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MEETING POSTING

TOWN OF NANTUCKET
Pursuant to MGL Chapter 30A, § 18-25
All meeting notices and agenda must be filed and time stamped with the Town Clerk's Office and posted at least 48 hours prior to the meeting (excluding Saturdays, Sundays and Holidays)

Committee/Board/s	COUNCIL FOR HUMAN SERVICES
Day, Date, and Time	MONDAY NOVEMBER 29, 2021 AT 6:30 PM
Location / Address	REMOTE PARTICIPATION VIA ZOOM Pursuant to Governor Baker's March 12, 2020 Order Regarding Open Meeting Law (Attached); the meeting will be aired at a later time on the Town's Government TV YouTube Channel https://www.youtube.com/channel/UC-sgxA1fdoxteLNzRAUHIxA
Signature of Chair or Authorized Person	BROOKE MOHR, CHAIR
WARNING:	**IF THERE IS NO QUORUM OF MEMBERS PRESENT, OR IF MEETING POSTING IS NOT IN COMPLIANCE WITH THE OML STATUTE, NO MEETING MAY BE HELD!**

Please list below the topics the chair reasonably anticipates will be discussed at the meeting

https://us06web.zoom.us/j/84964913927?pwd=VDcwek1TMjhaQ014U2toRTRyRmU0dz09

Meeting ID 849 6491 3927
Security Passcode **164162**

1) Call to Order
2) Establish Quorum
3) Approval of Agenda
4) Approval of minutes from October 4, 2021
5) Presentation: Behavioral Health Assessment
   Greg Bellomo and Laura Sigrist from Government Performance Solutions
6) Update from Director of Human Services, Jerico Mele
7) "Meet the Providers: Courtney Bridges: Artists Association of Nantucket
8) Future Agendas: Potential Topics
   - Discussion about the publishing police blotter
8) Next Meeting Date: Monday, December 20th @ 6:30 PM
9) New Business
10) Public Comment
11) Adjournment

Nantucket Behavioral Health Assessment Report

October 2021

Contents

This version of the final report contains an executive summary with appendices. Links are used throughout to assist with navigation:

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A note to the reader:

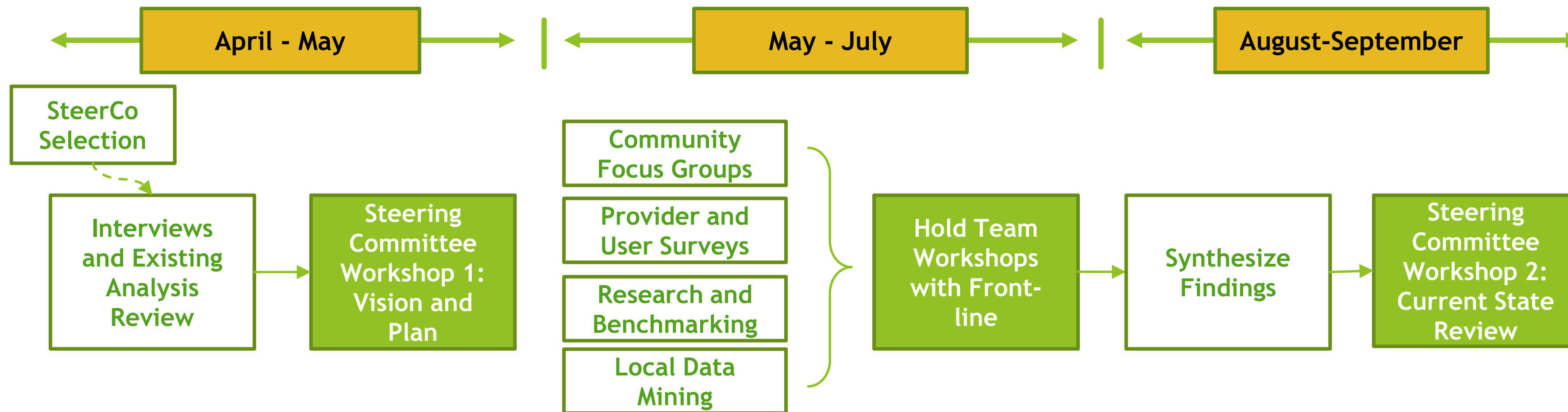
This report by Government Performance Solutions, Inc. (GPS) is the result of a practical endeavor to better understand the community's needs and what leaders can do about them. The report is not an academic study. Here are a few caveats:

- The analysis is quantitative where possible, with data gleaned from disparate sources. Consistent timeframes are not always available.
- COVID has likely contributed to changes in both the types and intensity of needs and also helped people understand that we are all vulnerable and that we can adapt really quickly when we must.
- Definitions commonly used by GPS include:
  - Behavioral health (BH) is comprised of Mental Health (MH) services and Substance Use Disorder (SU or SUD) services.
  - "Provider" may apply to anyone delivering MH/SU services, including licensed clinical social workers, counselors, specialty psychiatrics, and other roles. Additional granularity will be necessary when closing gaps.
- GPS has attempted to use plain language to describe the system's gaps and opportunities. No criticism is implied.
- There are many in the community who go above and beyond each day and yet services are not meeting the need. GPS is grateful to these professionals for their generosity in helping conduct this assessment.
- Each community member's experience with the BH system varies, and the same is true for providers. GPS has attempted to present a balanced picture of these experiences without using heart-wrenching anecdotes to illustrate needs, nor have we documented the efforts of providers as heroic, even when they are.
- There may be members of the community with valuable perspectives and contributions that did not participate in the analysis. GPS recommends reviewing these findings with the community in advance of any future planning to ensure that future services match the needs and preferences of the community.

Executive Summary (1 of 7)

Phase 1 Process

- To gather a complete picture of the current state and to inform coordinated action, leaders from several community organizations engaged Government Performance Solutions, Inc (GPS) to perform an assessment. The effort was guided by a steering committee of 15 system shapers and contributed to by 30 advisors across 12 organizations.
- GPS sought input via 9 community focus groups, individual interviews and small-group meetings, engaging 112 people. GPS also used a community survey (175 responses) and a provider survey (13 complete responses) to gather community inputs. Finally, GPS mined available data from various sources, both on the island as well as third-party research and reports. A process graphic is below:



- GPS consolidated community input into this final report, which highlights (15) system gaps, provider services as reported, the community's experience, and options for moving forward sourced both from participants and from best practices.
- This report is a summary of the findings in phase 1 of a 2-phase effort. During phase 2, it is envisioned that community leaders will collaborate to plan a coordinated response to these needs, developing an integrated plan organized into initiatives (each with one or more strategies to close gaps) that each have a clear action plan with ownership, timing, and resource requirements.

Executive Summary (2 of 7)

Reason for Action

- Nantucket is an isolated island with population ranging from around 17,000-20,000 year-round residents[X]. High season brings tens of thousands additional people on-island, swelling the seasonal population to 70,000-80,000. Note: the 2020 US Census officially cites Nantucket's population as 14,255; however, estimates from the Nantucket Data Platform, estimates from the Town's Department of Human Services and data from utility and transportation metrics indicate a significantly higher, though unofficial, year-round population. For purposes of this assessment, GPS has included information using the range of official and unofficial year-round population.
- The island is facing an escalating demand for behavioral health services both in terms of volume and variety:
  - The MDPH 2020 report indicated that Nantucket experienced the highest rate of suicide in the Commonwealth in 2017, at 62.1/100,000 (n=7). Further, Nantucket had the highest rate of self-inflicted harm deaths of all counties in Massachusetts from 1999-2017 (the last year or which data is available).
  - In the 2018-19 Pride Survey of NPSD, 6.6% of students (~41 students) in grades 6-12 reported thinking about suicide "a lot" or "often". Results also show concerning increases in students' use of substances from 2017-18 levels, including marijuana (+20.7%), illicit drugs (+18.0%), alcohol (+13.3%), and hallucinogens (+11.1%).
  - During COVID, the demand for domestic violence and sexual violence services increased 30% and 20%, respectively, in A Safe Place's adult programs.
- Nantucket's provider density is the lowest in the Commonwealth, and significantly lower than neighboring counties, with a provider to resident ratio from 1:250 to 1:370[Y], with the range representing US Census population data and Town estimates. Adding an additional 20-25 providers would bring the ratio to 1:270, meeting the average ratio of top-performing counties across the country (those in the 90th percentile of provider to population ratios) but still lagging Dukes and Barnstable County ratios. Provider recruitment and retention are extremely difficult problems on the island, exacerbating the provider to population ratio and disrupting both provider-patient relationships and treatment.
- Nantucket's lack of services and supports results in problems worsening to the point of crisis and/or requires people to seek treatment off-island, which is both costly and disruptive, but desired by some due to privacy concerns. More than 90% of patients seen in the hospital for a behavioral health evaluation did not have contact with a mental health professional in the 90 days prior to their assessment, based on NCH clinicians' experience.
- Fundamental social determinants of health like housing, employment, and cost of living make life stressful for many islanders. The cost of housing on the island is 6.5x the national average and inventory remains elusive. Sourcing appropriate housing is more than difficult, contributing to provider turnover and increased risk factors for individuals and community organizations.
- Despite efforts to normalize asking for help, behavioral health care remains stigmatized with 42% of community survey respondents selected "always" or "often" when asked how often being "afraid to seek out the service because someone might find out". There are services emerging, but awareness of these services is low.

[X] https://nantucketdataplatform.com/effective-population/; [Y] University of Wisconsin Population Health Institute, County Health Rankings (data from 2020 CMS-National Provider Identification database)

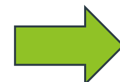
Click here to view details of the provider summary

Executive Summary (3 of 7)

Provider Summary

- The community has tried focused efforts to address specific needs and crises, but Nantucket's ability to meet these needs is hampered by a fragmented system of care, with many organizations providing services within their boundaries and no single systematic method of coordination. Nantucket's provider density is the lowest in the Commonwealth, and significantly lower than neighboring counties, with ratios ranging from 1:250 to 1:370. In addition to approximately 17[x] private behavioral health providers on-island (and others offering telehealth services off-island), Nantucket is home to the following organizations:
  - **Fairwinds** provides outpatient, medication management, urgent behavioral health care, and other community-based services for children and adults, regardless of ability to pay. Fairwinds employs (3) full-time clinicians, (7) part-time clinicians, and (3) community-based service providers. Three clinicians are bilingual.
  - **Gosnold** is the regional contractor for the state's Emergency Services Program (crisis services), via a contract held by Bay Cove Human Services, and provides some outpatient therapy services on-island. Gosnold currently employs two (2) clinicians located on Nantucket and additional off-island resources are available.
  - **Nantucket Cottage Hospital (NCH)** provides primary care and inpatient health care. The hospital's social work group includes three (3) clinicians who manage behavioral health needs, care coordination, and navigation support for NCH patients.
  - **Addiction Solutions** provides the island's only medication assisted treatment (MAT) services for opioids, alcohol, and other substances, with two (2) part-time clinicians on staff.
  - **A Safe Place** provides advocates, rape crisis counselors, social workers, and other master's level mental health professionals to those dealing with domestic and sexual violence. A Safe Place employs 3 part-time clinicians, including one who speaks Spanish, and refers clients to other treatment services their needs require.
  - **NAMI Cape Cod and the Islands** provides support, education, and advocacy for individuals and their families impacted by mental illness, neurological disorders, and substance use (via the Alliance for Substance Abuse Prevention). NAMI employs two (2) individuals on the island, responsible for support and connection services, with additional off-island resources, including the William James Interface referral helpline. NAMI also provides direct reimbursement to private practitioners to see patients not able to access other services.

- Access remains a challenge as evidenced by the differences in the community's reported experience concerning availability with provider-reported data

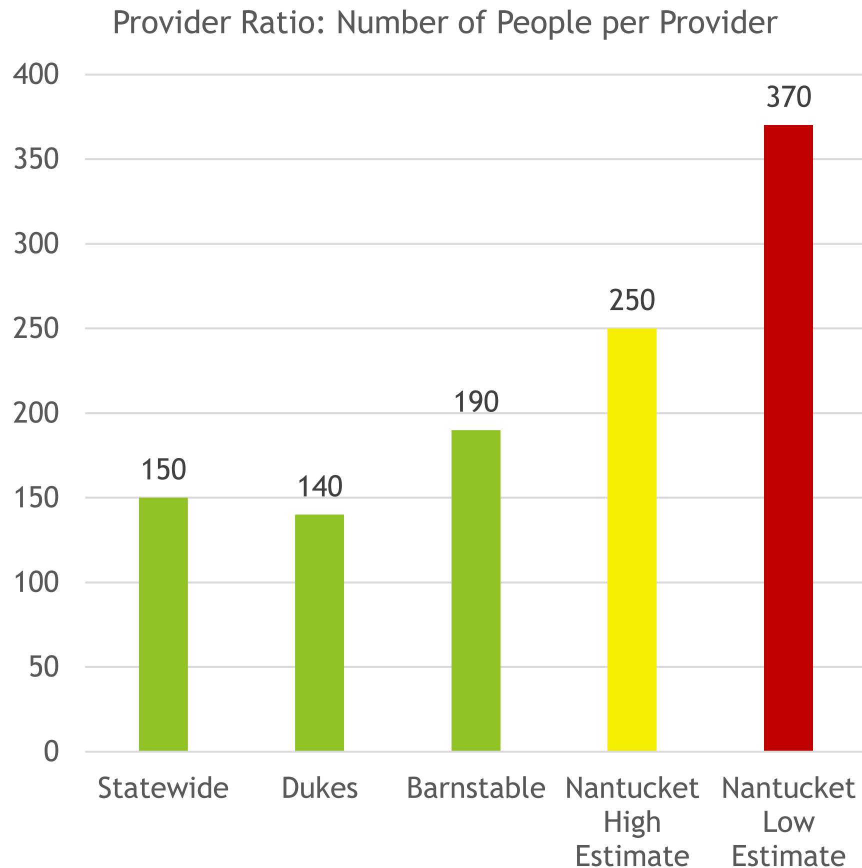
Provider view		Resident view
Nearly all of providers surveyed (12 of 13) report availability within 1 week…		…while only 5% of respondents reported same day service.
When asked whether there were cases in the last 6 months where people had to wait more than 48 hours for services, 7 providers (58%) said "no"…		… while 37% of community survey respondents report waiting more than a month and 69% report experiencing wait lists "often" or "always".

