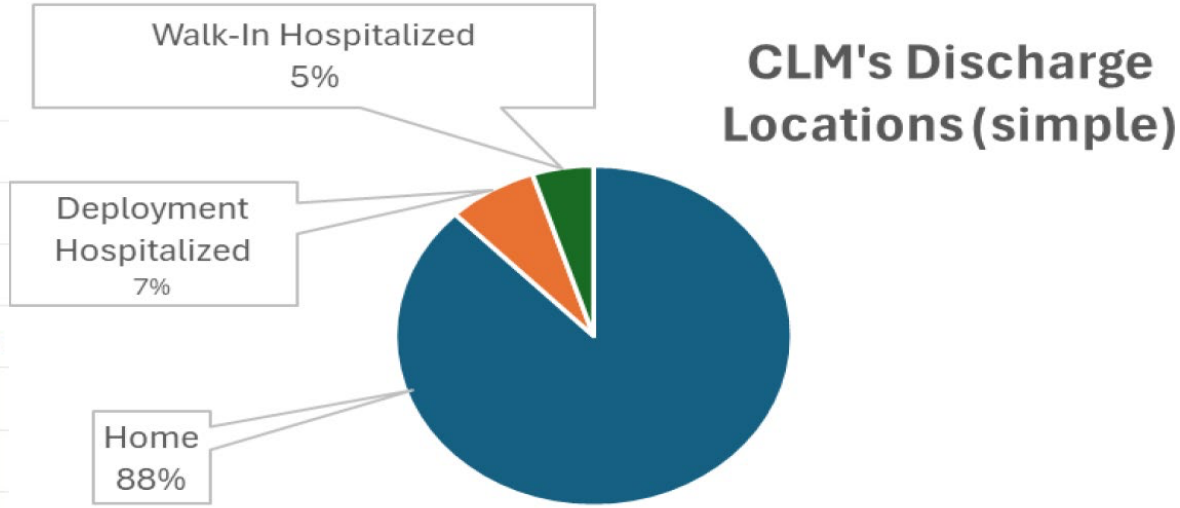
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A Safer Place To Be

Crisis Centers - Locations



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Sum of CrisisCtr UnitEvent	1	65	90	74	61	51	69	67	104	85	88	57	59
Sum of CrisisCtr DayEvent	1	22	16	28	27	31	42	34	54	70	34	49	49
Sum of CrisisCtr Events	2	87	106	102	88	82	111	101	158	155	122	106	108
Sum of CrisisCtr Medicaid	1	23	42	35	36	23	40	29	65	69	40	44	43



A Safer Place To Be

Crisis Centers - Locations

Crisis Center - Plymouth

Location:	81 Highland Street, Plymouth
Ages:	Any age
Hours:	7-11 pm Monday - Friday
Staff:	9
Positions:	Director (1), Assistant director (1) Provider (1) P/T Peer (6)
Services:	Observation Peer support Bridge medication





A Safer Place to Be

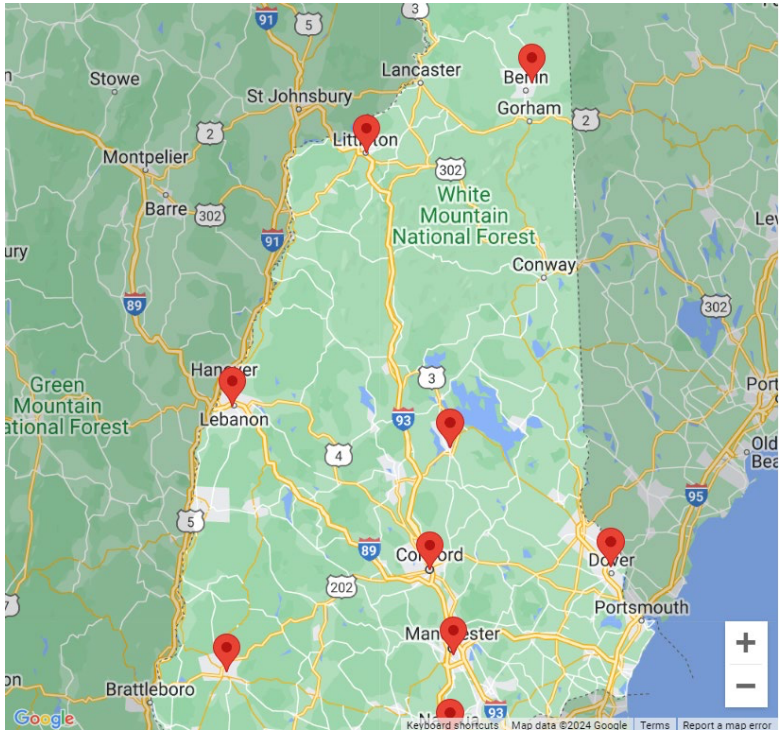
The Third Pillar



THE DOORWAY

The Doorways:

- Are low barrier access points for substance use supports and services, you call 211 to access your local Doorway.
- Wherever you live and wherever you are on your journey, The Doorway can help connect you to the substance use and recovery supports and services you may need and the level of care that's right for you.



Three Take Aways

Remember

1. NHRR Teams (mobile & crisis centers) are intended to serve anyone, anywhere, and at anytime.

2. Call 988 or (833) 710-6477 for support. If you need more, they'll direct you to:

- **A NHRR Mobile Team**
- **A NHRR Crisis Center**
- **Same-day/Next-day Appointment at a CMHC**

3. 211 and the Doorways are also available for substance use services and support.

4. IT DOESN'T MATTER WHO YOU CALL YOU'RE GOING TO GET HELP

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Public Safety & Behavioral Health Collaboration ECHO: Effective Crisis Responses in Your Community

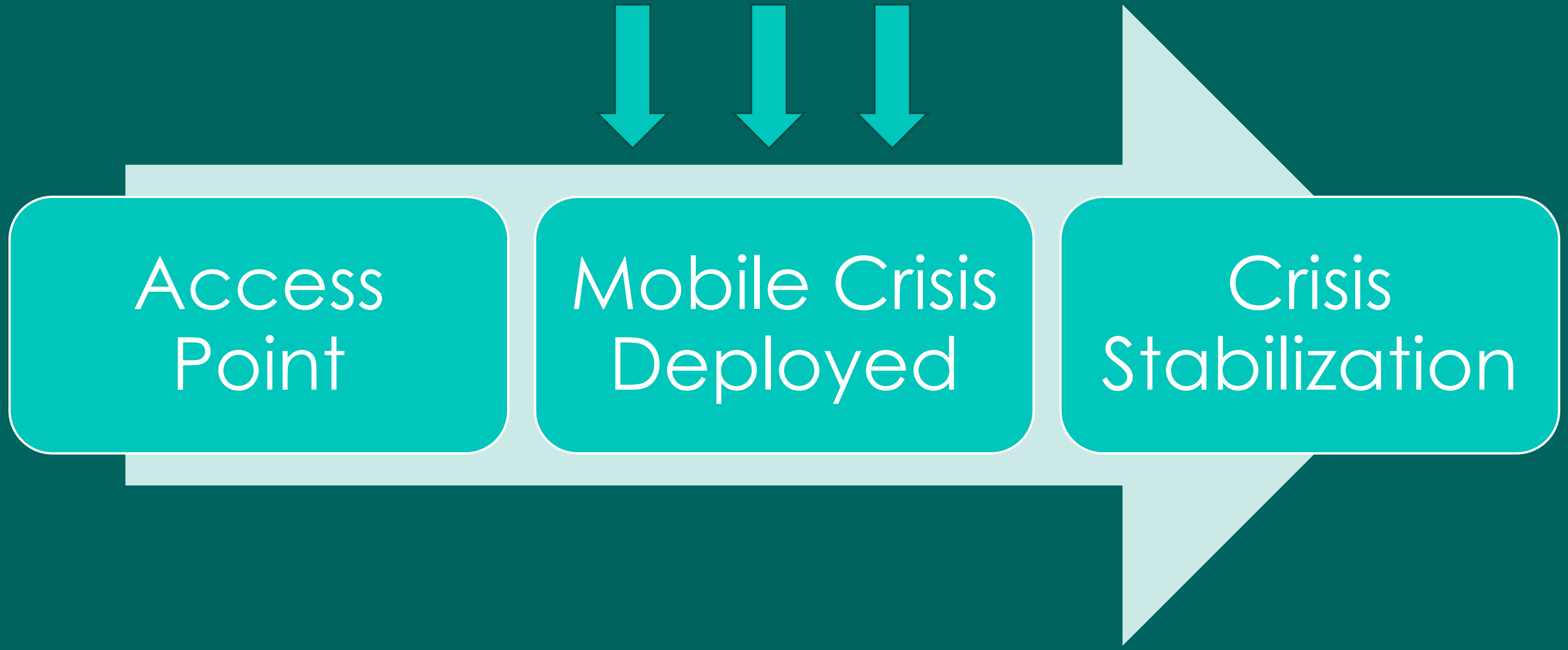
Session 4, Current State of Behavioral Health Crisis Response – Insights from three NH Regions, July 22nd, 2026