[x] NCH's provider list has 16, Fairwinds' list has 17, and NAMI's list from 2018 has 15

Executive Summary (4 of 7)

Provider Summary, continued

- Nantucket's provider capacity is believed to be insufficient to meet the demands by all participants encountered in this assessment. Provider density is indeed low compared to the statewide average and to neighboring counties, indicating a need to add perhaps an additional 20-25 providers to ensure comparable access to services.

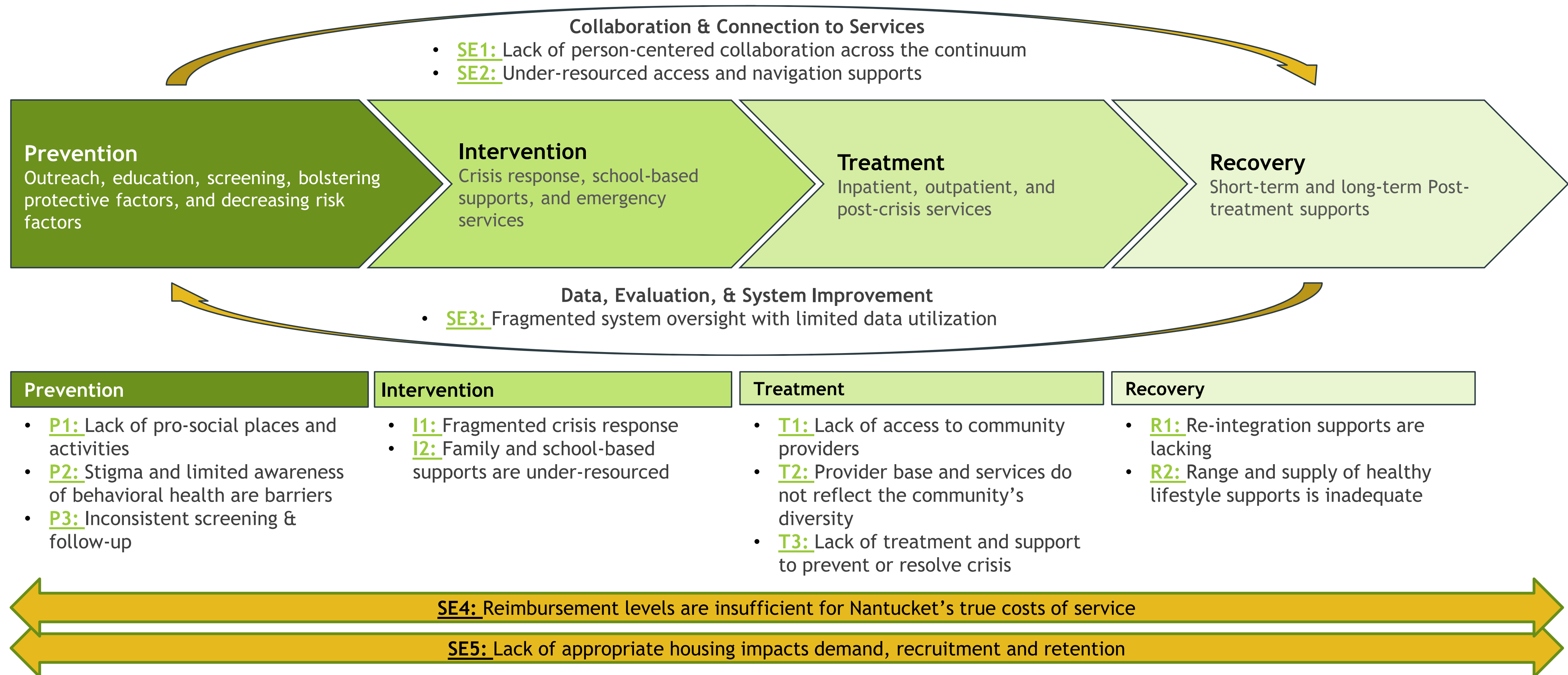


- Using the national Provider Identification database count of 46 BH providers and the US Census population, Nantucket's provider ratio of 1:250 ranks the lowest within Massachusetts. When factoring in the number of providers currently known to be active on the island (in-person or via telehealth), together with revised population estimates, GPS estimates the ratio to be closer to 1:370. For comparison, the statewide ratio is 1:150, Barnstable County is 1:190, and Dukes County is 1:140.
- The ratios presented are based on the year-round population estimate of 17,000. Other groups that may demand services are seasonal residents (~10,000) and visitors (~35,000-45,000 in the summer). The requirements of these groups are not completely understood, though Fairwinds, NCH, and first responders indicate that incidents related to substance use peak during the tourist season and that crisis volumes are higher during the non-tourist months of the year. Exact sizing requires further analysis.
- Provider density measurement is made challenging by three facts:
  - Licensed elsewhere: Providers' business locations in licensing systems are independent of where they actually provide treatment, and an active license is not necessarily indicative of an active provider.
  - Remote and tele-capacity: The ability to deliver services in a virtual environment makes true capacity challenging to determine. COVID has both exacerbated problems with reporting AND impacted the availability of providers.
  - Accuracy of reporting: Websites and referrals services indicate availability of providers who may no longer be accepting patients on the island. Some referral lists are outdated and inaccurate, while turnover and retention challenges mean that information becomes outdated quickly.

Click here to view 1-page overviews of each gap

Executive Summary (5 of 7)

- **Gap Summary:** GPS has documented 15 gaps across the continuum of care, including 5 "System Enablers" (SE) that will allow the system to function better as a whole. The coded links (underlined, bold) take the reader to a 1-page overview highlighting the unmet need, the size of the challenge, and options for how to address the gap.



Executive Summary (6 of 7)

Potential Response:

- Nantucket community leaders have the tough job ahead of them of addressing these needs in a comprehensive manner. To help jumpstart this process, GPS has outlined potential initiatives that could be planned to address one or more of the gaps across the continuum of care, building off the opportunities recognized during phase 1. At the risk of overwhelming the reader, the list below is not comprehensive, and understanding the range, diversity, priorities, and dependencies among these initiatives will be imperative in phase 2 planning.

Potential Initiative and Gaps Addressed	Potential Strategies

Establish a Coordinating Body to Drive System Design and Implementation (SE1, SE2, SE3, SE4)	• Design and staff (or identify and staff) an organization led by a community board of directors and charged with:
	  • Prioritizing needs and facilitating system design in response to needs
	  • Establishing expectations around services, collaboration, roles & responsibilities, and information sharing (e.g., EHR, ROIs, etc.)
	  • Facilitating outreach, navigation, and coordination efforts
	  • Monitoring state policy and funding changes and identifying opportunities to implement innovations and augment funding
	  • Engaging system payment experts to optimize methods for maximizing revenues, including adopting designations like the FQHC, CCBHC, etc., that require system-wide collaboration and allow the community to receive additional reimbursements
	  • Coordinating fundraising to expand contributions while avoiding competition and lowering development costs
	  • Developing a data and evaluation system and rhythm to measure the system's performance & coordinate continuous improvement

Increase Availability to the Right Level of Provider (T1, T2, SE5)	• Determine desired delivery system approaches (e.g., tele versus in person; primary care versus specialty care) and associated provider density and diversity needs, then consolidate recruitment, retention, and housing efforts to ensure collaboration
	• Expand peer support programming to help avoid crisis (nip escalation in the bud—no heroes and no tragedies)
	• Develop partnerships for telehealth[Z] that enable:
	  • Off-island service for those who want it
	  • Provider access to experts to help them expand their scope of practice
	• Develop collaborative internship and fellowship programs that augment the provider base while building a future provider pipeline
	• Think creatively about using summer workforce and possibly recruit psychiatrist or other professionals to work a few hours a month in person (training/supervision) and then pick up tele-practice when they return to their jobs or homes

[z] May need to assess existing broadband/cellular networks to ensure sufficiency

Executive Summary (7 of 7)

Potential Response (continued):

Potential Initiative and Gaps Addressed	Potential Strategies
Integrate Crisis and School-based Supports (I1)	• Align on a single response system that is blind to payer source and resourced to stabilize people in the least restrictive environment and connect patients to services that meet their individual needs (closed loop)[X] • Increase the number of bi- and multi-lingual school-based counselors to work directly with youth and their families • Develop a coordinated pathway from school-based intervention to community specialty care that involves family and includes ongoing school/community collaboration
Expand Intensive Treatments and Reintegration Supports (T1, T3, R1)	• Build community treatment team(s) to avoid escalation and reduce the need for off-island transport and residential treatment through early intervention, intensive treatment services (e.g., residential detox, MAT, etc.), wrap-around supports, and reintegration supports • Link community treatment teams to crisis and emergency care to facilitate stabilization on-island through immediate connection with intensive treatment and support when possible • Work with the justice system to prescribe community/peer engagement as part of sentencing for substance use/addiction-related crimes
Build or Modify Facilities and Alternative Delivery Approaches to Meet Needs (P1, T3)	• Once community treatment teams are established, determine what adjustments or additions to facilities will enable effective treatment on-island (knowing that some services will require off-island transport) • Consider non-traditional facilities such as tele-access hubs or mobile care delivery models • Develop or modify facilities to ensure adequate supply of low-cost prosocial gathering places for both youth and adults, as well as cost-free access to recovery and support groups • Invest in transitional housing for survivors of domestic/sexual violence and those returning from off-island treatment, as well as sober housing
Double Down on Prevention and Recovery Supports (P2, P3, R2)	• Design and launch an anti-stigma campaign to raise awareness of MH/SUD prevalence and treatment among targeted audiences and use metrics to measure efficacy and tune methods; use influencers to connect/humanize and consider an ongoing series in the Inky with real stats • Increase the availability of prosocial supports like groups and a community recreation center that do not revolve around alcohol • Expand/integrate screening and establish closed-loop referrals

[X] Police reforms may result in a change to the role that police are able to play in responding to MH crises

Executive Summary (8 of 8)

Implementation Considerations:

- Some community leaders have expressed interest in planning a coordinated response to transform the system of care. Any such effort should be carefully planned to avoid foreseeable risks. From our experience and from the advice received from the community, GPS has compiled a list of implementation considerations.
- Nantucket lacks a system of care and therefore has relied on committed individuals to prevent people from falling through the cracks. This results in missed opportunities to prevent or intervene in escalating problems, unnecessary suffering and provider burnout. Establish ground rules and operating principles across providers that enable a continuum of care where the provider boundaries are invisible to the people seeking care and minimize competition for limited funding.
  - Find a leader or cohort of cooperative leaders: Transformative efforts require persistent, passionate leadership through current challenges to a higher-functioning system. Work the current system while working toward the desired system by maximizing existing resources while intentionally building the leadership capability and capacity needed.
  - Maximize expertise in system design: Engage a group of on-island leaders AND a group of off-island experts to help design the system, mixing the knowledge of the island's current system and boundaries with the opportunities presented by leading practices for treatment, payment, and organization. Seek lessons that can be learned from other communities and adapt them to Nantucket's strengths and challenges. Establish measures of system progress and make a commitment to monitoring and celebrating achievements.
  - Be willing to consolidate: The island's current system is fragmented, and each group is operating at small scale. Combination of some of these organizations will yield operating efficiencies and reduce the challenge of coordinating between fragmented groups. State the organizational incentives and concerns openly and build a system where everyone succeeds. Operating agreements could be a middle ground.
  - Engage differently: GPS was unsuccessful at gathering adequate participation from underrepresented communities. Leaders in phase 2 and beyond must find trusted leaders in these communities and engage them in initiative design and execution, co-opting existing trust channels to break down barriers. Further, unified (and early) messaging and and constant reinforcing will strengthen community engagement and ensure a diverse, comprehensive community voice and an honest appraisal of gaps and opportunities. Raise community awareness and supports and create easier ways for people to understand and access services.
  - Make use of community endowments: Nantucket is home to many influential individuals. Leverage these connections to leading experts (e.g., Mass General) and a well-established philanthropic community to both design a better system AND provide the funding to bridge toward a sustainable and flexible cost model.
  - Strengthen advocacy and strategy efforts: Stay on top of state and federal policy, both monitoring and positioning for changes and advocating for policies that will further goals of access, affordability, and engagement.

Appendix 1:
Prevalence Estimates

Estimating Need Based on Prevalence (1 of 3)

Self-reported data is often understated even when anonymous. National prevalence of conditions, or prevalence across Massachusetts, may help Nantucket size the true need for services, with appropriate caveats.

Caveats:

- The estimates that follow are not to be confused with a proper epidemiological study. They are rough order of magnitude estimates of the at-risk population on the island and may be useful for system design.
- Nantucket is a resort community and may therefore be at greater or lower risk for certain conditions.
- The latest available Substance Abuse and Mental Health Services Administration (SAMHSA) data is 3 years old and COVID has likely changed prevalence in certain conditions.
- Nantucket's census report may have variance and GPS used the accepted 17k estimate from the Nantucket Data Platform as a baseline. Other groups that may demand services are seasonal residents (~10,000) and visitors (~35,000-45,000 in the summer). The requirements of these groups are not completely understood, though Fairwinds, NCH, and first responders indicate that incidents related to substance use peak during the tourist season and that crisis volumes are higher during the non-tourist months of the year. Exact sizing requires further analysis.
- Not all people with a condition are willing to seek help, so systems of care can and should be sized based on more formal estimates & experience with penetration rates.
- Census data and SAMHSA data do not use the same break points for population groups. Calculation assumptions are included for transparency.
- Footnotes tied to the sources on page 15, where the reader will also find links to the research.

Estimating Need Based on Prevalence (2 of 3)

Table of Estimates for Children and Adolescents:

BH Condition	Estimated Number of People at Risk Based on 17k Year-round Population	Assumptions
Anxiety (diagnosed)	169	7.1% of school-aged kids nationwide are diagnosed with anxiety[1] and 14% of Nantucket's population are aged 5-17
Depression (diagnosed)	76	3.2% of school-aged kids nationwide are diagnosed with depression[1] and 14% of Nantucket's population are aged 5-17
Marijuana use in the past month	83	12.2% of kids aged 12-17 in MA have used in the past month[2] and 4% of Nantucket's population are aged 14-17
Alcohol use in the past month	92	13.6% of kids aged 12-17 in MA have used in the past month[2] and 4% of Nantucket's population are aged 14-17
Illicit drug use in the past month	93	13.7% of kids aged 12-17 in MA have used in the past month[2] and 4% of Nantucket's population are aged 14-17
Major depressive episode in the past year	106	15.6% of kids aged 12-17 in MA reported having a major depressive episode in the past year[2] and 4% of Nantucket's population are aged 14-17
Alcohol use disorder in the past year	12	1.8% of kids aged 12-17 in MA met the criteria for diagnosis in the past year[3] and 4% of Nantucket's population are aged 14-17
Illicit drug use disorder in the past year	22	3.3% of kids aged 12-17 in MA met the criteria for diagnosis in the past year[3] and 4% of Nantucket's population are aged 14-17

Estimating Need Based on Prevalence (3 of 3)

Table of Estimates for Adults:

BH Condition	Estimated Number of People at Risk Based on 17k Year-round Population	Assumptions
Alcohol use disorder in past year	873	6.5% of adults in MA met the criteria for diagnosis in the past year[3] and 79% of Nantucket's population are aged 18+
Illicit drug use disorder	457	3.4% of adults in MA met the criteria for diagnosis in the past year[3] and 79% of Nantucket's population are aged 18+
Major depressive episode past year	1,088	8.1% of adults in MA reported having a major depressive episode in the past year[4] and 79% of Nantucket's population are aged 18+
Serious mental illness past year	712	5.3% of adults in MA met the criteria for diagnosis in the past year[1] and 79% of Nantucket's population are aged 18+
Any mental illness in past year	2,834	21.1% of adults in MA met the criteria for diagnosis in the past year[4] and 79% of Nantucket's population are aged 18+
Serious thoughts of suicide past year	685	5.1% of adults in MA reported having serious thoughts of suicide in the past year[2] and 79% of Nantucket's population are aged 18+
Anxiety/depressive disorder during majority of past 7 days	3,894	29.0% of adults reported having symptoms of an anxiety or depressive disorder during the majority of the past 7 days[5] and 79% of Nantucket's population are aged 18+
→ Of those with anxiety/depressive disorder who needed but did not receive counseling/therapy	837	21.5% of the adults who reported having symptoms of an anxiety or depressive disorder in the last 7 days who also reported that they needed but did not receive counseling or therapy in the last 4 weeks[5] and 79% of Nantucket's population are aged 18+

COVID point in time April 2021 (applies to the last two rows)

Sources for Prevalence Data

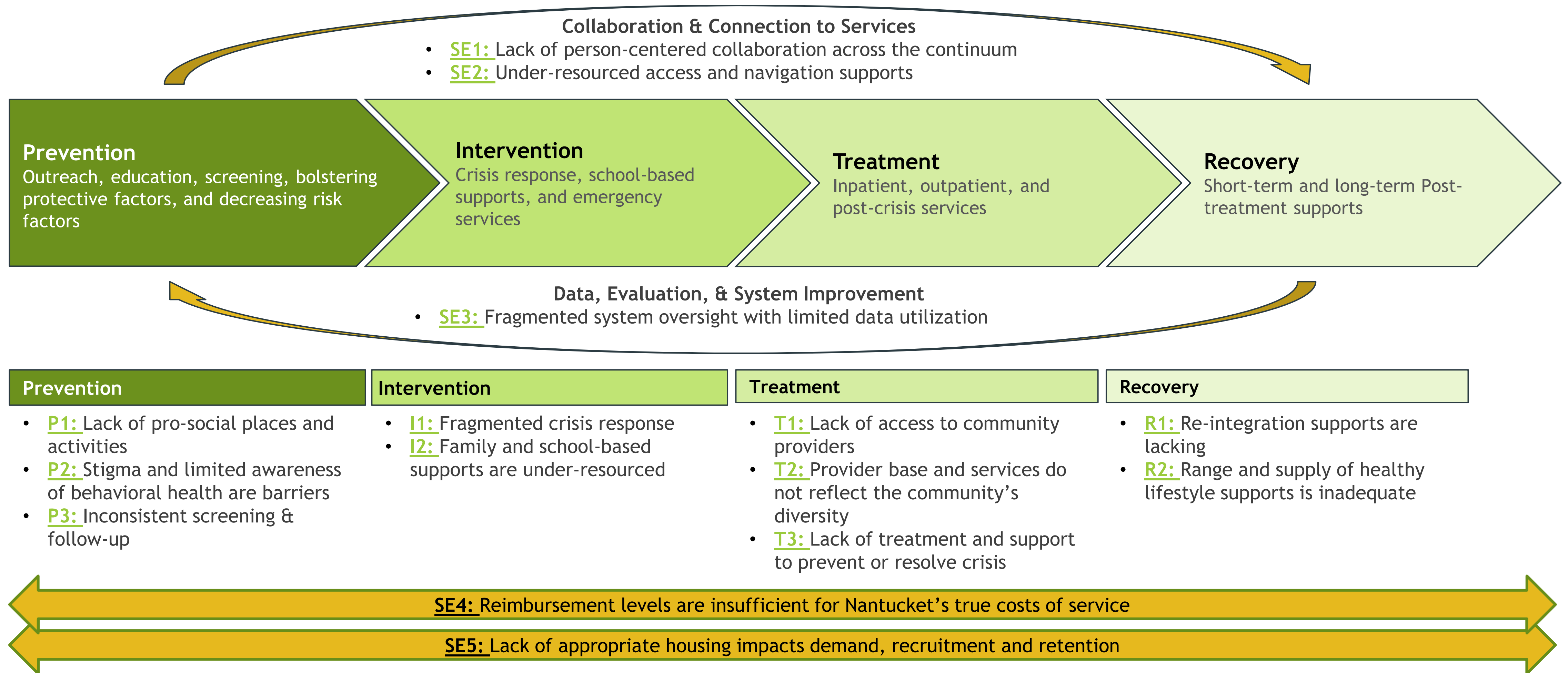
GPS used data from various sources to approximate the number of at-risk people on the island. Here are the sources:

Footnote Number	Citation	Link
1	Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. Prevalence and treatment of depression, anxiety, and conduct problems in U.S. children. The Journal of Pediatrics, 2018. Published online before print October 12, 2018	Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children - The Journal of Pediatrics (jpeds.com)
2	Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services, HHS Publication No. SMA-20-Baro-19-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020	Behavioral Health Barometer: Massachusetts, Volume 6 (samhsa.gov)
3	SAMHSA, 2018- 2019 NSDUH State Estimates of Substance Use and Mental Health Use Disorders as analyzed by Kaiser Family Foundation	Mental Health and Substance Use State Fact Sheets: Massachusetts | KFF
4	SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2018 and 2019	2018-2019 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State | CBHSQ Data (samhsa.gov)
5	National Center for Health Statistics, Household Pulse, 2021	COVID-19 Data from the National Center for Health Statistics (cdc.gov)

Appendix 2:
1-Page Gap Overviews

Behavioral Health Continuum

GPS identified 15 gaps across the continuum of care, including five "System Enablers" (SE) that will allow the system to function better as a whole.



SE1: Lack of Person-Centered Collaboration Across the Continuum of Care

Description of the Unmet Need:
Because it has evolved over several years, Nantucket's BH system is comprised of practices and organizations each executing their missions and referring clients to partners when needs exceed their own capacity or capability. Referrals are guided by intrinsic or institutional knowledge of other providers' services, and most providers make good faith efforts to assist clients in making the connections that their care requires. Each organization expands offerings or ceases services based upon available funding and staff turnover, many citing their own examples of prior efforts or services deemed effective (and suggested for re-introduction).

Aside from professional ethics, commitment to service, and personal relationships, very little structural support or design exists to tie this system together. People's needs, however, are complex and often require provider collaboration as well as wrap-around services to address other barriers to personalized, person-centered care. Further, relying on committed individuals rather than a system of care can result in burnout and leave significant gaps when someone leaves the island or retires.

Details include:

- Payer boundaries are a significant barrier to an integrated continuum of care. Mass Health and Blue Cross/Blue Shield are prevalent insurers on the island, and the allowable services and provider networks for these coverages do not line up (for example, Peer Recovery Coaches and in-home therapy are just two of the services not covered by all insurance lines). These misalignments represent a barrier to understanding and a risk for incurring bills for non-covered services. "If I'm not sure that it will be paid for, maybe I'll just skip that appointment" is an understandable response to a confusing system.

Sizing the Need:

- Several providers shared challenges with warm hand-offs and referral follow up.
- Intensive care coordination services for child behavioral health needs is available via Community Service Agency (CSA) supports, but only for qualifying complex needs.

Note 1: This gap is tightly connected to T1: Lack of Access to Community Providers, SE2: Under-Resourced Navigation Supports, and SE3: Reimbursement Levels.

Note 2: Martha's Vineyard is not Nantucket, but their system of care is farther ahead in terms of person-centered collaboration. They have built a campus to house related services in a single location, are actively advocating at the Statehouse, and have developed a more robust system of navigation and linkage to the full range of services.

Ideas to Close the Gap:

- Engage in a system design exercise, bringing to bear leading clinical minds and those who understand payment systems with those who know Nantucket's specific needs, services, and limitations. This group could collaboratively re-draw boundaries, align on what can be offered on-island v. regionally, design physical locations, enhance referral efficacy, and avoid inefficiencies stemming from operating many small organizations.
- Taking a whole-person perspective and expanding the service system boundaries to include primary care and schools (among others) will expose more of the islands' residents to services and supports that match their needs.
- Single entry points with coordinated releases of information will reduce repetition and enhance coordination.
- An integrated electronic health record (EHR) would enable providers and authorized users (e.g., school counselors) to access a complete picture of the individual's/family's needs and supports.
- Explore opportunities and limitations of insurance reimbursement and incentives for providing care coordination, case management, and wrap-around services that promotes whole person care.

SE2: Under-Resourced Access and Navigation Supports

Description of the Unmet Need:
Despite good faith efforts made by providers to assist their clients in making appropriate and necessary connections across the behavioral health system, clients and the community at large are not aware of the full breadth of the behavioral health network of providers and supports. Individuals have no single location to gather details such as the comprehensive details of provider offerings, how to select the best fit for need, payment requirements, insurances taken, etc. Many referrals are "push" referrals, without ongoing follow-up, and most organizations do not have the staff nor the mandate to assist with closing loops.

Details include:

- Nantucket is served by a number of providers who maintain offices elsewhere, and because providers are listed in statewide indices by their home office, they may not appear to offer services on Nantucket.
- The rise of telehealth supports means that there are more options for clients than previously known but navigating to these additional supports is dependent upon support from their existing providers and insurance groups to facilitate those connections.
- Some providers maintain individual lists of options for clients to see other providers, but these lists are admittedly not maintained and may contain outdated information, which can serve to frustrate clients seeking support.
- There are a number of support groups and programs on both the prevention and recovery ends of the continuum, however, the awareness of and capacity for these have not been continually maintained. For example, Vinfen is a state care management resource that appears to be underutilized on the island, perhaps because providers and clients are unaware of its existence.

Sizing the Need:

- 54% of community survey respondents report lacking information of what is available is "always" or "often" a barrier to care.
- National data indicate that approximately 4% of Americans have 1 or more co-occurring condition (SU and MH)[x]. Anecdotal reports from local providers suggests that a higher percentage of community members seeking treatment have co-occurring conditions.
- 30% of those completing the provider survey and 21% of those completing the community survey identified case management to help people access things like food, child care, and/or legal assistance as one of the five services they would most like to see on Nantucket.

Ideas to Close the Gap:

- The Nantucket Department of Human Services has invested to create a network of care system with functionality beyond a simple service directory. Additional investments could be directed toward publicizing, curating, and increasing language access to this resource based on feedback from providers, clients, family members, and other community resources (e.g., groups, faith-based organizations, etc.).
- As other communities have done, and because many people are not comfortable navigating systems electronically, Nantucket could invest in BH navigators that help individuals seeking service make the connections. Bolstering use of resources currently available, such as the William James Hotline, with a single contact number staffed by personnel that know the system and can direct clients accurately, with greater navigation support like warm hand-offs to intake staff at provider practices, could foster faster and lasting connections.
- Explore models of intensive care coordination services provided as part of the CSA arrangement for scaling (and funding) opportunities.

[x] Substance Abuse and Mental Health Data Archive, US Dept of Health and Human Services

Data, Evaluation, & System Improvement

SE3: Fragmented System Oversight with Limited Data Utilization

Description of the Unmet Need:
The fact that the island's system has no single unifying vision and poorly understood capacity were some of the reasons to fund this assessment. The system has evolved over time with agencies expanding and modifying their services to meet needs within available funding. These changes are responsive and in many cases are improvements, but the system has not been designed strategically and is not operated as a single system. This is typical of BH systems nationwide, and experts are fond of saying that behavioral health lags physical health by 20-40 years.