Rapid Response/ Mobile Crisis Program

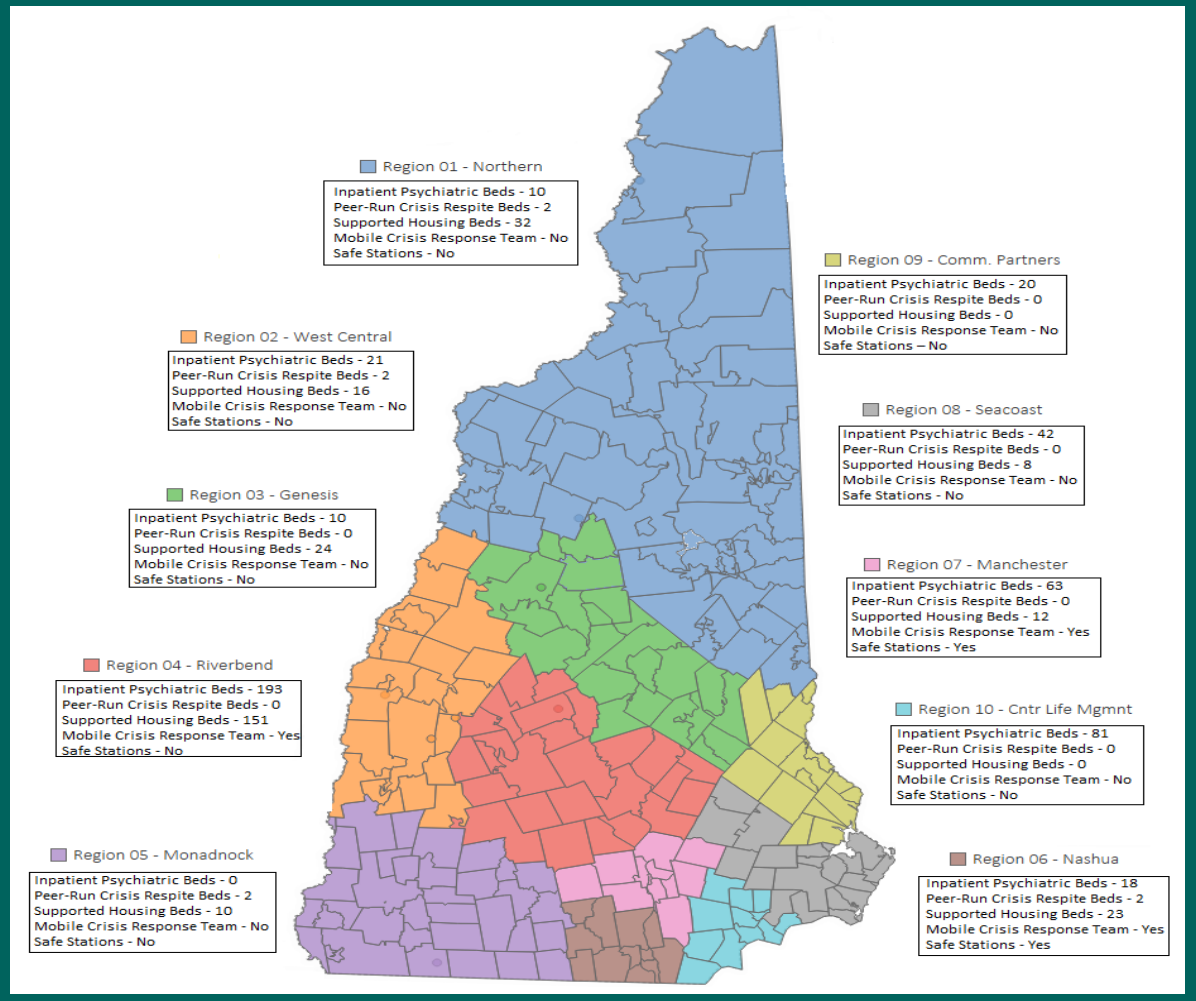
Serving Carroll County, Coos County and Upper Grafton County

Northern Human Services
Changing Lives

Three Stages of Crisis Intervention.



REGION 1



POPULATION

- Upper Grafton County 25,224
- Carroll County 48,138
- Coos County 31,543
- Total: Region 1 = 104,925

Northern Human Services Rapid Response Team Coverage



- "Volunteer firefighter model"
  - NHS continues to actively hire an "army of peer specialists
  - Piloting Peer imbedded in ER model
  - Dispatched from their homes to crisis.
  - We currently have 2 peer team deploying from Conway and Colebrook Sunday to Friday 5pm to midnight
  - 24/7 Telehealth services provided by a Master's level clinician for assessment and clinical assistance.

Follow-Up Options

30 days of Stabilization Services with appropriate mobile crisis team

Connection to local Community Mental Health Services

Connection to local private providers

Connection to Substance Use Services

Connection to IOP or PHP

Connection to NAMI supports

Connection to Inpatient services, some direct admit and some through ER

Data

	Deployments	Non-billable Deployments	Stabilization Appointments	Contacts
2026	59	23	327	37
2025	214	114	336	90
2024	86	9	59	16

Thank You

Jaime-Rose Kelly
NHS Director of Acute Services
jkelly@northernhs.org

Rapid Response:
An Urban Example

Jessica Lachance, MS, CCISM

Director, Rapid Response

The Mental Health Center of Greater Manchester



Manchester NH at a Glance:

- Largest City in NH , with a population of over 116,000 (2024 US Census Bureau)
- 20 public schools
- Citywide, including private and preschool facilities, over 100 schools in the Manchester area
- MPD has largest patrol unit in the state (132 uniformed and specialized patrol officers)
- 5 main shelters for unhoused population located in Manchester
- Lots of resources, however very high utilization and high need community
- 2 full size hospitals, Elliot and Catholic Medical Center, in addition to Cypress Center

Manchester RR Team at a Glance:

Began in 2017 as the second of 3 Mobile Crisis Teams Statewide, then integrated to Statewide RR model in 2022