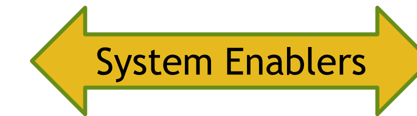
This fragmentation makes system improvement a challenge. Data collection is inconsistent and there are no performance measures that assess the system as a whole. Patient-specific collaboration is common, but organization-based collaboration is inconsistent and opportunistic rather than strategic. This results in a group of individual organizations and programs rather than a system of care that is integrated and coordinated. A community this small needs integration to drive meaningful, lasting, and truly impactful change.

Details include:
- Without shared agreement on the problems, needs and priorities, opportunities to collaborate are missed and competition is possible.
- Groups like the BH Task Force/Advisory Group and Healthy Community Collaborative are well attended, but their mandate is limited by funding.
- Regulatory structures bring with them varying oversight requirements related to documentation, and different standards hinder data sharing.

Sizing the Need:
- Nantucket's year-round population of ~17,000 increases dramatically in the summer months, with approximately 10,000 additional seasonal residents and 35,000-45,000 visitors on the island at any point during the tourist season. Many of these people will not interact with the BH system but the system design efforts should factor in potential needs.
- Of the more than 20 organizations GPS interacted with, only 1 maintains a dashboard with measures related to behavior health data. Many do not gather data in a usable fashion.
- There are 5 agency providers on the island (NCH, Fairwinds, Gosnold, Addiction Solutions, and A Safe Place), as well as approximately 17 private providers who may participate in a patient's care.
- The scale of available telehealth partners is not quantified.

Ideas to Close the Gap:
- Develop or identify a single organization chartered to lead the system transformation. Resource this organization to be able to provide administrative services and supports to the various member organizations, potentially including ongoing assessment and planning, fundraising, data evaluation, and continuous improvement.
- Align on collective success measures and specify the targeted interval for review and the data elements required from each organization.
- Develop or adopt a common database and engage in system-wide evaluation and continuous improvement activities.
- Develop a single standard for client satisfaction so that data can be aggregated across the system and used to identify gaps and drive improvement.

SE4: Funding is Insufficient to Respond to Nantucket's True Costs of Service



Description of the Unmet Need:
Nantucket's scale, isolation, and extreme cost of living are well known. Unit cost reimbursement, especially for services that must be available 24/7, is untenable when the volume of need is low. Costs of transportation of goods, services and people over water increases the costs of care. While the cost of living in Massachusetts is notably high compared with other states, the cost of living on Nantucket is among the highest in the state. Further, Nantucket is grouped in the vast DMH Southeast Area, comprising 6 counties (Bristol, Plymouth, Norfolk, Barnstable, and Dukes),s all of which have lower costs than Nantucket.

Reimbursement rates for Mass Health and other state supported services are not typically indexed to account for the factors of economies of scale and costs associated with living and doing business on an island. Reimbursement combined with the unique nature of island living result in safety-net providers experiencing significant challenges recruiting and retaining experienced clinicians. At the same time, the lucrative private pay business competes for experienced clinicians.

These factors are exacerbated by national behavioral health workforce shortages, and the impact of COVID-19 on the workforce in general.

Massachusetts' Roadmap for Behavioral Health Reform and the American Rescue Plan Act (ARPA) presents time limited opportunities for Nantucket to leverage state and federal funds to invest in Medicaid and non-Medicaid mental health and substance use services including state funded crisis response.

Sizing the Need:

- The table below compares Nantucket to Barnstable County and the Commonwealth as a whole, using a fixed score of 100 to reflect the national average cost. For example, Nantucket's cost of housing (674.7) means that housing on the island is ~6.7 times the national average.[x]

Cost Comparison of Critical Services
(100 = national average)

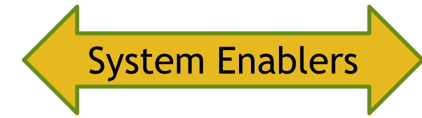
Dimension	Town & County of Nantucket	Barnstable County	Massachusetts
Housing	674.7	185.9	176.4
Health Care	102.9	84.3	83.7
Grocery	123.3	110.3	108.9

Ideas to Close the Gap:

- Maximize the use of collaborative codes for behavioral health and physical care recently activated in the Mass Health billing system to expand cross-organizational treatment coordination
- Engage a billing expert versed in Medicaid, Mass Health, and private insurer systems to assess partner billing practices and identify how to maximize reimbursement within current systems including potentially securing the necessary designations to qualify for reimbursement streams (e.g., FQHC, CCBHC, etc.).
- Develop and execute an advocacy strategy at both the local and state level to:
  - Create a compelling argument for the mismatch between costs and reimbursement to be used to communicate with state and local funders and policymakers
  - Leverage state and state-federal opportunities to expand programmatic funding
  - Identify and capitalize on the opportunities to maximize plans emerging from State Behavioral Health Reform, Mass Health reimbursement and ARPA funds
  - Advocate for policies and programs that respond to the unique challenges associated with delivering behavioral health care in island communities, possibly in coordination with Martha's Vineyard

[x] https://www.bestplaces.net/cost_of_living/city/massachusetts/nantucket

SE5: Lack of Appropriate Housing Impacts Demand, Recruitment and Retention



Description of the Unmet Need:
Nantucket's housing crisis pervades the life of residents, increasing stress and driving demand for services from community members, while at the same time posing a significant barrier to the recruitment and retention of qualified staff at both providers and partner organizations.

Lack of affordable housing is viewed as an intractable problem that extends beyond behavioral health and to date, market-based solutions have not met the needs of all residents. The typical progression of the "Nantucket shuffle" is changing, despite recent investments and gains. Increasing population and decreasing raw land will make these challenges worse. Secure housing represents a competitive advantage. Larger provider groups such as Fairwinds, NCH, and others have worked to identify a portfolio of housing options including workforce housing and single-family residences, though maintaining access to available and affordable options remains difficult.

Details include:
- Tying housing to employment is viewed as a trap: It may serve to tie a provider to an employer without wage increase/progression and/or inhibit a provider terminating an employee if that would result in homelessness.
- Workforce housing is available, but while this meets the needs of younger providers, it is not appropriate for top-tier, highly-credentialed providers bringing their family to Nantucket.
- Provider burnout, influenced by both an inability to have a balanced social life away from colleagues, as well as the reality of housing prices, contributes to providers setting up shop as private pay operations.

Sizing the Need:
- Based on preliminary information from the recent community needs assessment, lack of appropriate affordable housing continues to be a significant stressor.
- According to a representative of the Nantucket Affordable Housing Trust, one major private sector landlord has a fully-vetted list of qualified families actively seeking rentals that numbers 450 with and additional list of 500+ of as-yet unvetted applicants.
- Nantucket County is the nation's single most expensive county for housing, with median prices exceeding that of Manhattan
- A recent housing production plan is here and highlights data and progress including "In just the last three years, Nantucket has gone from less than 2% of its year-round housing stock being affordable, to now over 5 ½ %, or 273 residences, being eligible to be listed on the Town's Chapter 40B Subsidized Housing Inventory ("SHI").

Note: Accurate sizing of need is complicated by a significant, but uncounted undocumented population.

Ideas to Close the Gap:
- Contribute to shared-use workforce housing, mixing professionals from different organizations such as BH providers, police, and other groups to contribute to the balanced personal lives that help lower burnout and foster a greater sense of belonging that leads to retention.
- Development teams could collaborate to engage donors in investments that yield stability for providers across groups, tying access to housing to contribution to the BH field/system rather than to a single organization.
- Expand stipend programs to those professionals who do not qualify for traditional low-income subsidies but do not make enough money to secure housing.
- Engage collectively with the Town and land trust organizations to craft mixed-source programs that meet the needs of the BH community (e.g., deed restrictions, housing trusts, increased supply in the condo/middle market, etc.).

P1: Lack of Prosocial Places and Activities

Prevention

Description of the Unmet Need:
Nantucket has a seasonally-vibrant social scene, with beaches, a quaint town center, and a summer filled with community events. Many of the available activities center around alcohol, either because they occur in a festival setting or because they occur in establishments that serve alcohol (viewed as a necessity due to high rents).

Outdoor recreation facilities are well-established but indoor facilities are limited. Town resources include a wide variety of classes, but the costs associated with these represent a barrier in a community with very high cost of living. The island has no youth center, recreation center, or other facility dedicated to healthy social pursuits. Adolescents and young adults have few alternatives to "hanging out in the moors."

Details include:
- The island's physical isolation (30 miles offshore) is mirrored in social isolation, with limited groups to engage residents.
- The Boys and Girls club serves the island's youth population and offers rental space.
- Community members highlighted a duality between concern and permission related to youth substance use.
- Stress levels for year-round residents are reportedly high, and substance use serves as a coping mechanism.
- Closures due to COVID increased isolation and left island residents with few alternatives during a stressful time.

Sizing the Need:
- Youth Pride surveys indicate:
  - Increased use of substance use since the 2017-18 survey, including marijuana (20.7% increase), illicit drugs (18.0% increase), alcohol (13.3% increase), and hallucinogens (11.1% increase).
  - Only 67% of students consider alcohol use to pose moderate or great risk, compared with 83% of students who consider cigarette/tobacco use to pose moderate or great risk.
  - Low participation in protective activities like community or school activities (25% of students), and teachers or parents communicating about the dangers of drugs (27% and 36%, respectively).
- 25% of survey respondents highlighted a community recreation center for adults as highly desirable.
- 31% of survey respondents highlighted a community recreation center for youth as highly desirable.

Ideas to Close the Gap:
- Make facilities available that offer free or very low-cost gathering locations. Suggestions include:
  - Constructing a student-union style facility that offers games, low-cost healthy food, and study/socialization spaces, while avoiding "over-supervision" of youth
  - Contracting with breakfast-lunch restaurants to make their spaces available in evening hours to serve as convening places
  - Finding community vendors that are willing to host healthy alternative events
  - Subsidizing activities like recreational classes and sports leagues (both adult and youth) to reduce barriers to access (e.g., cost, transportation, child care, etc.); empower (or pay) influencers to increase appeal and participation
  - Design a facility that could serve double duty as a place that is used for recovery support (sober activities) and to bolster healthy activities for people with serious mental illness (recreation, cooking, music etc.)
- Provide alternatives and multiple options for social gatherings, not dependent upon facilities that serve alcohol or otherwise tolerate (or attract) substance use.
- Engage high-priority populations (e.g., youth, seniors, veterans, newcomers) in brainstorming and evaluating alternatives to ensure that the participation will match investments.

P2: Stigma and Limited Awareness of Behavioral Health are Barriers (to Seeking Help)

Prevention

Description of the Unmet Need:
Despite changing attitudes, both nationally and locally, concerns about seeking treatment for mental health and substance misuse services remain high. Typical concerns include privacy, shame, perception, loss of community stature, and fear of family rejection. These, and other concerns, form a barrier to seeking treatment and are magnified in a small community where residents often know the service providers. Further, a fear of law enforcement also affects some members of the community, including concerns about the impact of interacting with Police, DCF, and immigration officials. Official assurances that arrests will not occur and that children will not be removed from the home environment are often ineffective in overcoming this fear.

As a society, we do not yet speak consistently about seeking treatment for illnesses and diseases that affect the mind as we do for ailments like a broken arm or cancer. Often, these beliefs are at the root of stigma. In other cases, individuals have outdated perceptions of, or cultural biases related to, mental health and substance use conditions and are not aware that we ALL need BH services the same way we all need physical health services.

Details include:
- Nantucket is sometimes referred to as a “perfect island” or “fantasy island”; preserving this image may prevent some individuals from seeking services and supports.
- People report going off-island for treatment to maintain privacy.
- Substance misuse and addiction are reportedly viewed more negatively than depression, anxiety, & mood disorders.
- Those not yet in active recovery may struggle more with stigma than those whose treatment has progressed.

Sizing the Need:
- 38% of survey respondents identified that being “afraid that someone might find out” is “always” or “often” a barrier to care.
- 10% of survey respondents identified “fear of that law enforcement will find out” is “always” or “often” a barrier to seeking services.
- 54% of survey respondents indicated that there is a lack of information about the services available.
- Nantucket-specific data are not available, but a recent study by Optum shows that “relative to white non-Hispanics, all racial/ethnic subgroups had lower rates of individual psychotherapy utilization, and these differences were primarily driven by lower service penetration rather than differences in service use intensity.”[X]
- 31% of Americans indicate stigma as a reason to NOT seek treatment.[Y]

Ideas to Close the Gap:
- Invest to change community perceptions about behavioral health:
  - Launch community promotion and awareness campaigns utilizing best practices around behavior shifts, particularly in communities where the utilization of services is low
  - Normalize seeking help through media campaigns using images of people talking about seeking help
  - Gain public support from high-profile influencers to help put a familiar public face on BH struggle and triumph
  - Raise awareness of available services to both drive participation but also help normalize the processes of accessing services
- Provide additional private ways to access services (e.g., home visits, telehealth[Z], mixed use facilities, mobile facilities, primary care integration, etc.).
- Increase investments in:
  - Nantucket DHS’s emerging system of care guide to help connect people with services, and
  - Positions to help individuals connect to services, navigate the system of care, understand their benefits, etc.

[X] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6505415/; [Y] https://www.cohenveteransnetwork.org/wp-content/uploads/2018/10/Research-Summary-10-10-2018.pdf ; [Z] May need to assess existing broadband/cellular networks to ensure sufficiency

P3: Inconsistent Screening and Follow-up

Prevention

Description of the Unmet Need:
Screening is one of the cheapest, most effective methods of prevention because early detection intervention produce improved outcomes at lower cost. Closed-loop referrals based on screening results ensure that all members of the community receive supports that are targeted at their specific needs.

Details include:

- Universal screening integrated into primary/pediatric care is a best practice to identify mental health and substance use risk factors early. This includes screening adults, adolescents and children for depression, anxiety and substance misuse and delivering a brief intervention and/or referral to treatment.
- Schools and child-care centers also are valuable partners in a holistic approach to screening and early intervention both because of their access and connection to youth, but also because academic failure increases the risk of substance use, depression, and anxiety.
- Recent regulatory changes enabling office-based prescription of suboxone are likely to endure beyond COVID and offer an opportunity for expansion of addiction treatment in primary care.
- Limited provider capacity and inconsistent follow-up processes to address the needs of individuals result in fewer closed loop referrals and warm handoffs than is ideal.

Sizing the Need:

- Of the people participating in the community survey:
    - 47% reported interacting with a "medical doctor's office" in the last year
    - 58% reported interacting with NCH

Note: Related ideas in this assessment include T1: Lack of Access to Community Providers and P2: Stigma and limited awareness of behavioral health are barriers

Ideas to Close the Gap:

- For Adults:
    - Offer incentives and resources for integrated behavioral and primary care
    - Experiment with self-screening tools such as those found on the Mental Health America website - MHA Screening | Mental Health America (mhanational.org)
    - Strengthen processes and relationships between primary care and specialty behavioral health care providers through training, consultation and formal referral protocols
    - Investigate on-line screening to help manage screening load on primary care providers, factoring for technology access amongst targeted populations

- For Children:
    - Expand screening for all birth-age 5 children through community events and in partnership with all K-12 and Early Childhood education environments, both center-based and family-friend-and-neighbor settings

I1: Fragmented Crisis Response

Description of the Unmet Need:
Nantucket is facing an escalating demand for behavioral health crisis response to increasingly complex needs. Individuals experiencing a mental health or substance use crisis may be served by up to five organizations, including Gosnold, Fairwinds, the Nantucket Police Department, Nantucket Fire Department, and Nantucket Cottage Hospital. Beyond initial crisis call "fact finding," subsequent steps in response depend upon the insurance status of the person experiencing crisis and the problem type. The multiple systems of crisis response and care drive inefficiencies given the island's small population. This is exacerbated by the lack of intensive treatment which results in people who might be stabilized and treated on-island facing lengthy and expensive transportation for treatment in other parts of the state.

Details include:
- Gosnold holds a state contract, via Bay Cove, to operate a 24-7 mental health crisis hotline and provide evaluation for people who are enrolled in MassHealth, uninsured, and youth regardless of payer.
- NCH provides mental health evaluation for people with commercial insurance, stabilization for people awaiting transfer off-island for inpatient psychiatric care, treatment of medical complications, and social work supports.
- Fairwinds screens calls for urgent care and refers clients in crisis to Gosnold or NCH and prioritizes those emerging from crisis or with urgent needs in their treatment appointments.
- NPD trained in Crisis Intervention Team (CIT) methodologies respond to dispatched emergency calls and requests for wellbeing checks (as resources are available for wellbeing checks).
- For those experiencing a medical emergency associated with a MH crisis, overdose or substance related abuse, an ambulance is dispatched from the Nantucket Fire Department to treat and, if needed, transport individuals to NCH for continued emergency care. Working with the NPD, the Fire Department members trained in CIT work with the responding NPD officer to assure proper care.
- Identifying sustainable resources for off-island transportation is challenging. Currently, non-reimbursed costs are absorbed by NCH.

Sizing the Need:
- 73 average annual calls for service to NPD related to mental health; From 2017-2019, NFD and NPD responded to 30 substance use overdoses and administered Narcan 21 times[x].
- 82 BH incidents required NFD response from July 2020—July 2021; of those, 32 were related to mental health needs and 50 were SU-related incidents.
- Gosnold reports average crisis call volume to be 88/month (1,060/year, based on July 2019-June 2021 volumes). Gosnold further reports performing nearly 90 evaluations/year connected to Emergency Services Program calls.
- NCH clinicians performed 62 crisis evaluations in the hospital from July 2020-June 2021, including 26 suicide-related encounters, and 17 evaluations linked to substance use.
- Fairwinds reported 24 calls for crisis needs in addition to the channels described above during the period Nov 2020-May 2021.
- More than 90% of patients seen in the hospital for a behavioral health evaluation did not have contact with a mental health professional in the 90 days prior to their assessment, based on NCH clinicians' experience.
- On-island transports for BH crises range from $1,325 to $2,145 per incident; off-island transports range from $2,225 to $4,920 per incident.
- The MDPH 2020 report indicated that Nantucket experienced the highest rate of suicide in the Commonwealth in 2017, at 62.1/100,000 (n=7)[W]. Further, Nantucket had the highest rate of self-inflicted harm deaths of all counties in Massachusetts from 1999-2017[x].
- 6.6% of students in grades 6-12 reported thinking about suicide "a lot" or "often"[y].

Ideas to Close the Gap:
- Expand availability and cross-organizational promotion of telephone/text support to include crisis hotline, warm-line and referral support.
- Integrate and harmonize crisis response from hotline, dispatch, mobile, and emergency room (evaluation, referral, and follow-up) regardless of problem (mental health or substance use), age, or insurance status (create a "payer blind" system).
- Create smooth transitions from crisis response to intensive community-based treatment with follow-up to ensure continuity of care, including individuals returning to the island after treatment.
- Related ideas in this assessment:
    - Ramp up prevention, screening, and early intervention supports to reduce acuity—help BEFORE crisis
    - Invest in intensive treatment and supports

[W] https://www.mass.gov/doc/suicide-in-massachusetts-2017-data-report/download, [X] https://www.nantucket-ma.gov/DocumentCenter/View/35203/Chronic-Disease-Report-2020-PDF,
[Y] 2019 Pride Survey (NPS)

I2: Family and School-based Supports are Under-Resourced

Description of the Unmet Need:
Provider shortages like Nantucket's are a nationwide phenomenon. There simply are not enough providers to meet needs in a traditional fashion. Services for children are particularly lacking, with relatively few providers specializing in serving children and youth with psychosocial concerns.

Family and school-based supports are proven ways to ensure that children receive the help they need to continue their development. The exposure to children is primarily through two environments: home and schools.

Both home-based and school-based supports are lacking and asking parents and school staff to do more does not appreciate the "maxed out" feelings of these two groups. Additional resources can be brought to bear and there is also the opportunity to equip both school staff and parents with skills to increase the quality of interactions and their skill at removing barriers. NPSD has invested in services and acknowledges an opportunity to do more.

Details include:
- Connection to higher-order interventions is best done AFTER less extreme approaches are exhausted.
- Through COVID, parents and teachers report children's behaviors moving from "disruptive" to "disengaged".
- Parenting support and education begins at birth (or earlier) and effective supports of families and children, from birth through high school, have significant positive impact.
- There is confusion around who in the community can evaluate and diagnose ADHD, as well as available reimbursement
- Culturally-competent methods must be employed given the mix of cultures in NPS.
- In the 20-21 school year, the DESSA screener tool was introduced at the elementary, intermediate, and middle schools to assess the social-emotional needs of students.

Sizing the Need:
- Based on the most current official census information[x] and Nantucket Public School District enrollment data[y], there are are approximately 2,400 children aged 0-17 on Nantucket, accounting for 21% of the total population
  - Age 0-4: 756 (7%)
  - Age 5-13: 1,103 (10%)
  - Age 14-17: 509 (4%)
- Of the 1,666 students enrolled in the school district:
  - 56% are English Language Learners or First Language is not English
  - 52% are considered "high need"
- Nantucket Public Schools employs:
  - 4 social workers, one per building (none are bi- or multilingual)
  - 7 school counselors, providing a range of supports (2 NES, 2 CPS, 3 NHS)

Ideas to Close the Gap:
- Investigate evidence-based programs that help support thriving children through education of the adults who support them. Examples include:
  - The Think Kids program is a cost-effective, evidence-based program designed to teach adults skills, approaches, and perspectives to understand children's challenging behaviors.
  - Incredible Years is an evidence-based program provides training to adults of children of different ages to foster parent's involvement in children's' school experiences and promote children's social, emotional, and academic skills.
- Employers can play a role, and increase the stability of their employee base, by offering short training and information in many languages during paid time.
- Fund additional school-based counselors/clinicians, recruiting a mix of licensing levels and cultural backgrounds to increase relevance.
- Invest in an evidence-based home visiting parenting program, supported broadly by community organizations (NCH, Fairwinds, NCS/NPS, etc.).
- Provide additional funding to enable those unable to afford treatment to receive cost-free/subsidized visits with a private provider (that is, expand NAMI's current program).

[X] July 1, 2020 Population Estimate (US Census)
[Y] Nantucket Public School District Enrollment 2020-21

T1: Lack of Access to Community Providers

Description of the Unmet Need:
Nantucket has a committed base of community providers who work to meet the needs of individuals seeking treatment. The number and variety of providers, however, is not adequate for the community's needs, both in specialties and in general treatment. Hours of service are limited by low staffing levels, posing a barrier to community members who work and/or care for others. Some people are reluctant to seek care with local providers due to stigma and privacy concerns. Elevated levels of turnover, long hiring cycles, high costs of housing, and low reimbursement rates all contribute to challenges in matching capacity to demand. Waitlists are commonplace.

Details include:
- Appointments for students are understood to be only available from 3-5pm with some providers, limiting the number of available slots. Those private providers who responded to the survey advertise some flexibility.
- Contributors to provider burnout and turnover include housing instability, high cost of living, caseloads with all patients at high acuity, and inability to "turn off" due to the small community and lack of formal back-up systems.
- COVID has increased the use and acceptability of telehealth visits, while this is not appropriate for all patients due to challenges with technology, privacy concerns, and language needs, some prefer accessing care through telehealth.
- The community has expressed concern over the availability of substance use treatment, eating disorders, and child and youth-focused behavioral health.

Sizing the Need:
- Of those completing the community survey:
  - 37% reported that they or someone they were assisting waited more than a month for an appointment
  - 67% reported waiting lists were "always" or "often" a barrier to care
  - 27% reported that the hours or days of service were "always" or "often" a barrier to services
  - 43% reported that finding a provider that accepted their insurance "always" or "often" presented a barrier to care
- Nantucket has 5 providers of any level who report accepting Mass Health.
- Addiction Solutions is the only Medication Assisted Treatment (MAT) provider and is not a full-time operation.
- Nantucket's provider ratio of 1:250[x] ranks the lowest within MA; when accounting for higher population estimates, the provider ratio is much closer to 1:370 (if not higher).
- The percentage of Americans saying they would use telehealth services for mental healthcare increased from 49% in 2020 to 59% in 2021. Younger adults were more likely to say they would use telehealth for mental health services (66% of 18-29-year-olds) compared to older adults (36% of those 65 and older)[y].

Ideas to Close the Gap (significant overlap with ideas related to other gaps):
- Expand integrated behavioral health care in primary care settings.
- Innovate models of supervision, training and consultation (in person and by telehealth) to increase both competency and comfort with full scope of practice for all providers.
- Formalize and expand use of peers to coordinate care, connect with recovery supports, and supplement telehealth services while allowing behavioral health treatment providers to work at top of scope of practice.
- Create additional prescriber capacity through improving efficiencies in scheduling and completing telehealth appointments (e.g., screening for referral appropriateness, managing no shows, providing space), investigating need for, and availability of, advance practice nurses, and formalize same day appointments for urgent needs.
- Reimagine access and services across organizations to better match the needs of the community within existing capacity while specifying and pursuing additional capacity in valued positions or specialties. Consider clinical fellowships and internship models and expanding service hours to include weekends and evenings.
- Drive utilization of telehealth[Z] for patients where accepted or preferred, providing spaces to access telehealth when privacy or connectivity are issues.
- Advocate for alternative pathways to licensure and reimbursement reform at the state level.

[X] University of Wisconsin Population Health Institute, County Health Rankings (data from 2020 CMS-National Provider Identification database); [Y] https://www.psychiatry.org/newsroom/news-releases/New-Nationwide-Poll-Shows-an-Increased-Popularity-for-Telehealth-Services; [z] May need to assess existing broadband/cellular networks to ensure sufficiency

T2: Provider Base and Services Do Not Reflect the Community's Diversity

Description of the Unmet Need:
Nantucket mirrors the nation in that providers often do not come from the communities they serve. On Nantucket there are large populations of Spanish speakers, Portuguese speakers, as well as others.

These community members bring with them language, values, and practices of their respective cultures, and serving them means taking these features into account. The faces seen, the services delivered, and the way populations are reached must reflect cultural diversity, or the results of care will be suboptimal.

Details include:

- Linguistic competency is not enough. Due to the sensitive nature of behavioral health services, cultural competency is an appropriate goal.
- Cultural norms differ related to the community response to mental health and substance use and help-seeking. The differences in cultural norms present both challenges and opportunities to engage community members in change. Members of the LatinX community indicate that participation in BH services are viewed with significant stigma and overcoming this barrier will require intentionally designed approaches.
- Despite media push, utilization of faith-based channels, and personal appeals from members of the community, very few non-English speaking residents participated in a community listening session or took a survey. More work needs to be done to understand the best way to engage and empower various communities in developing strategies that improve behavioral health outcomes.

Sizing the Need:

- Conservative estimates show that 12% of the island's population is foreign-born with a corresponding percentage speaking a language other than English (2015-2019 ACS).
- Of the 1,666 students enrolled in the school district, 56% are English Language Learners or First Language is not English
- Of those completing the community survey:
  - 16% responded that the provider not speaking the language needed was "always" or "often" a barrier for themselves or the person they were assisting
  - 25% reported that the people at the service sites were not helpful, "always" or "often"
  - 28% identified more outreach to people who speak Spanish as among their top priorities for services on Nantucket
- 6 of 10 providers answering the question report providing service in other languages, Spanish (6), Portuguese (5), and French (1); 3 others offer services via interpreter.

Note: Select community provider details are included in the Provider Summary section.