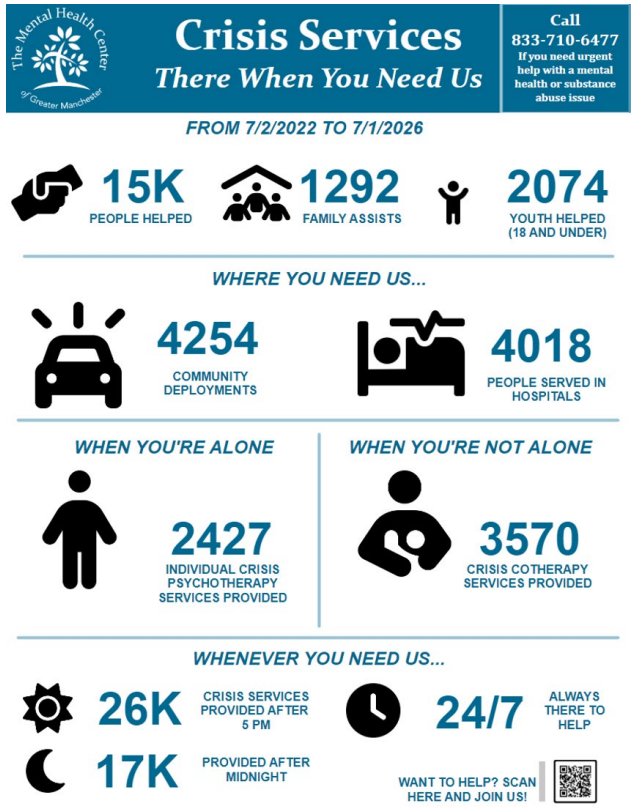
Self contained, from triage to deployment to crisis stabilization up until 2022

Trained with the BEST team (Boston Emergency Services Team) to understand urban model

Partnered with Manchester Police Department, developed model for integrated response, CIT training (Memphis Model) through grant funding

MPD second highest referral source (first = self referral)

Someone to Respond:



- Deploy clinician and peer together
- Vast majority of deployments are face to face, in person
- 7 nights per week MPD CIT officer is embedded in the team (4pm-10pm)
- From 2017 to 2022, Diversion rate 95%, 2022-current Statewide around 85%

Strengths and Challenges

- High concentration of resources
- Opportunities for Partnerships/Collaboration
- Access to local hospitals
- Large pool of FT and per diem staff (over 50 staff combined)

- Safety considerations, many “hot spots” in the city
- Unique challenges with volume
- Housing is a huge challenge, large unhoused population with significant and complex needs
- High volume of local requests from community partners, first responders and continued adjustment to Statewide model vs local response model.

Rapid Response in a Mixed Rural/Suburban Area

Detective Eric S Adams
Laconia Police Department

Meredith Anderson, MS
Lakes Region Mental Health Center

Community Deployment

- Outpatient mental health residential program manager reached out to mobile crisis in regards to a male in their housing complex acting erratic/disheveled and disturbing other residents. Mobile crisis team (including a clinician and a peer support specialist) reached out to Laconia Police Department to meet at the individual's place of residency as a precaution due concern for unpredictable erratic behavior.
- Other known past information: Individual has history of schizophrenia as well as stimulant use.

Response

- Officer approached individual's apartment door and was able not only able to secure the area but also convince him to come out of his apartment and talk with the mobile crisis team.
- Individual spoke with mental health clinician and peer support specialist about how he had been struggling with the anniversary of his mother's death and had been having difficulty regulating his emotions.
- Officer was able to step back and allow mobile crisis team to provide therapeutic support and safety assessment to which the individual responded well do. Individual had been able to express his grief and was able to return to his baseline.

Before Rapid Response Implementation

- Individuals in crisis would either call 911 or Lakes Region Mental Health Center's Crisis Line
- Oftentimes if individual called 911 Law Enforcement would bring person in crisis to local Emergency Room
- If individual called crisis line the individual would talk with a Clinician from Lakes Region Mental Health
  - If Clinician had concerns about individual's safety (danger to self or others) Clinician would call PD to do a wellness check which would most likely result in individual being brought to ED.
  - If Clinician thought individual was safe and de-escalated, person in crisis would remain in community without meeting a person face to face

After Rapid Response Implementation

- Address crisis in the moment
  - Rather than lengthy ED wait
- Allows members in community to readily access resources
- Address crisis where people feel more comfortable

Obstacles

- Dispatch time to travel time
  - Receiving dispatch
- Non Discreet Intervention

Questions?

Law Enforcement Perspective

- 24/7 service
- Roughly half of all calls for service involve mental health.
- Historically Law Enforcement was ill-equipped to handle these types of calls
  - Lack of training biggest factor
- Over last 5-7 years training has improved.
  - De-escalation
  - CIT (Crisis Intervention training)
  - Mental Health First Aid
  - Implicit Bias Training
  - Ethics Training

Law Enforcement Perspective

- Between additional trainings and Mobile Crisis we are better equipped to handle mental health calls for service.
- Types of calls for service Mobile Crisis works with LE
  - Suicidal Individual
  - Person Experiencing Psychosis
  - Welfare Check on an Individual in Crisis
  - Youth Behavioral Health Crisis
  - Frequent Utilizer of Emergency Services
  - Person experiencing homelessness with Mental Illness
  - Family Crisis Involving Mental Illness
  - Substance Use and Co-Occurring Mental Health Crisis

Law Enforcement Perspective

Benefits of Mobile Crisis Team and Law Enforcement Collaboration

- When Mobile Crisis Teams and law enforcement work together, communities often experience:
  - Reduced use of force incidents.
  - Increased voluntary compliance with treatment recommendations.
  - Fewer arrests of individuals whose behavior is driven by mental illness.
  - Reduced emergency department utilization.
  - Improved officer safety.
  - Better outcomes for individuals in crisis.
  - Stronger relationships between law enforcement, behavioral health providers, and the community.
  - Increased diversion from the criminal justice system into appropriate treatment and support services.





Questions for our speakers?

Case discussion is next





WELCOME to the

Public Safety & Behavioral Health Collaboration ECHO: Effective Crisis Responses in Your Community

*Session 5, Continuing engagement to support people with **recurrent crisis encounters**, August 5th, 2026*

Today's Program

- Brief housekeeping
- Didactic: Continuing engagement to support people with recurrent crisis encounters
  - Dave Suckling - Chief of Police, Alexandria, NH
  - Detective Eric Adams - Prevention, Enforcement & Treatment Coordinator, Laconia Police Department
- Case Discussion
- Up Next