Ideas to Close the Gap:
Convene influential stakeholders from underrepresented communities to identify ways to better align with cultural norms and contribute to closing these gaps, including:

- In the near-term:
  - Expand peer supports and experiment with community health workers ("Promotoras" in Spanish) models to quickly ramp up relevance and connection to underserved communities
  - Avoid recruiting and retention challenges by home-growing a local talent pipeline, potentially using high-school career programs to grow non-degreed personnel who come from the communities being served
- Develop a joint recruiting pipeline to share administrative burdens.
- Endow fellowships and expand internship programs with a priority on recruiting diverse candidates; consider joint interns across organizations like Fairwinds and NCH to offer experience in multiple settings (note: additional resources must be provisioned for supervision as these duties are significant). Incorporate opportunities for fellows and interns to focus efforts on identifying culturally specific evidence-based practices and make a commitment to implementing them.

T3: Lack of Treatment and Support to Prevent or Resolve Crisis

Description of the Unmet Need:
Nantucket lacks intensive community and/or facility-based stabilization and treatment for individuals in crisis, people escalating toward crisis, and individuals requiring support after a crisis. The lack of intensive treatment and support results in people being stabilized in the emergency room and either transferred off-island for inpatient care or returned home without intensive follow-up. Further, there is an inadequate system of care for people returning to the island following inpatient or residential treatment that can assist with reintegration.

Off-island transport for treatment is expensive, disruptive, and in some cases contributes to more significant conditions than if treatment were available in familiar environments. While NCH has 2 beds in rooms modified for patient safety, there is a lack of continuity of treatment during the stay in the hospital due to changing physician and nursing coverage. This results in missed opportunities to stabilize individuals on-island. Further, hiring “sitters” to supervise patients and transporting patients off-island is costly and consumes resources that might, in part, be redirected to providing additional treatment to avert and stabilize crisis on the island.

Nantucket’s small scale makes it unlikely that higher levels of care such as inpatient and residential treatment will be provided on-island, but there are opportunities to enhance the continuum of care to more often avert, stabilize, and treat individuals closer to home and to bolster supports for people returning to Nantucket after an inpatient or residential stay.

While individual organizations are providing pieces of the treatment services needed to prevent crisis, stabilize people after a crisis, and help people returning to the island after an inpatient stay, there is no systematic approach to service delivery.

Sizing the Need:

- 54% of those responding to the community survey identified that providing mental health beds for people in crisis was among their top priorities and 53% identified providing help for people returning to Nantucket after a crisis as a priority.
- By definition, crisis services need to be available 24/7 but the low demand for crisis evaluations (75-100/year or fewer than 2 per week as reported by Bay Cove) makes it challenging to staff without significant down time.
- The proportion of youth requiring evaluation increased from 26% to 35% from 2019 to YTD 2021.
- NCH and Bay Cove data (state Emergency Services Program) suggest that approximately 45 people a year are transported off-island for care each year (not including individuals who arrange their own transport outside of NCH or other organizational support).
- People are waiting for available inpatient beds and/or transportation arrangement in the emergency room or on med surg unit for between 1 day and 9 days.
- 65% of those responding to the community survey reported wait times of more than a week for access to services and 37% reported wait times exceeding a month.

Ideas to Close the Gap:
- Develop a community-based crisis treatment and support system specifically for people escalating toward a crisis or following a crisis that includes elements such as rapid access to mental health and addiction medications and counseling, clinical case management, peer support, and respite. (Note: A NAMI-Gosnold partnership for intensive outpatient services is being planned.)
- Integrate the crisis treatment services with crisis evaluation to ensure that whenever possible, evaluation is completed in the community (rather than emergency room) and that follow-up is immediately available following a community or emergency room evaluation.
- Use the community crisis treatment team to work with the hospital to develop care protocols and treatment plans while people are awaiting transfer to inpatient care off-island.
- Deploy the community treatment team, particularly peers, to provide support to the hospital while individuals are in the emergency room and inpatient hospital beds at NCH.
- Explore models for in-home and/or family care crisis respite and peer companion crisis respite services.

R1: Reintegration Supports are Lacking

Description of the Unmet Need:
The island's lack of inpatient and residential treatment requires that individuals in crisis make a lengthy and often traumatizing trip off-island for intensive psychiatric or substance use treatment. This separates people from their support system, further perpetuates isolation, and creates challenges when reintegrating into the community. The lack of intensive support for reintegration further contributes to potential for relapse.

Similarly, the lack of transitional housing and foster care alternatives serve as significant barriers for survivors of domestic/sexual violence in need of safe accommodation.

Connection to re-entry supports, transition supports, and step-down care is inconsistent, and no specific programs are known for those with behavioral health issues. People are left to navigate this challenging time with whatever supports they had when they experienced the behavioral health issues that required treatment off-island.

Details include:

- Inpatient and residential treatment programs for substance use typically have reintegration planning capacity, but this must be matched on-island to create the necessary connections.
- The lack of intensive clinical treatment on the island means that individuals have no step-down treatment.
- Inadequate lifestyle supports such as supported housing or peer support means that informal supports are also often lacking.
- Individuals ready to discharge back to the island after off-island treatment for crisis needs often lack essentials like means of identification, transportation home, sufficient funds for the return trip, etc.
- Addiction and/or substance misuse can lead to involvement in the justice system, but sentencing does not address the root causes of addiction (e.g., isolation, health challenges, social determinants, prior trauma, etc.)

Sizing the Need:

- NCH reported arranging off-island transport for treatment for approximately 45 individuals from July 2020-June 2021; in addition to those individuals who left the island via other means (no known data on total volume).
    - While it is unclear whether all of those individuals returned to the island, this report assumes that number as a proxy for reintegration needs.
- Relapse rates are not available for Nantucket, but nationally average 40-60% in SUD situations[x], indicating a significant need.
- Over half (53%) of those participating in the community survey identified "help for people when they come back after going to the hospital or receiving treatment off Nantucket" as one of the top five priorities.
- During COVID, the demand for domestic violence and sexual violence services increased 30% and 20%, respectively, in A Safe Place's adult programs.

Note: For purposes of this assessment, GPS differentiates clinical supports from lifestyle support (R2: Range and supply of healthy lifestyle supports is inadequate).

Ideas to Close the Gap:

- Increase the availability of intensive, community based (and in-home) treatment that can both prevent the need for higher level care off the island and provide step-down care when someone returns to the island following inpatient or residential treatment.
- Establish peer support partnerships tailored to individual needs, including connection to groups, etc., prior to discharge and return to the island.
- Identify a point person/team to coordinate reintegration service planning.
- Invest in transitional housing for survivors of domestic/sexual violence and those returning from off-island treatment, as well as sober housing.
- Work with the justice system to prescribe community/peer engagement as part of sentencing for substance use/addiction-related crimes

[x] https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

R2: Range and Supply of Healthy Lifestyle Supports is Inadequate

Description of the Unmet Need:
For individuals in recovery from substance misuse and those with mental health conditions seeking healthy lifestyles, social supports are essential. These supports include safe, supportive housing; employment assistance stress management, life skills, recreation and social connections and peer and recovery support. Further, the culture of alcohol use on the Island is strong and very few options exist for socializing without alcohol.

A variety of open and closed groups are available in person on Nantucket on topics such as diagnosis specific mental health support groups, AA/ALANON and family and friends of people mental illness and a variety of other groups that meet virtually or in person on Cape Cod. However, the privacy concerns on a small island can inhibit participation. In addition, Fairwinds and NAMI offer peer support and Fairwinds offers certified peer recovery coach (PRC) initiatives. However, capacity is limited.

Details include:

- There is no recovery housing and no low intensity residential care for people struggling with substance use
- The island's AA/ALANON chapter is active but struggled to find meeting space during COVID.
- There is currently no organized cooperation with AA, though AA has the no-cost manpower to be of help to people who are in or coming from treatment.
- NAMI offers support groups for individuals and families affected by mental health and/or substance use and would like to expand their offerings.
- COVID-19 has expanded participation in virtual support resources but there is no central place for people to access information about what is available.

Sizing the Need:

- Approximately 9% of Americans report having resolved a substance use problem:
  - 45% of people report using support groups to resolve problem use
  - 35% of those who used support groups to enter and sustain recovery now classify themselves as in recovery
  - 30% used formal treatment to resolve problem use (Kelly et al, 2017)
- Recovery living environments can be important supports for helping people in early recovery avoid relapse (SAMHSA, 2021); there is no recovery living home on Nantucket.
- Individuals in outpatient treatment for substance use who participate in recovery housing have significantly fewer addiction symptoms, improved legal and employment outcomes than those in outpatient treatment alone. (Polcin et al, 2010)
- Participation in self-help groups is associated with better substance use outcomes for people in treatment and those who do not seek formal treatment. (Moos & Moos, 2006)
- There is accumulating evidence that peer support can facilitate transitions in care, continuity in the community and offer alternatives to hospitalization and emergency room use. (Mental Health America)
- Virtual peer support for people with mental health concerns shows promise. (Fortuna et al. 2020)

Ideas to Close the Gap:

- Develop and implement plan to expand access to recovery housing and supported housing for people in recovery from substance use and/or serious mental health disorders.
- Create a clearinghouse of in-person and virtual support groups.
- Expand availability of healthy social and recreational activities through a community center or other shared space.
- Expand the use of peer support and recovery coaching.
- Provide time-limited educational opportunities to maximize the connections between people with like interests and build natural and formal supports.
- Promote alternatives to alcohol-related activities in conjunction with prevention initiatives such as P1:Lack of pro-social places and activities; and recovery initiatives such as R1: Reintegration supports.

Appendix 3: Provider Summary

Provider Summary (1 of 7)

The community has tried focused efforts to address specific needs and crises, but Nantucket's ability to meet these needs is hampered by a fragmented system of care, with many organizations providing services within their boundaries and no single systematic method of coordination. Nantucket's provider density is the lowest in the Commonwealth, and significantly lower than neighboring counties, with ratios ranging from 1:250 to 1:370. In addition to approximately 17[x] private behavioral health providers on-island (and others offering telehealth services off-island), Nantucket is home to the following organizations:

- **Fairwinds** provides outpatient, medication management, urgent behavioral health care, and other community-based services for children and adults, regardless of ability to pay. Fairwinds employs (3) full-time clinicians, (7) part-time clinicians, and (3) community-based service providers. Three clinicians are bilingual.

- **Gosnold** is the regional contractor for the state's Emergency Services Program (crisis services), via a contract held by Bay Cove Human Services, and provides some outpatient therapy services on-island. Gosnold currently employs two (2) clinicians located on Nantucket and additional off-island resources are available.

- **Nantucket Cottage Hospital** provides primary care and inpatient health care. The hospital's social work group includes three (3) clinicians who manage behavioral health needs, care coordination, and navigation support for NCH patients.

- **Addiction Solutions** provides the island's only medication assisted treatment (MAT) services for opioids, alcohol, and other substances, with two (2) part-time clinicians on staff.

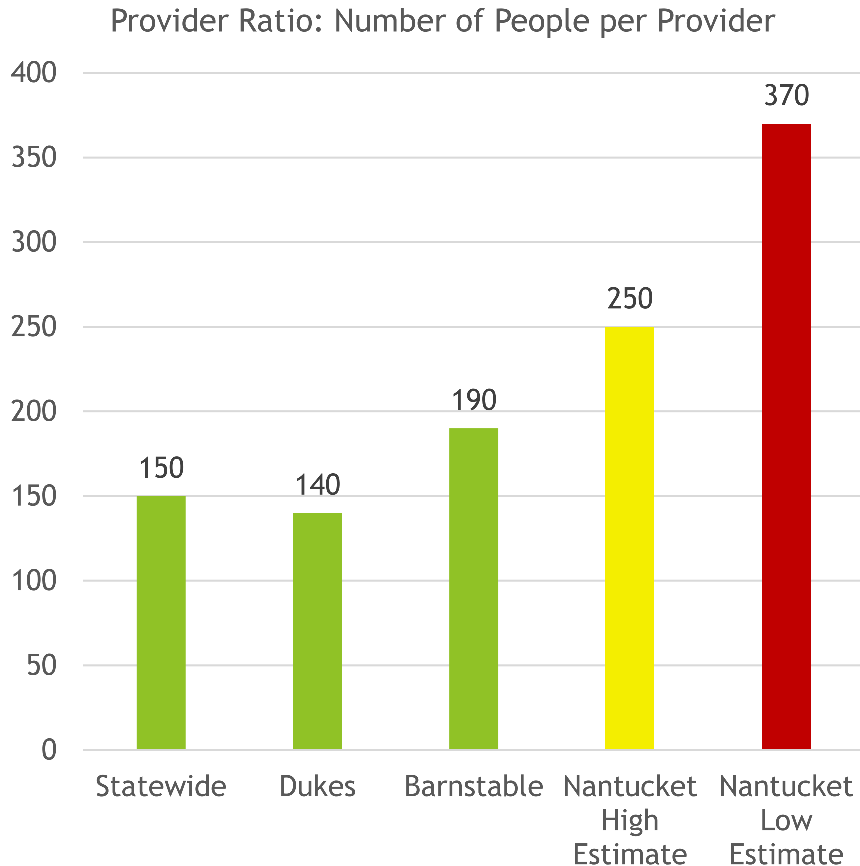
- **A Safe Place** provides advocates, rape crisis counselors, social workers, and other master's level mental health professionals to those dealing with domestic and sexual violence. The organization employs 3 part-time clinicians, including one who speaks Spanish, and refers clients to other treatment services their needs require.

- **NAMI Cape Cod and the Islands** provides support, education, and advocacy for individuals and their families impacted by mental illness, neurological disorders, and substance use (via the Alliance for Substance Abuse Prevention). NAMI employs two (2) individuals on the island, responsible for support and connection services, with additional off-island resources, including the William James Interface referral helpline. NAMI also provides direct reimbursement to private to see patients not able to access other services.