Continuing Engagement to support people with recurrent crisis encounters

Dave Suckling, Chief, Alexandria Police Department

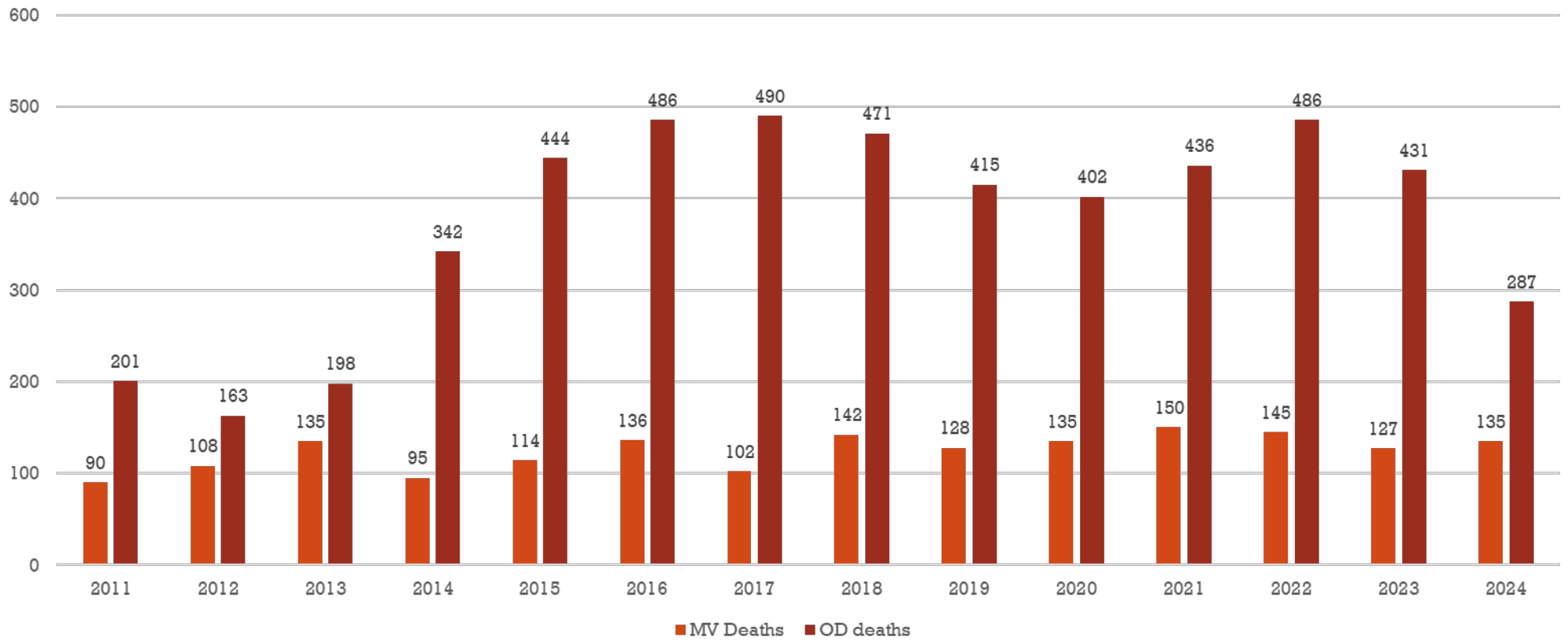
Eric Adams, Detective, Laconia Police Department

Why Should this matter to Law enforcement?





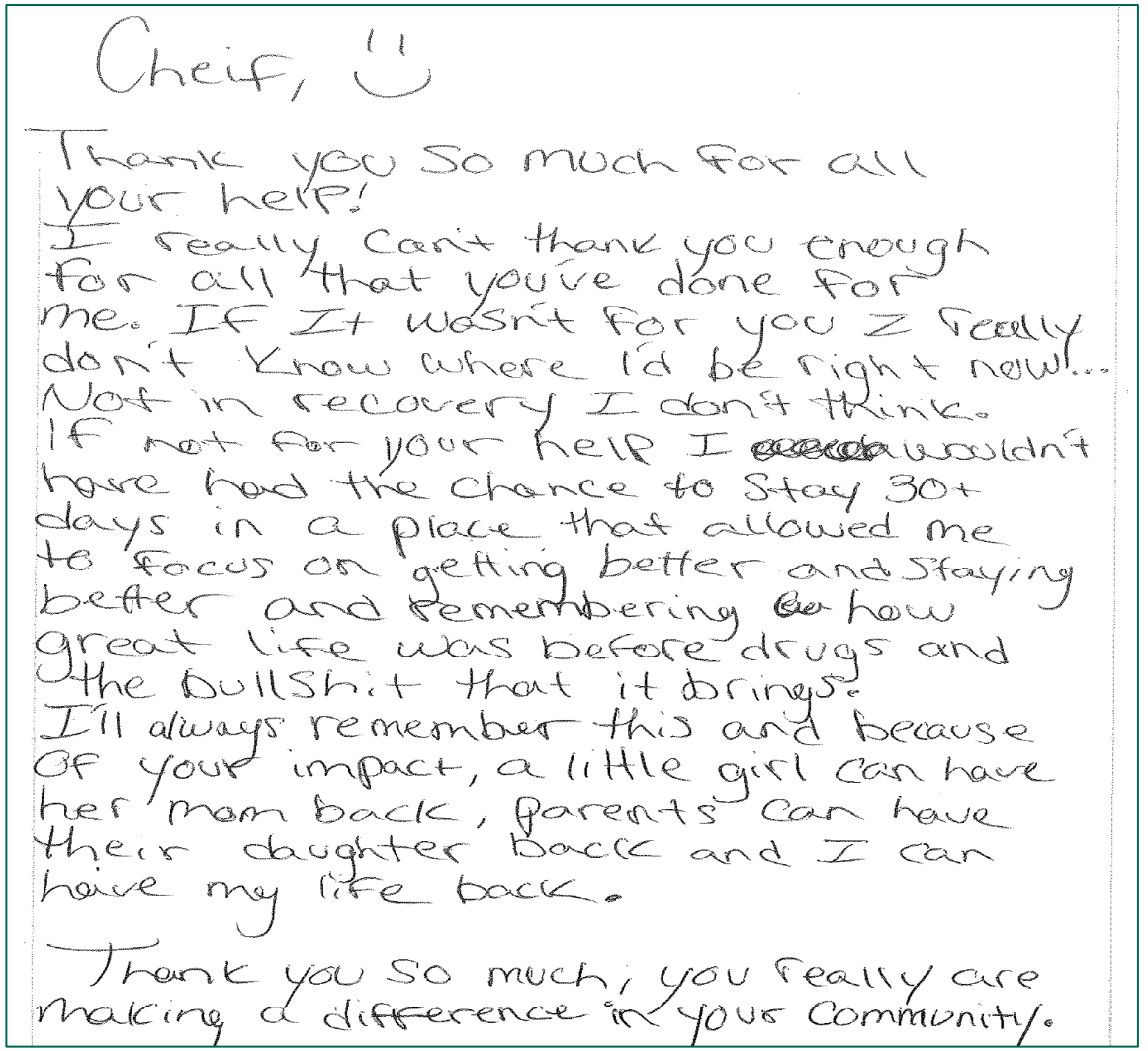
Motor Vehicle Deaths and Overdose Deaths by Year



Legitimacy

When law enforcement agencies actively support and facilitate pathways to addiction recovery, it directly addresses the root causes of crime rather than just treating the symptoms.

Plus - It feels good when it works



Cheif, :)

Thank you so much for all your help!
I really can't thank you enough for all that you've done for me. If It wasn't for you I really don't know where I'd be right now... Not in recovery I don't think. If not for your help I ~~would~~ wouldn't have had the chance to stay 30+ days in a place that allowed me to focus on getting better and staying better and remembering ~~be~~ how great life was before drugs and the bullshit that it brings.
I'll always remember this and because of your impact, a little girl can have her mom back, parents can have their daughter back and I can have my life back.

Thank you so much, you really are making a difference in your community.

Dartmouth Health

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The Bottom Line…

Law enforcement is often the first—and sometimes only—point of contact for individuals at their absolute lowest points. Utilizing that contact as an entry point to recovery doesn't mean being "soft on crime." It means being smart on crime by permanently solving problems rather than temporarily policing them.


People don't fail treatment nearly as often as systems fail people.
This reflects the guiding philosophy of our work and the belief that persistent support creates the opportunity for change.

Round And Round We Go…



Time For Change…



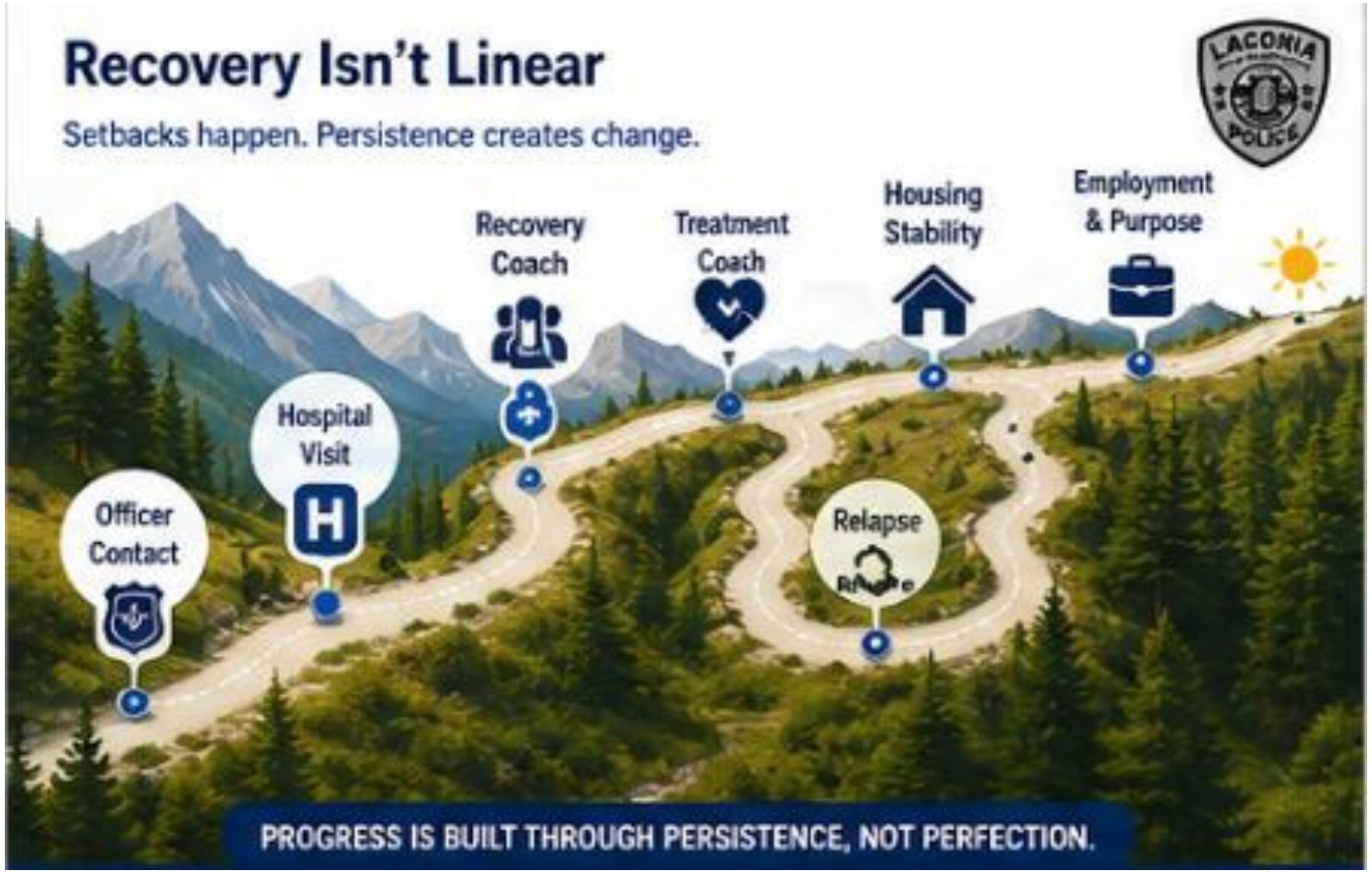
How We Shifted Our Focus…



Ways We Continue Engagement



Each Person's Path Is Their Own Journey



Each Person's Path Is Their Own Journey



Our Takeaways







Questions for our speakers?

Case discussion is next

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WELCOME to the

Public Safety & Behavioral Health Collaboration ECHO: Effective Crisis Responses in Your Community

Session 6, Trauma and vicarious trauma: caring for ourselves and colleagues, August 19th, 2026

Today's Program

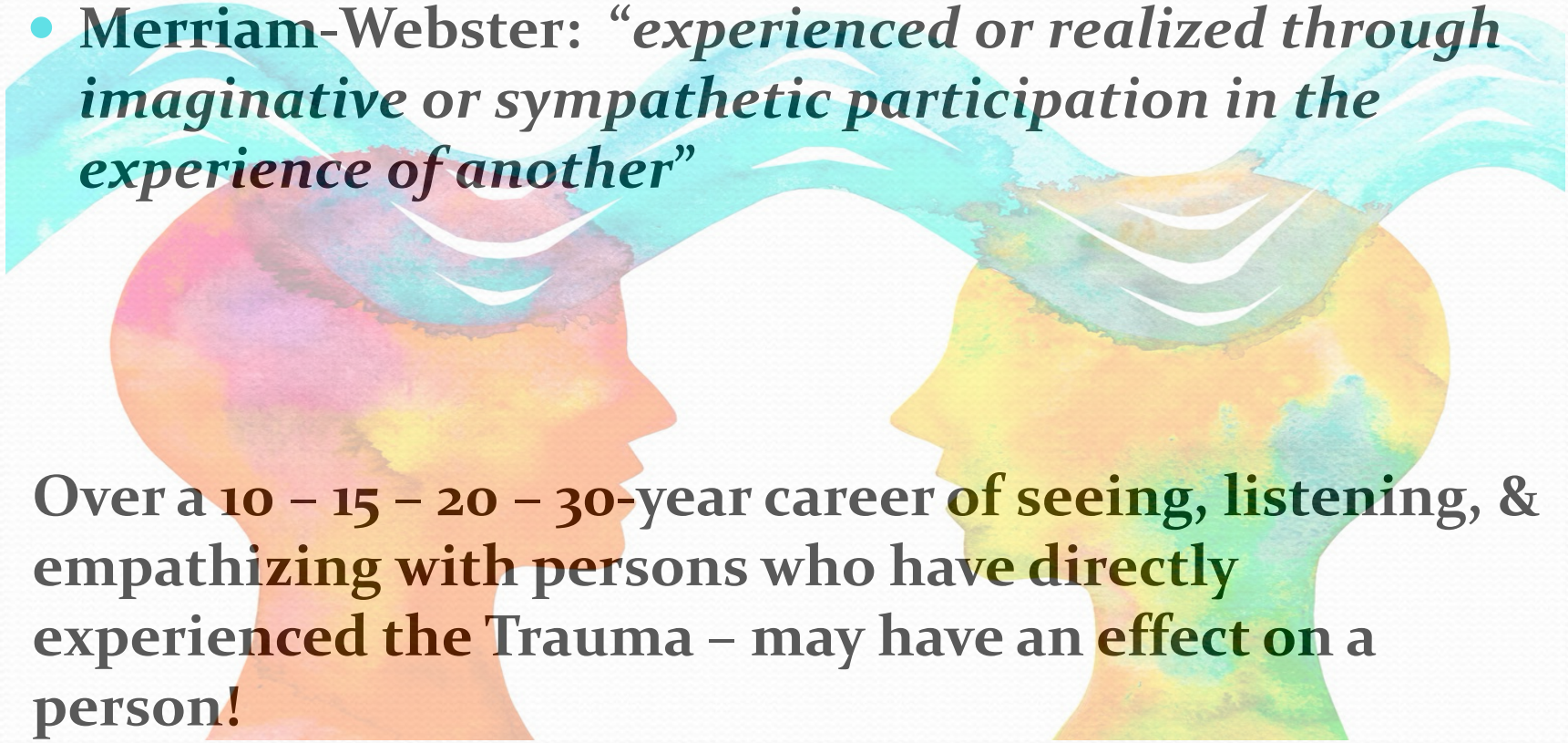
- Brief housekeeping
- Didactic: Trauma and vicarious trauma: caring for ourselves and colleagues
  - Jeffrey Stewart, NRP, CAI - Ambulance Chief & Health Officer, Brookline NH Owner Dragon Shield Consulting, LLC
  - Russell S. Conte, Major (Ret.) - New Hampshire State Police, Mental Health and Wellness Coordinator
- Case Discussion
- Up Next