[X] NCH's provider list has 16, Fairwinds' list has 17, and NAMI's list from 2018 has 15

Provider Summary (2 of 7)

- Nantucket's provider capacity is believed to be insufficient to meet the demands by all participants encountered in this assessment. Provider density is indeed low compared to the statewide average and to neighboring counties, indicating a need to add perhaps an additional 20-25 providers to ensure comparable access to services.



- Using the national Provider Identification database count of 46 BH providers and the US Census population, Nantucket's provider ratio of 1:250 ranks the lowest within Massachusetts. When factoring in the number of providers currently known to be active on the island (in-person or via telehealth), together with revised population estimates, GPS estimates the ratio to be closer to 1:370. For comparison, the statewide ratio is 1:150, Barnstable County is 1:190, and Dukes County is 1:140 .
- The ratios presented are based on the year-round population estimate of 17,000. Other groups that may demand services are seasonal residents (~10,000), and visitors (~35,000-45,000 in the summer). The requirements of these groups is not completely understood, though Fairwinds, NCH, and first responders indicate that incidents related to substance use peak during the tourist season and that crisis volumes are higher during the non-tourist months of the year. Exact sizing requires further analysis.
- Provider density measurement is made challenging by three facts:
  - Licensed elsewhere: Providers' business locations in licensing systems are independent of where they actually provide treatment, and an active license is not necessarily indicative of an active provider.
  - Remote and tele-capacity: The ability to deliver services in a virtual environment makes true capacity challenging to determine. COVID has both exacerbated problems with reporting AND impacted the availability of providers.
  - Accuracy of reporting: Websites and referrals services indicate availability of providers who may no longer be accepting patients on the island. Some referral lists are outdated and inaccurate, while turnover and retention challenges mean that information becomes outdated quickly.

Provider Summary (3 of 7)

GPS released a provider survey that was forwarded by assessment leaders to all known providers on the island. 18 providers began the survey, representing 13 unique providers of behavioral health services. Out of respect for varying operations and privacy, few respondents answered all questions, so sample size varies throughout. Below is a graphic summarizing responses and the following pages contain select insights from the survey.

Service offerings:

- 9 respondents report offering treatment services to children and adolescents with MH concerns.
- 5 organizations offer services to adults with substance use concerns.
- 1 organization offers addiction treatment services; 1 organization offers medication management service.
- 2 organizations offer involuntary mental health treatment (Section 12) and 2 offer involuntary substance use treatment (Section 35).
- 7 respondents report offering couples or family services.
- 6 of 10 providers answering the question report providing service in other languages, Spanish (6), Portuguese (5), and French (1); 3 others offer services via interpreter.

Availability and payment methods:

- In terms of the next available appointment, the 13 organizations responding, reported:
  - Within one day: 7
  - Within two days: 1
  - Within a week: 4
  - Within a month: 1

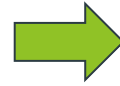
  Note this does not agree with data from the community survey. See the next page for a comparison of different experiences.
- 9 providers answered the question of how many people do you serve per month and the sum of their high-end estimates indicates that 186 people are served per month.
- Of the 11 respondents who answered whether or not they accepted Mass Health (Medicaid), 5 indicated that they did and 6 indicated they did not.
- Of the 12 respondents who answered whether or not they accepted commercial insurance, 6 indicated that they did and 6 indicated they did not.

Provider Summary (4 of 7)

Comparing the community's experience with availability with provider-reported data reveals very different experiences:

Provider view

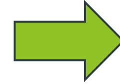
Nearly all of providers surveyed (12 of 13) report availability within 1 week…



Resident view

…while only 5% of respondents reported same day service.

When asked whether there were cases in the last 6 months where people had to wait more than 48 hours for services, 7 providers (58%) said "no"…



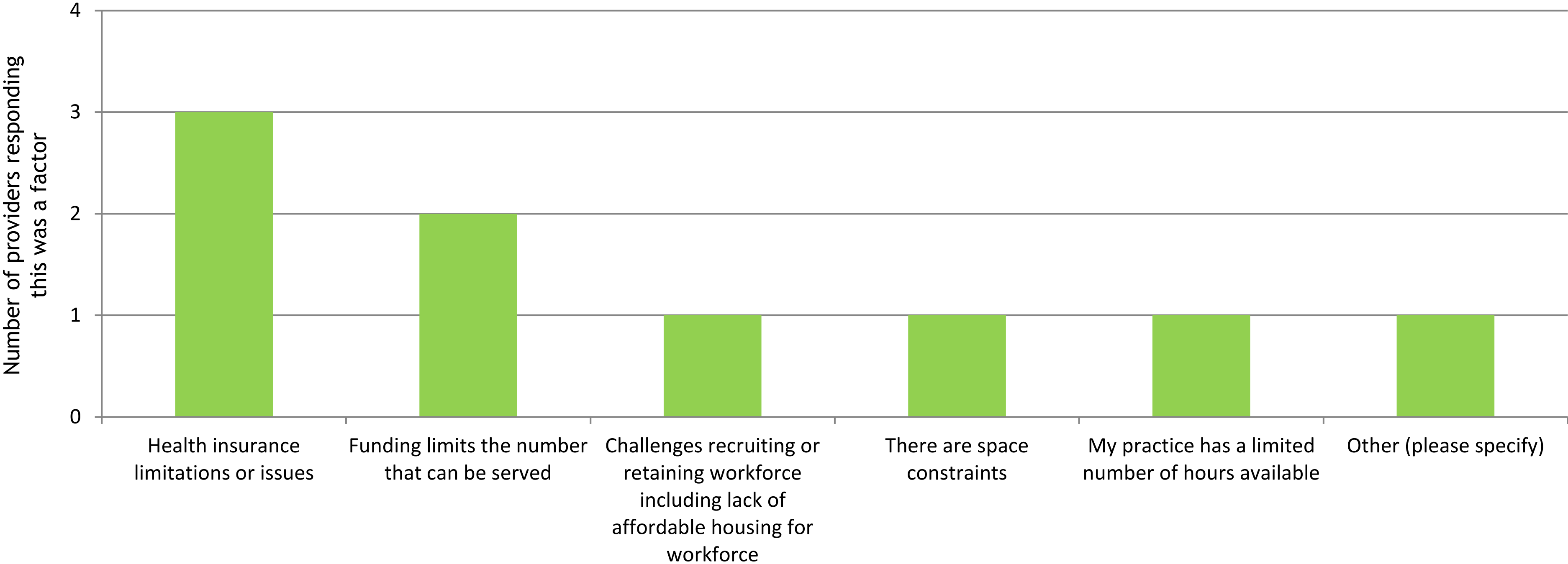
… while 37% of community survey respondents report waiting more than a month and 69% report experiencing wait lists "often" or "always".

Without an integrated data system, it is impossible to reconcile the differences between these realities. Complicating factors include:

- For those expecting to see a licensed clinician or to receive medication, an intake visit is not considered "treatment" or "services".
- Peer services have been proven to be effective but reinforcement by primary care physicians and other referrers is inconsistent
- Capacity is not static. A provider may have availability to accept new patients today but the addition of one or two individuals puts them at or over capacity.
- Not all providers are full-time, introducing variance between the count of providers and the number of appointments available.

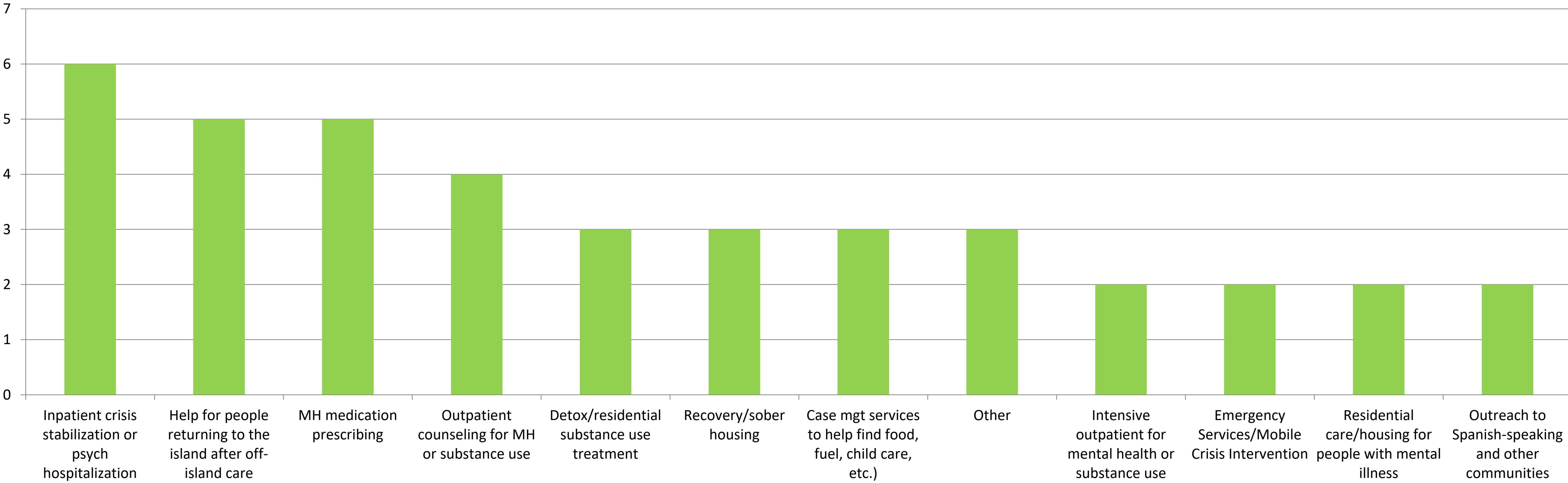
Provider Summary (6 of 7)

Respondents report varying reasons for wait times, citing insurance and funding as top reasons:



Provider Summary (7 of 7)

When asked to select the 5 most critical gaps to fill, providers rated inpatient crisis stabilization, support for individuals returning to the island after inpatient or residential care, medication prescribing, and outpatient and substance use services as top needs:



Appendix 4:
Community Survey Insights

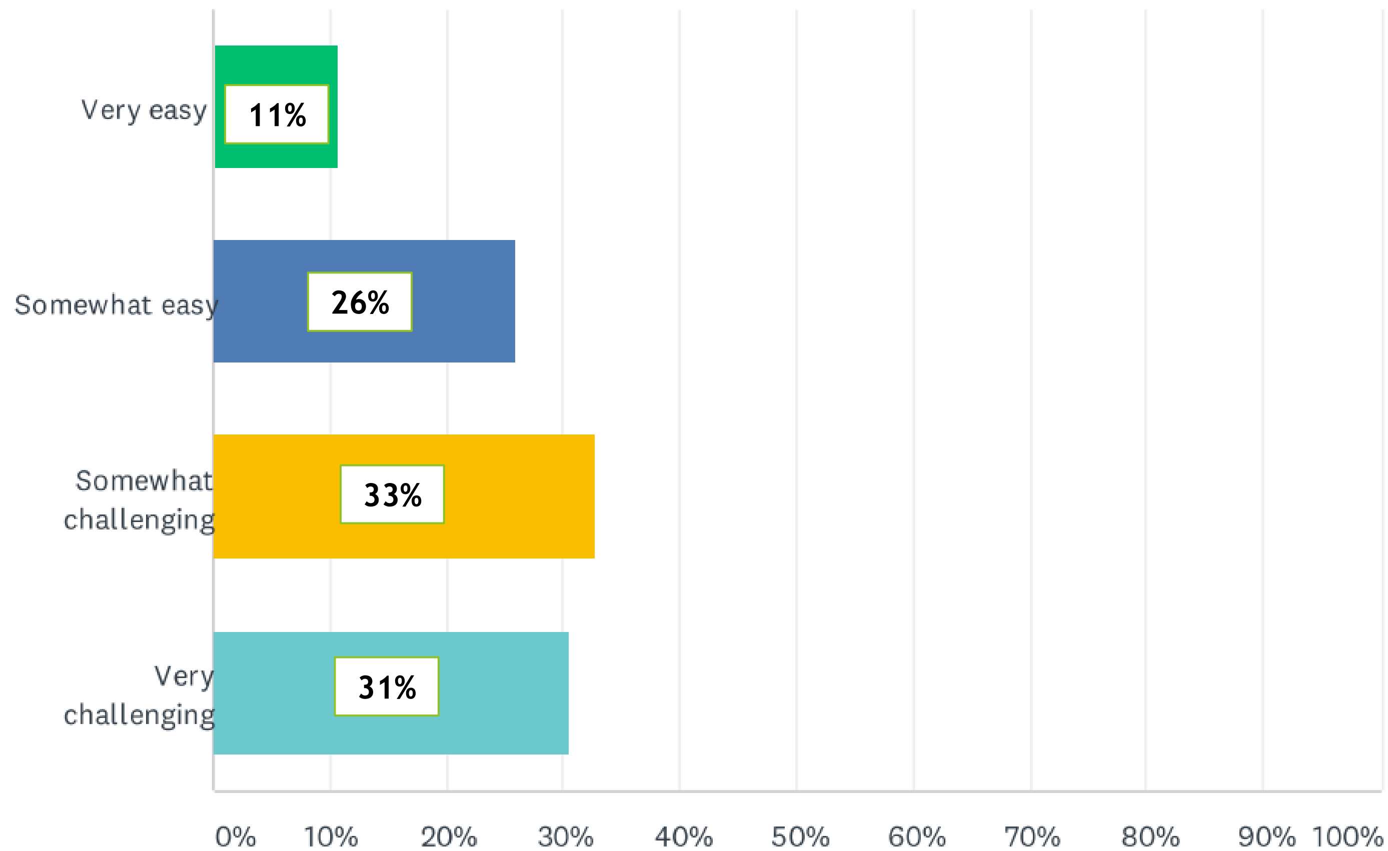
Community Survey Summary (1 of 6)

- GPS located no consistent source of community perception of services and so developed a 10-question community survey. The surveys were released electronically and on paper, and were available in English, Spanish, and Portuguese. Partners including the schools, the Human Services Board, Fairwinds, NCH, NAMI, and some private providers pushed the requests to participate to their networks and several organizations posted the opportunity to participate on their websites.
- GPS received 175 total responses in which more than 3 questions were answered (or that included ratings of the services). We consider these 175 surveys complete and included responses in the survey findings. Because of the variety of experiences and the sensitive nature of the questions, the survey did not require answers to all questions. Therefore, sample size varies on the following pages. We believe this is valid community experience and therefore have included it.
- Of the 175 total complete responses, only 3 were Spanish-language and 3 were Portuguese language responses. Because of these limited numbers, we aggregated those responses with the English language responses. GPS also recognizes that there are significant populations of Russian-speaking, Bulgarian-speaking, and French-speaking individuals, along with others whose experiences with the system and insights may not be represented.
- The following pages contain charts for several of the survey questions, as well as select insights and quotes from respondents. Responses that might identify the respondent were not included.
- Because of rounding, not all percentages add to 100.