DHMC ECHO:
Public Safety & Behavioral Health Collaboration –
Trauma and Vicarious trauma: caring for ourselves & colleagues

Jeffrey Stewart, NRP, CAI
Chief Brookline Ambulance / Owner Dragon Shield Consulting, LLC
Major Russell Conte (Ret.)
NHSP Mental Health & Wellness Coordinator

Vicarious Trauma / Secondary Trauma

- **Merriam-Webster:** *"experienced or realized through imaginative or sympathetic participation in the experience of another"*



Over a 10 – 15 – 20 – 30-year career of seeing, listening, & empathizing with persons who have directly experienced the Trauma – may have an effect on a person!

ASD vs. PTSD

- An event that creates physical harm or threat of physical harm.
- Person may be object of harm, his/her loved one, or may witness a harmful event.
- ➢ *Not everyone!!??*
- ❖ <u>Resilience Factors</u>

- DSM V
  - 8 Criteria
    1. Stressor (s)
    2. Intrusion Symptoms
       - ❖ Nightmares / Flashbacks
    3. Avoidance
    4. Neg. Cognition & Mood
    5. Alterations in arousal & reactivity
       - ❖ Irritable / sleep / hypervigilant
    6. Duration / + 1 month
    7. Functional significance
    8. Exclusion

ASD vs. PTSD

- Symptoms: + 1 month
  - Flashbacks
  - Nightmares
  - Avoids places / event reminders
  - Memory issues
  - Feeling of numb
  - Loss of interest
  - On edge
  - Sleep disturbances
  - Easily startled
  - Etc.

- Treatments
  - Mental Health Therapies
  - Medications combined with other therapies
- Is covered under worker's comp – NH Senate Commission 2019-2020



Critical Incident Stress Management (CISM)

The Terrible 10:

- L.O.O.D.
- Death/Injury Child
- Long/Failed Rescue
- Safety is Jeopardized
- Colleague Suicide
- Mass Casualty Incident
- Victim known to Responders
- Administrative Betrayal
- Excessive Media Coverage
- Other significant event that causes considerable emotional distress

PEER – SUPPORT!!!!

What might we see/hear to raise concerns?



- Isolation
- Tardiness / Absent
- Weight gain/loss
- Increase in OT
- Insubordination
- Anger
- Conflict
- Comments
- Substance Use



Patterns / Patterns / Patterns

Is it an IMMEDIATE LIFE THREAT?



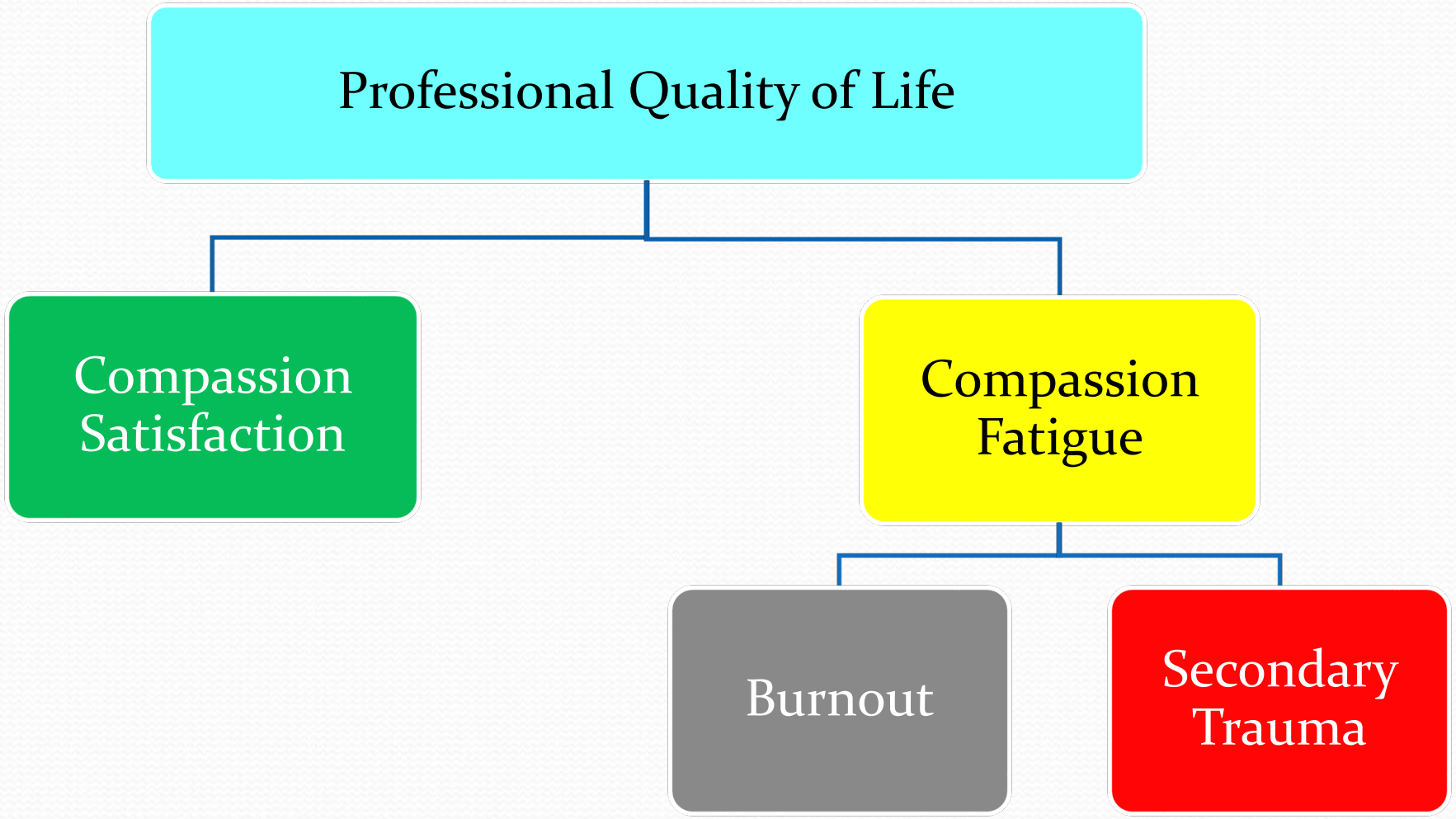
YES = GET ASSISTANCE & INTERVENE – DO NOT LEAVE ALONE!!