Respondents: 170

Community Survey Summary (2 of 6)

Q4: How easy was it for you or the person you were helping to get the help they needed?



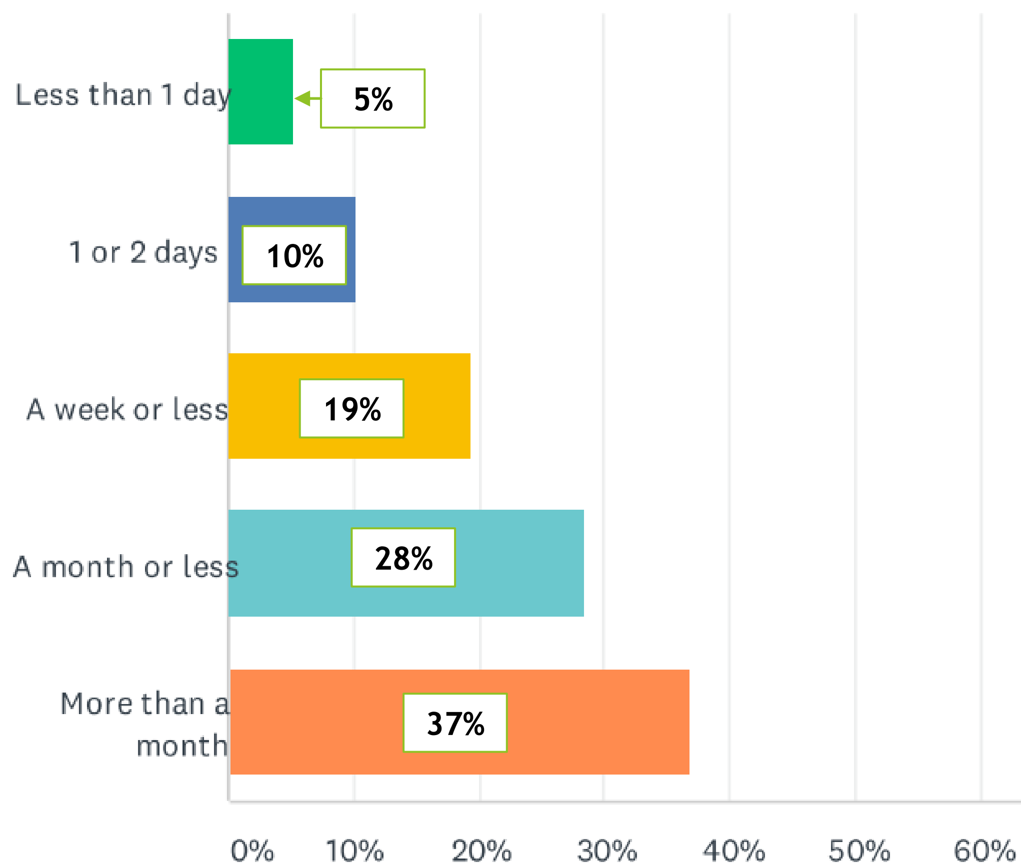
Insights:

- 64% of respondents believed it was somewhat challenging or challenging to get the help needed.
- 37% reported that it was either very easy or somewhat easy to get the help needed

Respondents: 155

Community Survey Summary (3 of 6)

Q5: How long did you or the person you were helping need to wait to receive services?



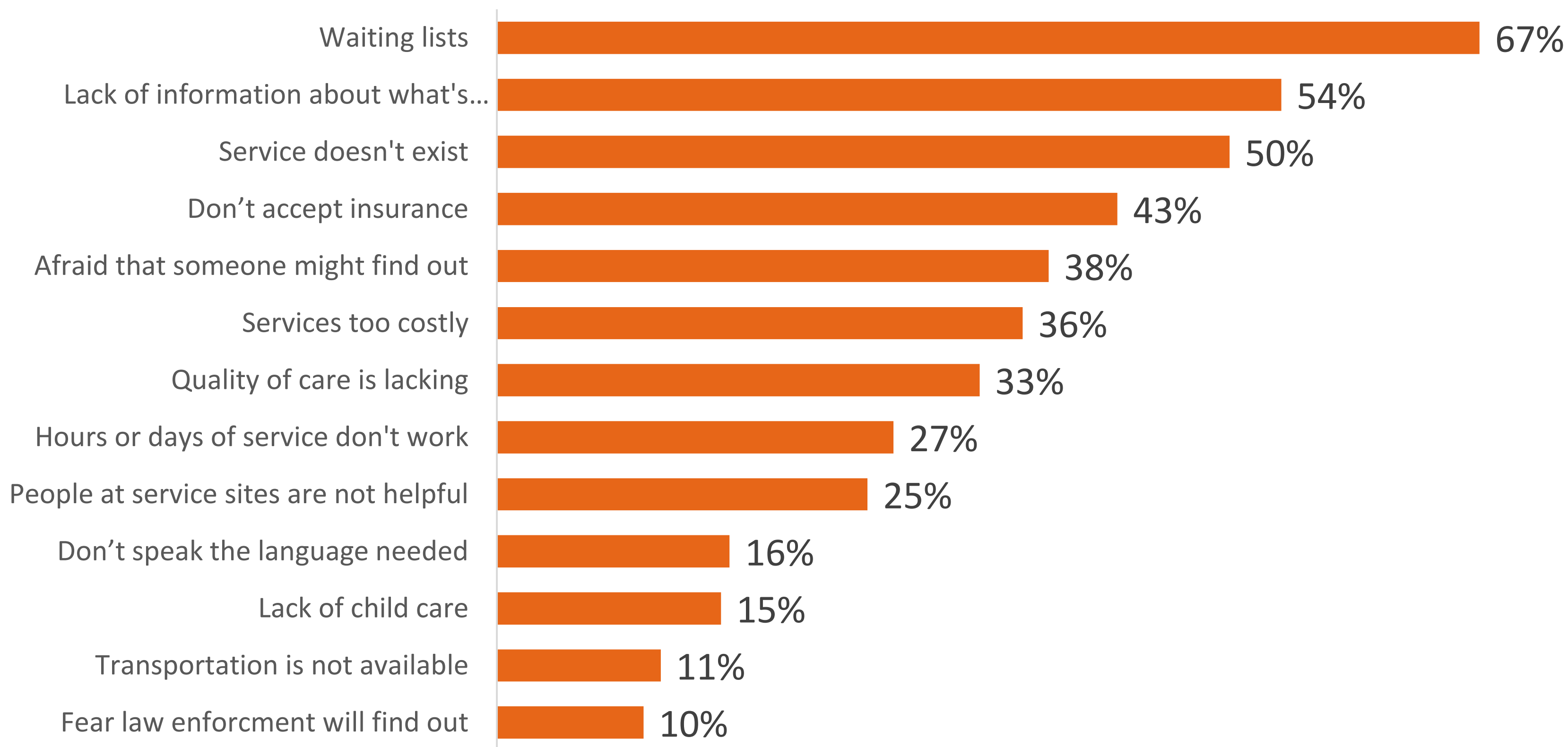
Insights:

- Only 5% of respondents reported same day service while 37% reported waiting more than a month
- Comments:
  - “Varies from a month to more”
  - “9 weeks”
  - “In crisis, no help on island”
  - “Depends on the provider/level…it took less than a week to receive counseling support from Fairwinds and NCH because I was in crisis”
  - “Still waiting”
  - “It was a matter of picking the right person”

Respondents: 169

Community Survey Summary (4 of 6)

Q6: How often have you or others you helped experienced the following challenges when accessing mental health or substance use services on Nantucket?



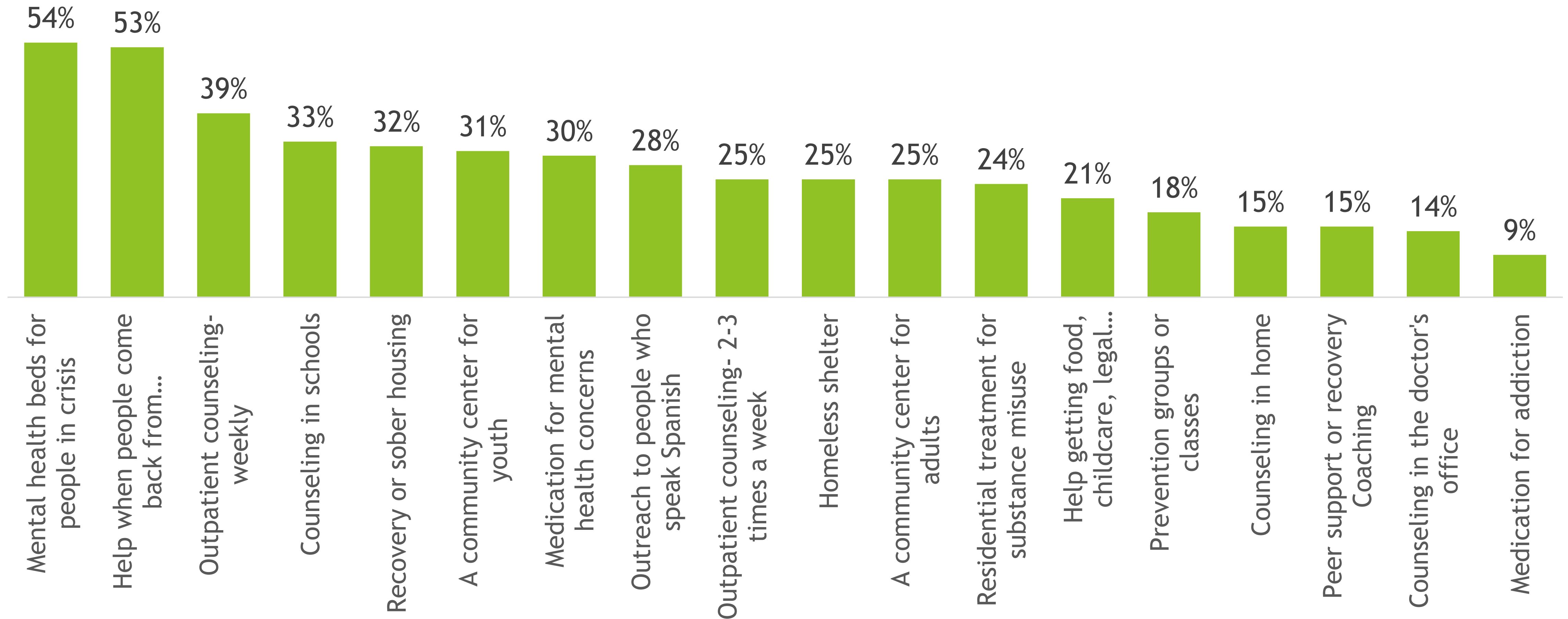
Insights:

- 67% of respondents experienced wait lists "often" or "always"
- "Lack of information about what is available" was cited by 54% of respondents
- Some of the lower-ranked items are significant given the small portion of the population to whom them may apply (e.g., don't speak the language, law enforcement concerns, etc.")

Respondents: 171

Community Survey Summary (5 of 6)

Q8: What services would you like to see available on Nantucket? Pick the top five.



Respondents: 98

Community Survey Summary (6 of 6)

Q7: When you or a person you were helping had a positive experience getting help, what worked well?

Select Quotes:

- “(Provider name) is great/amazing/extremely helpful”—4 different professionals mentioned by name
- “Services were available on weekends”
- “Personal referrals seem to be the best way for people to get into (a) therapist.”
- “Talking to someone who has gone through the same experiences. Like peer recovery.”
- “Consistency of message to the patient and the family. Counselor availability.”
- “Financial assistance through Fairwinds was a game changer for me – I was never able to afford mental health services anywhere else.”
- “Knowing that my privacy was respected and our conversations would be kept confidential.”
- “Feeling welcome and safe.”
- “The community cares for the community, so once you have a caring human being ‘on the line’ the help improves. That was a challenge with Covid, there was less of that.”

Appendix 5: Abbreviations

Abbreviations

- ADHD: Attention Deficit Hyperactivity Disorder
- ARPA: American Rescue Plan Act
- CCBHC: Certified Community Behavioral Health Center
- EHR: Electronic Health Record
- FQHC: Federally-Qualified Health Center
- GPS: Government Performance Solutions, Inc. (authors of this report)
- Inky: Nantucket Inquirer and Mirror
- MAT: Medication Assisted Treatment
- NAMI: National Alliance on Mental Illness
- NCH: Nantucket Cottage Hospital
- NFD: Nantucket Fire Department
- NPD: Nantucket Police Department
- NPSD: Nantucket Public School District
- PRC: Peer Recovery Coach
- SAMHSA: Substance Abuse and Mental Health Services Administration
- ROI: Release of Information

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