Professional Quality of Life

- Compassion Satisfaction
  - Positive aspects of helping people
  - The “Good Stuff”
- Compassion Fatigue
  - Negative aspects of helping people
  - The “Bad Stuff”

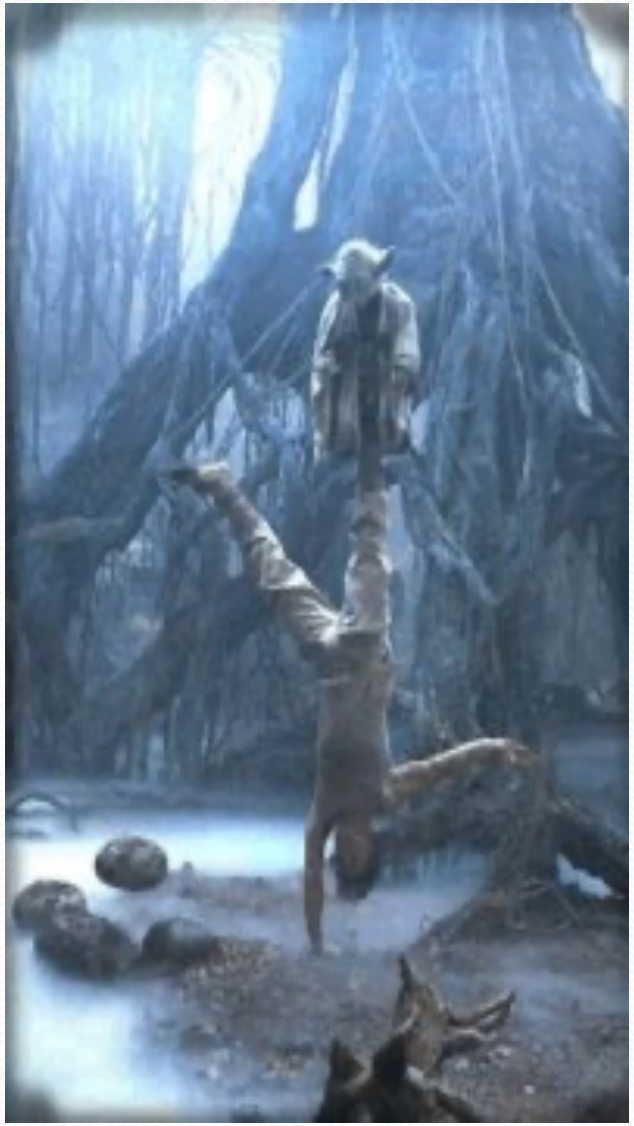


CS-CF Model


Professional Quality of Life
Compassion Satisfaction
Compassion Fatigue
Burnout
Secondary Trauma

RESOURCES

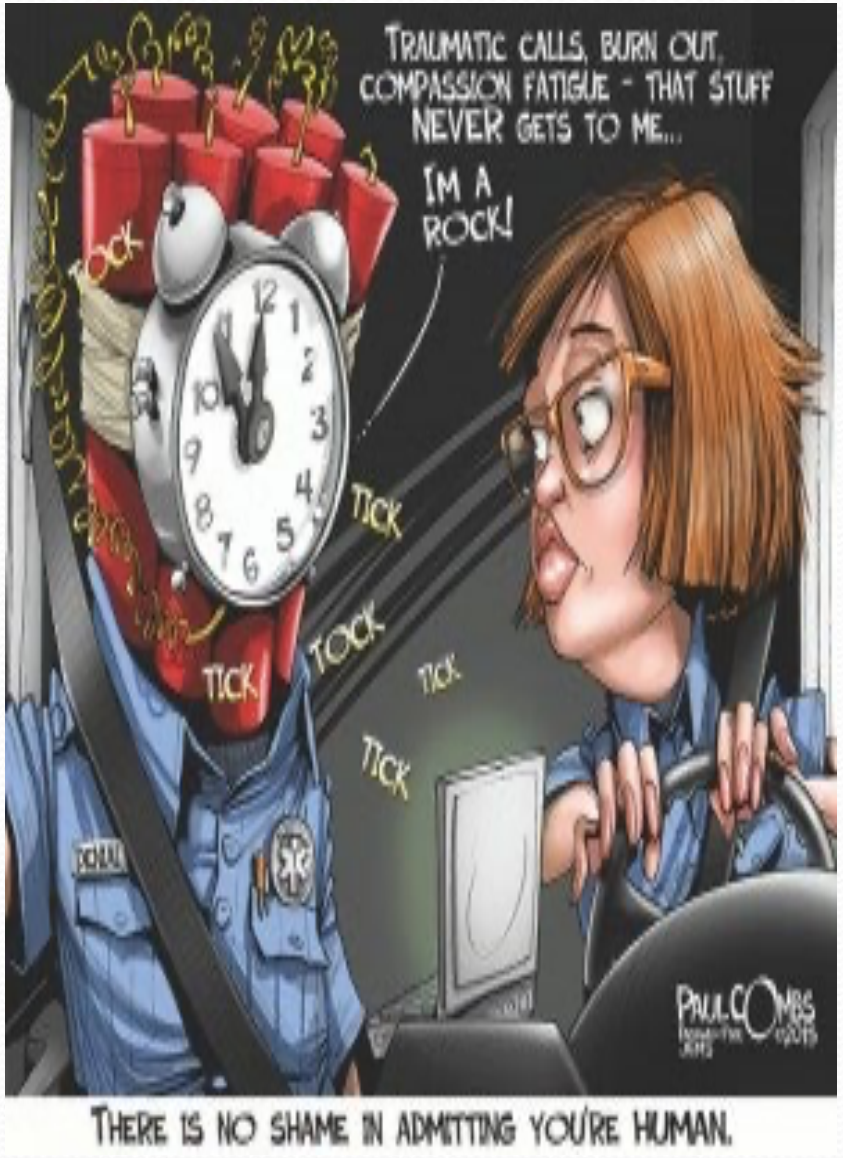
- 988 (if Vet: Press 1)
  - National Suicide Line
  - Veteranscrisisline.net
  - PTSD.VA.GOV
- 1-800-242-6246
  - National Alliance on Mental Illness
  - NAMI.org
- QPRinstitute.com
- PROQOL.org
- Codegreencampaign.org
- American Association of Suicidology
  - Suicidology.org



THANK YOU!

NOT Immediate Life Threat.....

- Collect the Observations/Facts
- Are you ok / ready to confront?
- NO – Get Help
  - Supervisor
  - Mentor
  - Professional
- YES – Review Facts/Observations
  - Assistance?
  - Deep Breath / Check your pulse....



TIMING & APPROACH

- RESOURCES / PLAN
- LOCATION / TIME
- Anticipate BARRIERS
- Anticipate DENIAL
- Anticipate ANGER
- APPROACH
  - Compassion
  - Non-judgmental
  - Non-threatening







WELCOME to the

Public Safety & Behavioral Health Collaboration ECHO: Effective Crisis Responses in Your Community

Session 7, Community level actions and State/Federal resources to support coordinated responses, September 2nd, 2026

Today's Program

- Brief housekeeping
- Didactic: Community level actions and State/Federal resources to support coordinated responses
  - Susan Stearns – NAMI New Hampshire
  - Mark Belanger – NH Behavioral Health Workforce Center
- Case Discussion
- Wrap up of our series





Community level actions and State/Federal resources to support coordinated responses

Susan Stearns – NAMI New Hampshire

Mark Belanger – NH Behavioral Health Workforce Center

Why we are here

- A Crisis impacts everyone involved (Individual, their caregivers, law enforcement and first responders, clinical teams)
- When we are aware, and trained, and work together, and do our best in these very difficult situations, we reset the trajectory of a person's life and everyone around them



Purchased stock photo used with permission – no personal information

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 1:
First responder preparedness and roles in behavioral health crises

Speaker(s):

- Jeffrey Stewart, NRP, CAI, Ambulance Chief & Health Officer Brookline NH
- Christopher M. Lewis, MBA - Lieutenant, NH Police Standards & Training
- Susan L. Stearns, Executive Director, NAMI New Hampshire

In this session we learned…

- Fire fighters, emergency medical services (EMS), and Law Enforcement personnel are often first on scene for a behavioral health (mental health and/or substance misuse) crisis
- In NH, Fire has authority for an emergency scene
- All first responders are highly trained – most have training in behavioral health including
  - Crisis Intervention Training (CIT Program)
  - Mental Health First Aid
  - Self care for Physical and Mental Health
- First responders bring valuable support to BH crises and have become good at working together and with BH clinicians to help individuals in challenging situations

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 2:
Behavioral health provider preparedness and roles in behavioral health crises

Speaker(s):

- Dr. Nicole L Sawyer, Licensed Psychologist, Crisis Intervention Specialist

In this session we learned…

- Mental Health Professionals sometimes co-deploy with Law Enforcement – In crises and even in SWAT
- Teams are built on trust - Shared goal is Preservation of life through communication and de-escalation
- BH clinicians advise and bring clinical expertise – Their role is to help everyone on scene to see an individual and situation through the additional lenses of…
  - Risk and threat of harm to self or to others
  - Trauma
  - Substance misuse
  - Developmental disabilities

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 3:
Vision for Behavioral Health Crisis Care – NH Rapid Response

Speaker(s):

- Brian C. Harvey, M.Ed. New Hampshire Rapid Response Program, NH Division for Behavioral Health, DHHS

In this session we learned…

- The 3 pillars of the NH Rapid Response Program
  - "Someone to Call" – 988 or (833) 710-6477 in NH
  - "Someone to Respond" – 10 regional Crisis Teams
  - "A Safer Place to Be" – Crisis Stabilization Centers
- The NH Rapid Response Program is…
  - Free and available to children and adults
  - Integrated mental health and substance use care
  - Person-centered, recovery oriented, trauma-informed, committed to Zero Suicide, and upholds safety of individuals served & responders
- NHRR teams co-deploy with Law Enforcement and/or first responders when support is needed with scene safety

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 4:
Current State of Behavioral Health Crisis Response – Insights from three NH Regions

Speaker(s):

- Jaime-Rose Kelly, LCMHC, Director of Acute Services
- Jessica Lachance, MS, J.P. CCISM, Director, Rapid Response Team
- Kristy Pearce, MSW Director of Acute Services at Lakes Region Mental Health Center
- Detective Eric Adams, Prevention, Enforcement & Treatment Coordinator, Laconia PD

In this session we learned…

- The current state of BH crisis response in 3 types of NH regions, the rural North Country, the mixed rural/ seasonal/ small urban Lakes Region, and the Urban greater Manchester Region
- There is great overlap (e.g., 50%) in Law Enforcement and BH Crisis calls: Calls may include:
  - Suicidal Individual, Person Experiencing Psychosis, Welfare Check on an Individual in Crisis, Youth BH Crisis, Frequent Utilizer of Emergency Services, Person experiencing homelessness with BH, Family Crisis Involving BH, Substance Use and Co-Occurring BH Crisis
- Historically Law Enforcement was ill-equipped to handle these types of calls. Training and coordinated responses are changing all of this

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 5:
Continuing engagement to support people with recurrent crisis encounters

Speaker(s):

- Dave Suckling - Chief of Police, Alexandria, NH
- Detective Eric Adams - Prevention, Enforcement & Treatment Coordinator, Laconia Police Department

In this session we learned…

- Behavioral Health matters to Law Enforcement
  - Overdose deaths in NH are 3x greater than Motor Vehicle deaths
  - Officers often come across situations that involve mental health and Substance Misuse – These are often the repeat calls aka. ‘revolving door’
- Opening pathways to recovery directly addresses the root causes of crime rather than just treating symptoms.
- Law enforcement is often the first—and sometimes only—point of contact for individuals at their absolute lowest points. Utilizing that contact as an entry point to recovery doesn't mean being "soft on crime." It means being smart on crime by permanently solving problems rather than temporarily policing them.



Cheif, ☺

Thank you so much for all your help!
I really can't thank you enough for all that you've done for me. If It wasn't for you I really don't know where I'd be right now... Not in recovery I don't think. If not for your help I ~~would~~ wouldn't have had the chance to stay 30+ days in a place that allowed me to focus on getting better and staying better and remembering ~~be~~ how great life was before drugs and the bullshit that it brings. I'll always remember this and because of your impact, a little girl can have her mom back, parents can have their daughter back and I can have my life back.

Thank you so much, you really are making a difference in your community.

Dartmouth Health

Project ECHO

Highlight Reel

ECHO Session 6:
Trauma and vicarious trauma: caring for ourselves and colleagues

Speaker(s):

- Jeffrey Stewart, NRP, CAI - Ambulance Chief & Health Officer, Brookline NH Owner Dragon Shield Consulting, LLC
- Russell S. Conte, Major (Ret.) - New Hampshire State Police, Mental Health and Wellness Coordinator

In this session we learned…

- Acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) - Related mental health conditions that happen after a person experiences or witnesses a traumatic event – Offset by resilience factors
- Symptoms and what others may observe
  - Flashbacks, Nightmares, Avoids places / event reminders, Memory issues, Feeling of numb, Loss of interest, On edge, Sleep disturbances, Easily startled
  - Isolation, Tardiness / Absence, Weight gain/loss, Increase in OT, Insubordination, Anger, Conflict, Comments, Substance Use
- Ask, Are you ok? Follow up. Offer help
- Responders do recover with support from therapies/ medications – and covered under worker's comp

A few closing points - The long arc of de-stigmatization is a story of liberty



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- People with behavioral health challenges have historically faced significant stigma and discrimination.
- Revealing an issue with mental health and/or substance misuse could lose a person their job, their family, and even their liberty.
- Slowly over the decades, we have undone the myths that behavioral health challenges are the result of poor choices or unfit character – but stigma is stubborn, discrimination remains, and we all have work to do to keep moving this ball forward.
- It is not beyond the realm of possibility that in our lifetimes we will reach a point where we support behavioral health challenges like we do any other preventable and curable condition.
- Until then, our work is to promote help seeking behaviors, knock down as many barriers to care as we can, and support individuals to live and thrive in the safest least-restrictive environment possible.

And when an individual is well supported – everyone benefits

- An individual receives acute care in crises and that creates the opening to get ongoing support for BH challenges
- First Responders can invest time to bring in supports and start to undo the repeat calls to the same address
- With more support, families can function better and can in turn support an individual to stay in their homes



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Onward: What does it take to continue this work?

The work of collaborating across clinical care, first response, law enforcement, and community to support our community members spans many possible funding sources.

- Collaborate and Communicate
- NH Commission to Study the Incidence of PTSD in First Responders
  - Legislative and rules changes
  - Recognizing the impact of the work
  - Improving how we collect data
- Using data to tell a compelling story
  - Leverage Funding
  - Sustain the work

Finding funding for our shared work

Our jobs are to continuously move our shared work forward as the funding opportunities change.

Creating partnerships is essential to ensuring readiness to respond to funding opportunities.

Funding opportunities to watch

- CMS – Rural Health Transformation
- SAMHSA
- Opioid abatement settlement funds
- HRSA – Rural Healthcare Training
- Department of Justice
- Department of Education
- Congressionally-Directed Funding
- Private foundations and charitable organizations with shared interests

Dartmouth Health

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Questions for our speakers and our panel?

Case discussion is next





Thank you!

- This concludes our series and we are grateful for your participation!
- Please take our post-course survey, email coming shortly.
- For CME, please submit your attendance here: https://app.smartsheet.com/b/form/019e45d180507abc9fd31c9c9d95978f
- Recordings will be posted on the D-H ECHO website https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials