

New Hampshire's Substance Use Disorder Continuum of Care Assets and Gaps Assessment Results

August 2016

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Introduction:

The New Hampshire Department of Health and Human Services Bureau of Drug and Alcohol Services (BDAS) is committed to creating a robust, effective, and well-coordinated Continuum of Care (CoC) in all regions of the state for addressing substance use disorders (SUD) that includes health promotion (or environmental prevention), prevention, early identification and intervention, and treatment and recovery supports. At the regional level, CoC development will be incorporated into each Regional Public Health Network's (RPHN) mission to improve community health, and align with other related initiatives, as well as inform state plans for ongoing infrastructure development to address substance use issues. (See Appendix A for more information and a map of the RPHNs).

The following document utilizes the data from assessments conducted in each RPHN. The purpose of the assets and gaps assessment is to provide an overview of the array of substance misuse services available to individuals, families and communities within each region, as well as providing a look at what additional services are needed.

The information from the assets and gaps analysis will provide the basis for each region to develop a plan that

The Misuse of Alcohol and Other Drugs in New Hampshire: *A Snapshot*

- According to the 2014 National Survey on Drug Use and Health, New Hampshire has some of the highest rates of substance misuse by youth and young adults in the country, and ranks in the top nine in the country for youth binge drinking among youth and young adults.
- There were 439 drug overdose deaths in NH in 2015 (NH Information and Analysis Center, 2016)
- 25% of NH adults now identify "drug abuse" as the most pressing issue facing the state (2015 WMUR Granite State Poll conducted NH Survey Center)
- Substance misuse cost the NH economy over \$1.84 billion dollars in 2012 (PoIEcon Research. November 2014. The Corrosive Effects of Alcohol and Drug Misuse on NH's Workforce and Economy.)

(See Appendix B for more detailed information about the misuse of alcohol and other drugs in NH.)

proposes actions to maximize assets and address gaps in services. The information will also help inform state planning and funding opportunities related to CoC and service development.

NH's Continuum of Care Framework:

When the continuum of care interacts closely with the primary care and behavioral health systems in a community, there are many benefits to the individual and to the community-at-large.

Close interaction, characterized by regular, positive communication, bi-directional referrals, interagency agreements, and/or integrated data and billing systems, can lead to many positive outcomes, such as:

- More awareness and knowledge of SUDs across all service levels and staff
- Smoother transitions between levels of care
- Services that align closely with individual need
- More wrap-around care and supports
- Better patient outcomes

These outcomes bring the continuum full circle to a prevention- and recovery-ready community that can quickly and effectively prevent health problems, identify and respond quickly, deliver appropriate treatment as early as possible, and support all stages of recovery.

The core sectors within a community can further support a robust and effective continuum of care – by promoting health and delivering basic prevention services by helping people identify problems they may be having with alcohol or other drug use early, helping them find assessment and treatment services quickly and providing or connecting to recovery supports.



Continuum of Care Assets and Gaps

Assessment Methods:

In order to begin to better understand the current system of care for SUD in each region, assets and gaps among the continuum of care components were identified. Assessment reporting tools were provided by BDAS to the CoC Facilitators in each of the 13 regions. The reporting tools were designed to collect an inventory of assets and to identify gaps, barriers, communication & collaboration needs within each continuum of care component at the regional level. The CoC Facilitators carried out the regional assessment between July 1, 2015 and April 15, 2016 but primarily during late winter in 2016. Both quantitative and qualitative methods were used to determine the quantity, type, and range of services currently available to residents in each region. Quantitative data sources such as the substance misuse

prevention plans, NH Treatment Locator database, and the 211 database were used to create a list of existing services. While qualitative data were collected through semi-structured interviews and focus groups (See Appendix C for interview and focus group questions) with key stakeholders such as treatment and healthcare providers, law enforcement, recovery advocates and prevention professionals. In addition, relevant qualitative data describing the continuum of care components were gleaned from meeting minutes. Outcomes of discussions from a wide variety of regional and local meetings were also used as a data source in an effort to reduce the need for and burden of further interviews with meeting participants.

Although sample tools were provided by the BDAS (See Appendix C for the data collection tools provided to CoC Facilitators), the regions were advised to customize the assessment tools to meet the needs of their regions. Examples of how some of the tools were customized include the modification of interview and/or focus group questions and or survey tools. As mentioned above, each region submitted their assessment data to the BDAS using a common reporting tool.

To analyze the assets, a scan of each regions’ data was conducted to determine common themes. To analyze the “gaps” data, the data were first separated by category (e.g., Gaps, Barriers, Communication Needs, Collaboration Needs) and then the data were aggregated for all 13 regions by these categories. The NH Center for Excellence held a group coding session with three CoC Facilitators to begin the coding process. The coding categories were created based on group consensus. After the group session, the Center staff continued coding, recoding and cleaning the data using three top-level categories; namely: Primary Code, Secondary Code and Tertiary Code. See Table 1 for an example.

Table 1: Coding Example

Primary Code	Secondary Code	Tertiary Code	Description
Workforce	Licensure	CRSW	There is a lack of Certified Recovery Support Workers who are available and able to assist those looking for help with recovery.

In total, 313 gaps, 196 barriers, 41 communication needs and 29 collaboration needs were identified and used in the analysis.

Assessment limitations and possible confounding factors

During the data collection process, a novel approach was necessitated based on the lack of established validated tools for collecting the data. The methods used for this assessment process meet both face validity and construct validity measures. While a variety of data collection methods were employed, all have been tested for reliability and validity when used to collect qualitative research data. Due to limitations in variables collected, there was no way to accurately weigh the scores for any given gap or barrier. An individual gap may have been identified by a small population or a large population within any given region, though this limitation is tempered by the frequency of reporting across all regions which provides a much larger sample size. The categorization of gaps and barriers did vary by region, which posed another quantification limitation at higher levels of interpretation. However, that limitation only extends to higher level analysis and can be accounted for in future assessments.

Results: Assets

The assets outlined below represent a summary of the inventories of assets submitted by the 13 CoC Facilitators. (See Appendix D for a summary of assets in each region).

HEALTH PROMOTION AND PREVENTION ASSETS

Health promotion and prevention assets were defined in a number of ways during this assessment. The data show that CoC facilitators leverage assets available at the national, regional, state, and community levels. Prevention efforts noted in the assessment included the Partnership for Drug-Free NH (3), community-based organizations and school-based initiatives, such as Life of an Athlete (6), Student Assistance Program counselors (3), safe schools program (1), youth councils (2) and Project Promise (1). Local fire departments (3) and police departments (7) were identified as prevention assets through their efforts for educating community members, as well as providing resources to prevent substance misuse, through events such as Prescription Drug Takeback Days, permanent prescription drug dropboxes, and other community efforts.

Activities encouraging community involvement were also highlighted as prevention assets for the regions. Of note, parks & recreation departments (2) and community centers (2) were identified for providing opportunities for youth, young adults, and adults to engage in pro-social activities.

EARLY IDENTIFICATION AND INTERVENTION ASSETS

Several intervention assets were reported as being available statewide by the regions. These assets included the “Anyone, Anytime” campaign (3), the Division of Children Youth & Families (2), the NH Prescription Drug Monitoring program (2), and the NH Treatment Locator (3).

There was some overlap between prevention and intervention assets identified through this data collection. For example, fire departments (3) and police departments (7) were identified as intervention assets due to their efforts in educating community members. Police and fire departments also provide resources to prevent substance misuse through events such as Prescription Drug Takeback Days and permanent prescription drug drop boxes provide means to intervene if there is suspected misuse of drugs. The distribution of naloxone (4) by police and fire officials was also reported as a notable means for intervention.

Other intervention programs reported at the regional level were juvenile court diversion (5), drug courts (6), and school programs, such as Student Assistance Programs (1) that allow for intervention in youth and young adult substance misuse directly in the school.

Intervention by trained behavioral health specialists and other medical professionals was also reported. The implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) was reported across seven regions as a means of intervention. Other organizations, such as New Horizons (2) and Harbor Homes Veterans FIRST (1) were reported as intervention assets. Over 50 individual providers were reported as assets providing local intervention services in the regions.

TREATMENT ASSETS

Statewide treatment assets were also reported by the regions. The NH Treatment Locator (3) and the “AnyoneAnytimeNH™” campaign (3) were both considered treatment assets, in addition to intervention assets. Treatment facilities, such as Phoenix House, Keystone Hall, Horizons, Southeastern NH Services, and PainCare were also reported as being available statewide.

At the regional and local levels, hospitals, community health centers, and individual treatment centers were the majority of assets listed. Other treatment assets included prisons (1), community support networks (2), and youth focused organizations that create and support treatment plans in schools (5). Table 2 provides a raw count of the number of treatment facilities and individual providers as reported by each region.

Table 2: Reported Number of Treatment Facilities & Individual Providers

Region	Treatment Facility	Individual Providers	Total
Capitol	26	0	26
Carroll	11	3	14
Central	13	1	14
Manchester	13	0	13
Monadnock	12	12	24

Nashua	21	0	21
North Country	10	0	10
Seacoast	13	0	13
South Central	13	5	18
Strafford	7	1	8
Sullivan	12	0	12
Upper Valley	15	21	36
Winnipesaukee	9	23	32
Total	175	66	241

RECOVERY SUPPORTS ASSETS

Several recovery assets were reported as available statewide, including Alcoholics Anonymous & Narcotics Anonymous meetings (3), and other support groups were available across the state, yet coordinated at the regional level. Fedcap (1) and New Futures (3) were also reported as a recovery asset for trainings provided, with New Futures specifically providing Recovery Coach Training (CCAR) throughout the state. HOPE for NH Recovery (3) was reported as both a recovery and recovery support asset by the regions, for the resources and support they provide to those in recovery and their families.

Two regions reported recovery assets specific to New Hampshire’s Veteran population - Veteran Homestead Inc. and Veteran Victory Farm. Veteran Homestead Inc. is a non-profit organization that provides housing and care to U.S. Armed Services Veterans from across the nation who are elderly, disabled or diagnosed with a terminal illness. Veteran Victory Farm is an eighty-acre working farm that provides a home for veterans with substance abuse issues and mild TBI, where residents tend the farm's organic vegetable garden and care for a variety of farm animals ranging from horses to cows to pigs to chickens during recovery.

Many of the recovery assets reported are attendant to treatment provided throughout the regions. Hospitals, community health centers, and other treatment providers throughout the regions were considered to be recovery assets in addition to treatment assets.

ANCILLARY RECOVERY SUPPORT ASSETS

Ancillary recovery services reported as being available at the state level were the Medicaid Transportation Line and ServiceLink, both of which provide information on access to long term services and supports as well as access to family caregiver information and supports.

Other ancillary recovery services assets reported at the regional level provided case management, child care support, transportation, food pantries, job training & placement, short and long-term housing support, and peer-to-peer support, among other services.

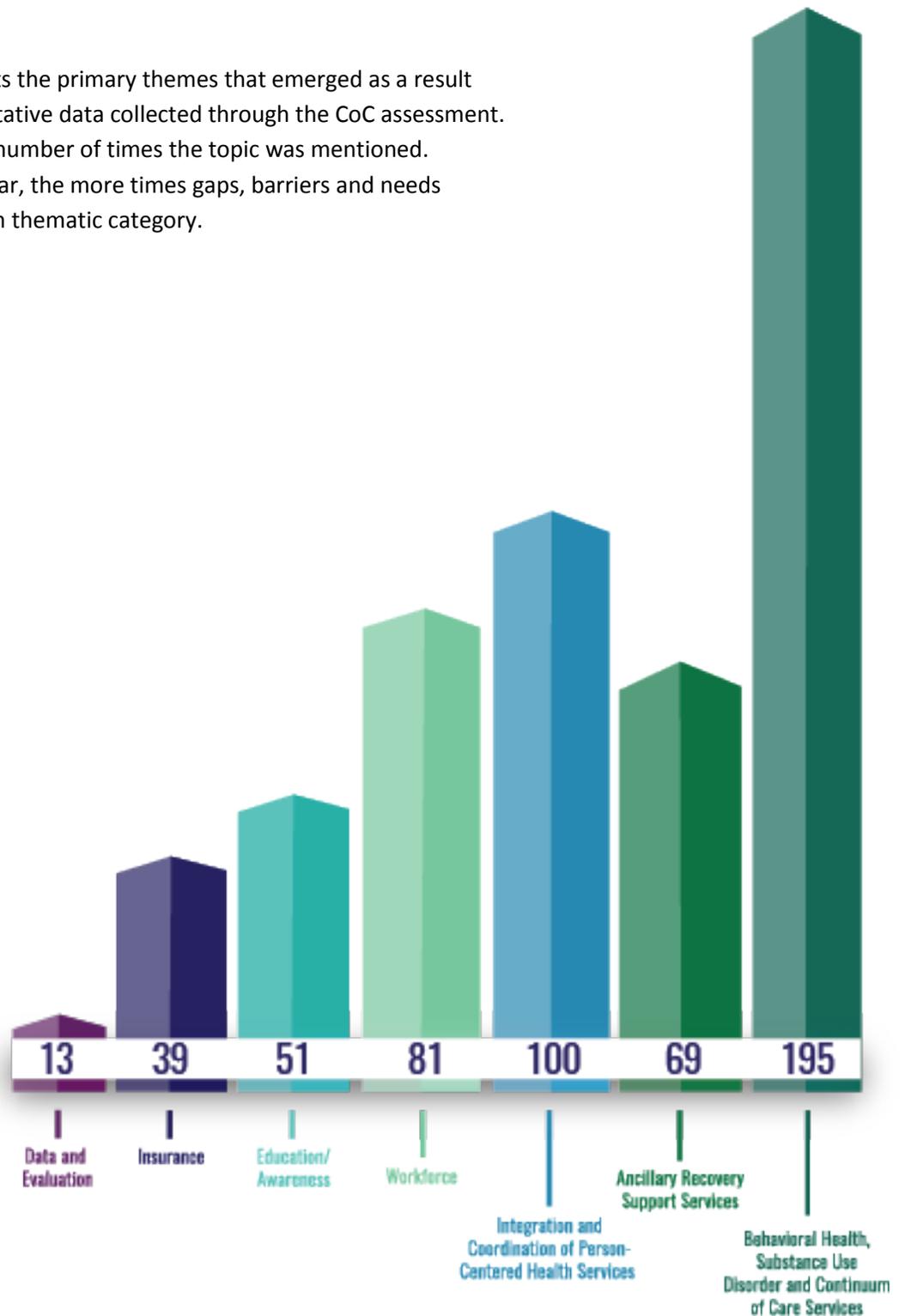
Table 3: Reported Number of Available Recovery Support Services

Recovery Support Service	# of Mentions Across Regions
Case management	4
Child care support	1
Transportation	2
Food pantries	8
Job training & placement	3
Short & long term housing support	11
Peer-to-peer support	13

See Appendix D for regional-level asset summaries.

Results: Gaps

The visual below represents the primary themes that emerged as a result of the analysis of the qualitative data collected through the CoC assessment. The number indicates the number of times the topic was mentioned. Therefore, the larger the bar, the more times gaps, barriers and needs were identified within each thematic category.



Theme 1: Behavioral Health, Substance Use Disorder and Continuum of Care Services

This category includes the utilization, accessibility and availability of prevention, early intervention, treatment and recovery support services.

HEALTH PROMOTION AND PREVENTION

Identified Gaps

The assessments highlighted the need for prevention to be **comprehensive, integrated and connected at all grade levels and across the lifespan**. Key identified gaps include: **curriculum** that is evidence-based and consistent; prevention for **parents** that focus on parental monitoring and communication; **environmental prevention** initiatives; **mentoring programs**; prevention initiatives that promote **resiliency**; and prevention initiatives that focus on increasing **perception of risk/harm**. There is a need to focus prevention efforts on **young children, parents of children and youth and young adults**. The assessment emphasized a need to increase prevention efforts in both **schools** and **community settings**.

“The K-12 evidence-based substance misuse prevention curricula is not consistent.” - North Country Region

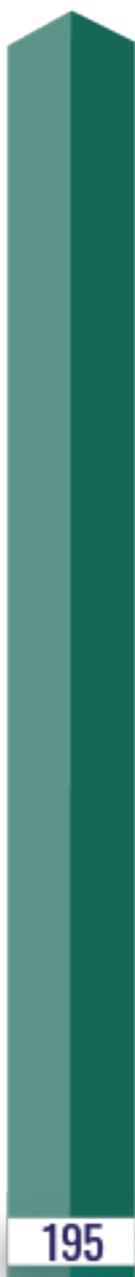
“There are a lack of prevention initiatives that focus on the young adult population.” - Central Region and Capital Area

EARLY IDENTIFICATION AND INTERVENTION

Identified Gaps

Policies and protocols are needed in schools to address **early behavioral problems, risk factors AND use**. Policies and protocols should include a system for parental communication. **Parents** need tools to help them recognize the signs of use in children/youth and know how to respond.

“School systems need policy and protocol to deal with at-risk youth and/or youth suspected of using. Schools need to make sure protocols are followed reliable and consistently.” - Winnepesaukee Region



Behavioral Health,
Substance Use
Disorder and Continuum
of Care Services

TREATMENT

Identified Gaps

There is an urgent need for a crisis response system for individuals who have overdosed so that they have the opportunity to access treatment within 24 hours. **Withdrawal Management** and the need for **assessment centers** that use a standardized tool were also identified as priorities.

“There is a lack of immediate crisis response and resources.” – Greater Monadnock Region.

“Access to detox is needed - even when it’s not medically necessary. You can’t detox on the street.” - Greater Manchester Region

Intensive Outpatient Treatment, Medication Assisted Treatment (MAT) and Residential Treatment were identified as gaps across the state. The greatest barriers to MAT are the **low number of MAT prescribers and prescriber limits**. A need for **residential treatment for youth/adolescents** was noted as a priority for many regions.

“No treatment for adolescents within 50 miles of Strafford County. Majority of families send their child out of state.” - Strafford County

Targeted treatment is needed for **adolescents, veterans, rural communities, individuals with co-occurring mental health disorders, individuals who are incarcerated, perinatal women, young adults** and the **homeless** population. Regional assessments also noted the need for improved care coordination, resources for treatment and an overarching need for more treatment options.

“There is a lack of coordination of services. Individuals need a “warm hand-off” to ensure there is follow-up and that they are not falling through the cracks.” - Winnepesaukee Region

“There is a gap in the array of services available in the region.” - Capital Area

RECOVERY SUPPORTS

Identified Gaps

Recovery centers and support groups were identified as the two main types of recovery support services needed. There is a need for increased diversity, number and accessibility of recovery support groups including **12-step** based groups, **SMART Recovery** and groups held in rural locations such as the North Country. Organized and **coordinated systems and protocols** are needed to connect recovery services with institutions such as Police Departments and the Department of Children Youth and Families.

“The PD would like to have a system to make referrals to ‘certified’ recovery coaches.” - Capital Area

Several populations were identified as needing focused recovery support services for populations including **youth, young adults, socio-economically vulnerable populations, previously incarcerated, women and victims of trauma.**

FAMILY SUPPORT SERVICES

Identified Gaps

There are not enough **family support services** including support for **families seeking treatment for a loved one, for parents trying to find treatment for their children, for family members of an individual with SUD, for children and adolescents who have a parent with SUD and for families especially when the mother is being treated for SUD.**

“Recovery for families: When a family member suffers from addiction, the whole family suffers. Need treatment and recovery as well. Need additional support for families after a loss of a loved one.” – Greater Manchester Region

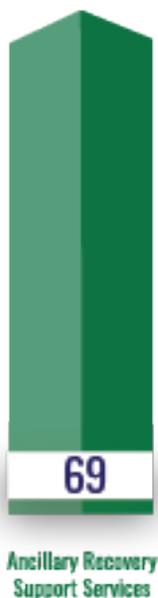
“Parents and family members don't know how to get treatment help and may end up resorting to expensive in-patient rehab without understanding necessity of assessment and other treatment options.” – Winnepesaukee Region

Discussion

RPHNs noted the NH Treatment Locator as an advantage to accessing the state’s existing treatment services. The number and types of services available vary statewide. Gaps identified in treatment services are primarily those that focus on assessment and withdrawal management, the lack of diverse treatment options in the state and treatment that focuses on high-need and specialized populations. On January 5, 2016, the Centers for Medicare & Medicaid Services, within the United States Department of Health and Human Services, approved for New Hampshire a Section 1115(a) Medicaid waiver, known as a Delivery System Reform Incentive Program (DSRIP) or “Building Capacity for Transformation” Waiver. This waiver will allow the State to invest \$150 million over five years to transform the State’s behavioral health delivery system in order to improve care and slow long-term growth in health care costs. This financial incentive program will promote the innovative, sustainable, and systemic changes New Hampshire needs to help providers deliver better care for years to come. Some current efforts that address some of the service array gaps include the New Hampshire DSRIP Waiver Program in which community project options include Medication Assisted Treatment, the expansion of intensive SUD treatment options, including partial-hospital and residential care, SUD treatment and recovery programs for adolescents and young adults and integrated treatment for co-occurring disorders. Additional information can be found at: <http://www.dhhs.nh.gov/section-1115-waiver/index.htm> supports. In addition, Federal MAT prescriber rules have been modified to allow more patients access to MAT and Regional Access Points are being developed in 11 of the 13 RPHNs that do not already have an existing RAP. RAPs will provide a resource to facilitate access to SUD treatment and recovery support services including American Society for Addiction Medicine (ASAM) level of care determination. A 24/7

Statewide Addiction Crisis Line was launched in May of 2016 and is staffed with trained professional counselors who can assist with identifying appropriate services.

The state of NH is fortunate to have many organizations focused on providing recovery services. However, the gap analysis identified the need for additional recovery centers throughout the state. Two regions identified recovery assets specific to New Hampshire's Veteran population nevertheless, many other special populations were identified as needed targeted recovery support services. Coordination of new and existing services was identified as a need and in part is being addressed through the BDAS' funding and support of Harbor Homes as a facilitating organization (FO) to support Recovery Community Organizations (RCOs). As part of this contract, Harbor Homes has developed an open Community of Practice for Peer Recovery Support Services (PRSS) to establish and strengthen collegiality, cooperation and collaboration to create a unified system of peer recovery support service providers in New Hampshire. SB533 appropriates an additional \$500,000 to create, initiate, expand or support the operational costs of PRSSs'. Finally, New Hampshire's DSRIP Waiver Program community projects menu includes the option for communities to utilize DSRIP funds to expand peer support access, capacity and utilization. As mentioned above in regards to prevention, parent and family supports remain a much needed service in NH.



Theme 2: Ancillary Recovery Support Services

This category includes services that promote and support a functioning and accessible continuum of care.

TRANSPORTATION AND CHILDCARE

Identified Gaps

Across the state, in almost every region, transportation was identified as a service gap. From Manchester to the North Country, **limited public transportation** options was cited as a barrier for individuals needing to attend **appointments, meetings and other services on a regular and consistent basis**. Several regions also cited **rural isolation** and the high **costs** of owning and maintaining a personal vehicle as a challenge. Transportation and childcare needs were often mentioned hand in hand in the assessment. Several regions noted that lack of **childcare** is a barrier to accessing both treatment and recovery. The **fear of potential loss of their children** is also a barrier to accessing services for mothers.

HOUSING

Identified Gaps

Housing needs were identified on many levels and across the entire state. The assessments identified a need for **emergency housing** and/or safe and **supportive housing** where individuals can stay while waiting to receive treatment services. It is critical that this type of housing be **staffed with professionals trained in mental health, SUD and co-occurring disorders**. In addition, the assessments highlighted the need for **transitional housing**, especially housing for **women, youth and families** and **sober housing** that supports recovery. **Affordable and accessible permanent** housing options are limited for everyone. **Previously incarcerated** individuals and **registered sex offenders** are faced with barriers to finding permanent housing.

“Women are often stuck in unhealthy relationships with family and partners due to housing affordability, job stability, transportation, and financial needs. Safe housing for those in transition that can accommodate children and also provide basic supports is required.” – Upper Valley Region

OTHER

Identified Gaps

Along with the supports mentioned above, regional assessments gave mention to several gaps/barriers that are along the periphery of the SUD continuum of care. Assessments noted a general **lack of community** and “neighbors caring for neighbors” (Central Region). One also mentioned a need for **Teen Centers** (North Country Region) and another emphasized the need for more **cross-regional collaboration** (South Central Region). **Parenting support** for everyone but specifically for **grandparents raising grandchildren** and **single parents** was noted. **Respite care** (Greater Monadnock Region) and the ability to accommodate **language barriers** (Greater Manchester Region) were also noted in this category.

“There is little support for vulnerable individuals in the age range of 17-25 regarding homelessness, education, vocational opportunities, SUD/MH services, transportation, employment.” – Central Region

Discussion

In addition to services that focus directly on supporting recovery, other community assets and gaps were assessed that are considered ancillary recovery supports. Of the ancillary services noted in the assessment, the availability of peer-to-peer services, housing support and food pantries were noted most frequently. Senate Bill 533 appropriated \$2,000,000 to the NH housing finance authority for the purpose of funding affordable supportive housing projects for person with SUD. Consistent with the gaps analysis, transportation and childcare services were found to be the category of ancillary recovery

supports that are least available throughout the state. Again, parenting support services was identified as a need within this category.

Theme 3: Integration and Coordination of Person-Centered Health Services

This category includes the integration of all behavioral healthcare services with primary care and focuses on the elements necessary to deliver a care model that is driven by individual needs.

INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTHCARE

Identified Gaps

The assessment demonstrated a substantial need across the state for the integration of medical and behavioral healthcare on multiple levels including **bi-directional referrals, increased types of services** offered and overall **care coordination**. The assessments highlighted the need for **coordinated referrals** across healthcare and behavioral health providers and community supports; **SUD assessment/evaluation services in medical facilities**; and **access to SUD treatment services in mental health centers**.

“Need a wrap around approach to assess and treat patients/clients.” - Greater Monadnock

“Improved system of communication for all agencies through continuum to communicate with each other to support anyone, anywhere on the continuum.” - Central Region

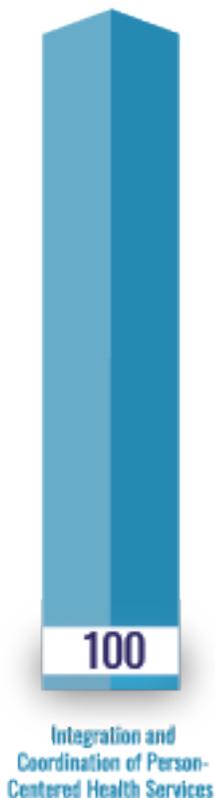
“No central/consistent point of contact for coordination of care in region (like coordinated access for homeless services).” - Seacoast Region

“We need to create a culture of engagement” where primary care providers are willing to engage in integrated SUD services.” - Capital Area Region

COORDINATION OF RECOVERY SUPPORTS

Identified Gaps

There is a need for **formalized systems** to mobilize peer recovery support services including **CRSWs and trained recovery coaches**.



“Lack of integration/coordination of recovery supports with law enforcement/medical & behavioral health community means no one is sure how to access recovery supports, when and from whom.” - Seacoast Region

“When individuals present to the ED [due to an overdose] there is an opportunity to connect them with services.” - Upper Valley Region

“Desire for greater communication between healthcare providers and peer support organizations.” - South Central Region

PRIMARY/MEDICAL HEALTHCARE PROVIDER KNOWLEDGE OF SUD RESOURCES

Identified Gaps

Many regions identified the need for primary care and other medical healthcare providers to have increased **knowledge of Substance Use Disorders** (what they are, how to screen, etc.) and increased knowledge of the **community resources** available for treatment and recovery support services. Primary care and other medical healthcare providers need to know when and how to make appropriate **referrals** and be willing to expand their scope of practice to be equipped with skills and processes for treating substance use disorders, such as a willingness to provide Medication Assisted Treatment.

Screening, Brief Intervention and Referral to Treatment (SBIRT) was identified in many regions as a need in primary care settings (beyond annual wellness visits) and hospitals. **Emergency services, schools and screening for the elderly population were also highlighted.**

“Not all providers are using SBIRT. Estimated that 46,000 patients in our region are not being screened.” - Winnepesaukee Region

Several **barriers to integrated care** were identified across the state. One major barrier to integrated care is **confidentiality laws and competing/conflicting agency-level policies and protocols**. Other barriers noted in several regions include providers’ lack of understanding of the **roles** other types of providers can play in integrated patient care, lack of **provider’s awareness of services** and the lack of a **“common language” amongst providers** (medical and behavioral healthcare).

“One of the things that hasn’t been talked about is the issue of confidentiality, because sometimes that is really wonderful for the client, because they feel safe, and in other ways it creates interference.” - Upper Valley Region

“Privacy laws are preventing the sharing of critical information; parents, healthcare providers and law enforcement need to be on the same page.” - Central Region

“Workflow can be challenging in settings where SUD treatment and primary care are integrated.” - Capital Area

Strategies identified by the regions to improve integration of care include **individualized wrap-around service planning, case management in healthcare settings, appropriate discharge planning, cross-**

training for medical and behavioral healthcare providers, drop-in resource centers for referral to services, coordinated funding streams, the utilization of **case managers/coaches as the connectors** who can help a person in treatment or recovery navigate services and **technology-based solutions**, such as telehealth or video-conferencing.

Discussion

Bi-directional referrals, coordination of recovery support services within the healthcare system and an increased knowledge of SUD amongst healthcare providers were the three main categories of behavioral health and primary care integration needs identified in this assessment. Again the goal of NH's DSRIP waiver is to provide better support for people on Medicaid by building capacity, integrating care, and smoothing transitions in care. This process will build capacity to deliver care for substance use disorders.

Theme 4: Workforce

This category includes types of trainings, populations in need of training as well as issues related to licensure and turnover.

Identified Gaps

The majority of workforce needs identified in the assessments focused on the need for **treatment clinicians**; with the most critical issue being the current shortage of **MLADCs, LADCs** statewide as well as clinicians who are trained in co-occurring disorders (Greater Manchester, Seacoast). The **licensure process** was identified as **the primary barrier to increasing the LADC/MLADC shortage, citing "complex, unclear and cumbersome" licensing procedures.**

"Limited provider expertise in the region to assess and treat co-occurring disorders." - Seacoast Region

"LADC/MLADC licensing is a complicated process that requires unpaid supervision, which deters students from pursuing the field or moves them out of state in search of pay." - Greater Monadnock region

The assessments also identified workforce gaps among **businesses, enforcement, and recovery and prevention professionals**. Employers need to know their role across the CoC, Employee Assistance Programs can offer counseling services and/or be a referral source, Law Enforcement needs a connection to treatment/recovery and many departments are interested in replicating the one or more models such as the Laconia Prevention Enforcement and Treatment Officer program, Gloucester's Police Assisted Addiction and Recovery Initiative, Manchester's Safe Stations program and the Seacoast's Community Access to Recovery initiative. The need for more Drug Recognition Experts was identified in at least one region. The Capital Area, Seacoast and Central regions each identified the need for an



Workforce

increased number of trained recovery coaches and Certified Recovery Support Workers. The Seacoast region identified the need for coalition building skills at the community level and the need for Student Assistance Counselors was identified in several regions.

Many regional assessments suggested various types of training needed for specific populations. See Table 4 for a summary of identified trainings.

Table 4: Identified Training/Workforce Education Needs

Type of Training	Suggested Targeted Population
Adverse Childhood Experiences	Individuals working with young children and families
Screening and Early Intervention Techniques (For example: Addressing Truancy)	Teachers, staff, parents, employers
Safe Language Trainings	Recovery Community
Compassion Fatigue Trainings	First Responders (anyone administering Narcan/naloxone frequently)
Co-occurring Disorders	Clinicians (LADAC, MLADAC, LICSW), CRSWs, Recovery Coaches
Managing pain for patients in recovery	Prescribers
Adolescent Substance Misuse Treatment Interventions	Counselors in private practice, social service agencies
Trauma Informed Practice (Identification, Intervention and Treatment)	Social Service and Treatment Providers, First Responders, Educators

The assessment results also emphasized **training needed for healthcare providers**. The need for training related to **safe and responsible prescribing practices** was consistently highlighted across multiple regions (5). In addition, **Addiction and SUD pathology** training was prioritized in multiple regions (3). Other training needs identified for healthcare providers included training on the recognition of **signs and symptoms for early intervention/prevention and Screening, Brief Intervention and Referral to Treatment (SBIRT)** training.

“More cross-training is needed for staff treating someone with SUD in settings where SUD treatment and primary care are integrated.” - Capital Area region

Discussion

The most pressing workforce need identified in the CoC assessment was the need for increased treatment clinicians; specifically LADCs and MLADCs. In this assessment, complex licensing procedures was cited most often as the reason there is a shortage of these types of professionals in NH. In recognition of this, one effort to increase the capacity of existing behavioral health professionals to treat SUD and Mental Health Disorders has been to recommend core competencies for Masters-Level licensed behavioral health counselors. In addition to the shortage of LADCs, the small number of Certified Recovery Support Workers was identified as a significant gap. Training needs (See Table 4) were identified for a variety of sectors including, most significantly, the need for increased knowledge of SUD amongst healthcare providers. The Healthcare Workforce Task Force established by Governor Hassan's executive order in the summer of 2015 was created to engage healthcare personnel and health systems in New Hampshire in preventing substance-related harm and in effectively addressing substance misuse and the DSRIP waiver will provide leadership and resources for this process. Specific goals of this task force include healthcare providers and clinical staff recognizing substance and addiction-related issues as important health issues and understanding the relevance to their patients and their practice.



Education/
Awareness

Theme 5: Education/Awareness

This category includes messaging as well as potential target audiences for messaging related to behavioral health including substance misuse and substance use disorder.

Identified Gaps

The **stigma** associated with SUDs was the most frequently identified barrier in the assessments. Stigma is a **barrier to disclosing a mental health or substance use disorder and identification of and early intervention in early signs of addiction.**

Stigma contributes to **agency stigma** and thus **underutilization of services** offered by those agencies and the **reluctance of community leaders** to engage in community-led discussions about SUDs.

Many stakeholders do not understand the **science of addiction** and continue to feed the stigma. This happens with acute care providers, first responders and educators. The **media** was also noted as major contributor to perpetuating stigma.

“There is a stigma attached to parenting classes and many believe parenting classes are considered a punishment.” - Greater Nashua

“Stigma is very alive in our communities. Many people are still feeling afraid to talk about SUD, admit there is an issue, seek treatment, etc. There are varying levels of a ‘pull yourself up by your

bootstraps' mentality throughout the region and stigma of a 'junkie.'” - Greater Manchester Region

“Those in early recovery feel unwelcome in the larger community.” - South Central Region

Other key messages that need to be addressed include the **misperception that all treatment needs to be inpatient** and the need to **focus on education and awareness efforts on parents**. This includes reaching the “disengaged” population of parents, engaging Parent Teacher Organizations beyond elementary school and overall ensuring that parents understand SUD, the importance of prevention and the general concepts of asset building.

Communication strategies identified in the assessments include **community-wide education** and **increased patient education by primary Care and family practitioners** about Alcohol Tobacco and Other Drugs contributing factors related to family history/genetic predisposition.

“Need more ongoing messaging in FREE print for low income population of service array, social media and FB to raise awareness and education for signs and symptoms.” - Central Region

The Monadnock Region and Carroll County Region also identified the need for Community Forums to educate the public, professionals and social service agencies on the science of addiction and what is happening to address SUD statewide and regionally.

Discussion

The Partnership for a Drug Free NH (PDFNH) was identified as an asset in NH. The PDFNH hosts DHHS’ social marketing campaign "AnyoneAnytimeNH™" "AnyoneAnytimeNH™" was created in response to the opioid crisis in New Hampshire, to educate the public and professionals about addiction, emergency overdose medications, and support services for anyone experiencing opioid addiction. This campaign is designed to help anyone affected by this crisis: people experiencing addiction, parents, family and friends of those experiencing addiction, and healthcare, safety, and other system staff working with people who may be experiencing addiction. Additional information can be found at:

<http://drugfreenh.org/anyoneanytime>.

Despite the relatively large reach of this campaign, the CoC needs assessment demonstrated that stigma remains a significant problem and is a major barrier to accessible prevention, treatment and recovery services. The assessment also noted a need for more education and communication to increase community’s and provider’s knowledge of the science of addiction; including the biological and environmental causes and impacts of addiction.

Theme 6: Insurance

This category includes accessibility to healthcare insurance coverage for behavioral healthcare as it pertains to both the client and the service provider.



Identified Gaps

Access to insurance was identified remains a barrier to seeking and receiving SUD services across the state. Populations with significant challenges to accessing insurance include **low-income individuals who are not eligible for Medicaid, 19-25 year olds and previously incarcerated individuals.**

High costs and the **complexity of the system** was cited in many regions as barriers to accessing insurance and receiving care even for individuals with insurance. Costs continue to be a barrier in accessing insurance due to high premium costs and co-pays. Some examples of the complexity of the system include navigating the enrollment process and providers not accepting all types of insurance including Medicaid. The lack of consistent coverage for **medication assisted treatment** and the **prior authorization process** were cited as barriers to receiving timely services.

“Preauthorization for insurance coverage of SUD benefits/MAT can be daunting and delayed.” – Seacoast Region

“Lack of payment/reimbursement for recovery supports limits capacity.” – Seacoast Region

The regions reported that parity laws are not publicized or enforced and despite the regulations, many providers still cite denial of insurance payments for SUD services.

“Community members do not know about availability of insurance and what is covered. Providers are not aware of robust payment possibilities under parity.” – Greater Sullivan Region

“Parity is not utilized and providers are not aware of services that can be billed for or do not know how to bill for services that qualify.” – Greater Sullivan Region

Discussion

In recent years following the passing of the Affordable Care Act, NH legislation has improved access to health insurance. The continuation of the New Hampshire Health Protection Program (NH HPP) through the passage of House Bill 1696 ensures that beneficiaries continue to have access to benefits for substance use disorder services. Also, for the first time in New Hampshire, effective July 1, 2016, benefits for substance use disorder treatment services are being extended to traditional Medicaid beneficiaries. This will ensure that pregnant women, people living with severe mental illness, and other medically frail New Hampshire residents will have access to care for substance use disorders. Coverage includes a range of services including screening and brief intervention, outpatient treatment, residential treatment, medication assisted treatment, and recovery support services.

As noted above, there was an expansion the last few years in the number of New Hampshire residents with health coverage that includes substance use disorder treatment services as a covered benefit. Under both state and federal law, as of 2014, private health insurance coverage in the individual and small group markets became subject to behavioral health parity requirements, and to the requirement that mental health and SUD treatment services be covered as one of ten “essential health benefits.”

Despite the continuation and expansion of the NH HPP, the CoC assessment findings indicate that the population of those with SUD who do not qualify for Medicaid remain underserved due to lack of insurance and/or high premiums and deductibles.



Theme 7: Data and Evaluation

This category includes assessment and evaluation and needs related to evidence-base.

Identified Gaps

The gaps, barriers and needs coded in this category were broken into three categories: **Data Collection/Sharing, Program Evaluation and Evidence-based Strategies**. Table 5 demonstrates the needs identified in this category.

Table 5: Gaps/Needs by Data & Evaluation Type

Gap/Need	Type
Consistent access to crime/arrest data	Data Collection/Sharing
Dashboard of indicators in each CoC component that can be tracked in each region	Data Collection/Sharing
Type and number of controlled substances being prescribed by providers	Data Collection/Sharing
YRBS data release to RPHNs	Data Collection/Sharing
Increased data sharing in communities	Data Collection/Sharing
Measures of effective treatment	Evaluation
Follow-up evaluation of treatment and recovery services	Evaluation
Cost vs. outcome evaluation of prevention services	Evaluation
Prevention implementation fidelity	Evaluation
Effectiveness of PDMP	Evaluation
Prescribing practices	Evidence-base/Research
Registry of best practices across the continuum	Evidence-base/Research

Discussion

Several data and evaluation needs were identified in the CoC assessment that fell into three categories: Data Collection/Sharing, Program Evaluation and Evidence-based Strategies (See Table 5)

Acknowledging that the State must establish approaches to collect, analyze, and assess outcomes that reflect the efficacy and sustainability of its initiatives, a Program Monitoring and Evaluation Task Force of the Governor's Commission has been formed. Recent legislation included provisions requiring the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery to create a dashboard of indicators, to be updated twice each year, which will include measures such as the number of deaths attributable to overdoses; the number of people known to be in treatment or recovery programs; the accessibility and availability of treatment programs, including waitlists; and performance outcomes of funded services.

Other

Identified Gaps

Several regions mentioned the lack of **restorative justice** and **Drug Court** programs and the need for **needle exchange** programs. **Policy and advocacy** were noted in regards to the need for citizen advocacy education and training and **PDMP enforcement**. **Reentry programs** were also noted as a gap in services.

“Need for organized advocacy for citizens to learn how they can be engaged at the city or state level to impact laws/policies.” – Greater Monadnock Region

“Need for TREAT legislation to come into effect. Incarcerated individuals have difficulty with Medicaid closing and not being able to access services as soon as they are released.” - Greater Monadnock Region

“PDMP There is limited monitoring on the use of the system and it is reported to be cumbersome.

“– North Country Region

“Prison program/re-entry: Lack of coordinated efforts for those exiting County Jail that is systematic. Transitional program allows up to 4 people.” – Strafford County Region

Discussion

Drug Courts, needle exchange programs and the enforcement of the Prescription Drug Monitoring Program were specifically identified by several regions as needed throughout the state. In May 2016, Senate Bill 464 was signed by Governor Hassan, which allocated state funding establishing a statewide drug court program. House Bill 1681 established a commission on hypodermic syringes and needles. The intent of the commission is to study the national standards for best practices for syringe services programs; discuss the feasibility of implementing syringe services programs in New Hampshire and

identify recommended solutions. Senate Bill 576 allows the PDMP to accept state/general funds for the operation of the program; allows federal health practitioners working in federal facilities in New Hampshire, Maine, Vermont, and Massachusetts eligible to access the PDMP; allows the New Hampshire Chief Medical Examiner to request data for the purpose of investigating the death of an individual; required dispensers to submit information by the close of business on the next business day from the date the prescription was dispensed; requires prescribers to query the program for a patient's initial prescription when prescribing Schedule II, III, and IV opioids for the management/treatment of pain and then periodically, at least twice per year (except when controlled medications are administered in a health care setting and treating acute pain no more than 30 days); and continuing education courses for prescribers that are relevant to pain management and addiction disorders.

Conclusion

This assets and gaps analysis identified many of the state's strengths as well as the challenges that continue to face the state which need to be addressed in order to create a comprehensive and long-term approach to SUD prevention, treatment, recovery supports and the integration of primary care and behavioral health. The discussions highlight some of the state's current response to many of the needs identified in the assessment. Ongoing monitoring and strategic efforts that either fill the remaining gaps or sustain existing services will be necessary to bring about a system of care where the SUD continuum of care interacts closely with the primary care and behavioral health systems in communities resulting in increased prevention of and reduced substance misuse across the lifespan.

It is important to note here that the CoC assessment was set up in such a way that it focused mostly on gaps in service delivery systems needs to increase communication and collaboration and barriers to preventing, treating and recovering from SUD in NH and not on funding needs. However, of the funding needs identified across the continuum by the regions, there was a focus on the need to fund the implementation of evidence-based programs. It is important again to reference Senate Bill 533 which appropriated \$2,500,000 to the Commission for contracts for program services within DHHS. The funds, which are under the management of the Commission, are allotted to existing priorities within the state plan, Collective Action-Collective Impact. The Commission is working with applicable partners to quickly move those resources into the community within the next few months.

Recommendations for Next Steps

- Discuss opportunities to share, disseminate and present state and regional-level findings.
- Prioritize focus areas based on assets, needs and areas already being addressed and to what extent they are addressed.
 - Include priority focus areas and strategies to address the needs in the Regional CoC Development Plans.
- Integrate Continuum of Care assessment results into the Integrated Delivery Network assessment and planning for NH's DSRIP Waiver Program.
- Utilize findings to inform the Governor's Commission state plan.

Appendix:

Appendix A: New Hampshire's 13 Regional Public Health Networks

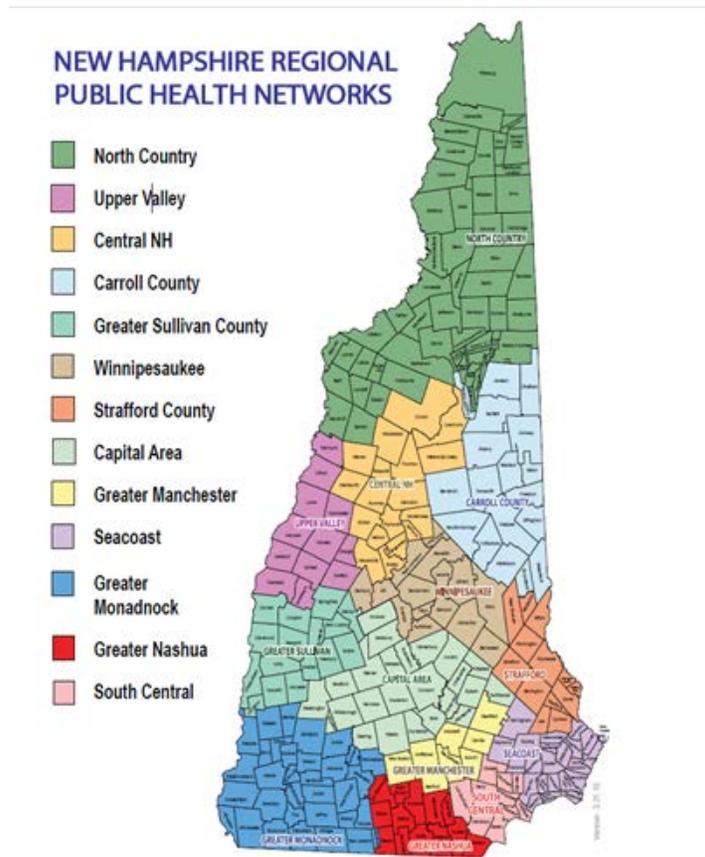
The goal of the New Hampshire Regional Public Health Networks is for all New Hampshire residents to be healthy and safe.

There are 13 Regional Public Health Networks (RPHNs) involving broad public health interests, including local health departments and health officers, health care providers, social service agencies, schools, fire, police, emergency medical services, media and advocacy groups, behavioral health, and leaders in the business, government, and faith communities, working together to address complex public health issues. We are successful when our residents lead long and healthy lives.

Currently, there are 13 Regional Public Health Networks statewide, each serving a defined Public Health Region. The 13 RPHNs include all of New Hampshire's cities and towns.

For more information go to:

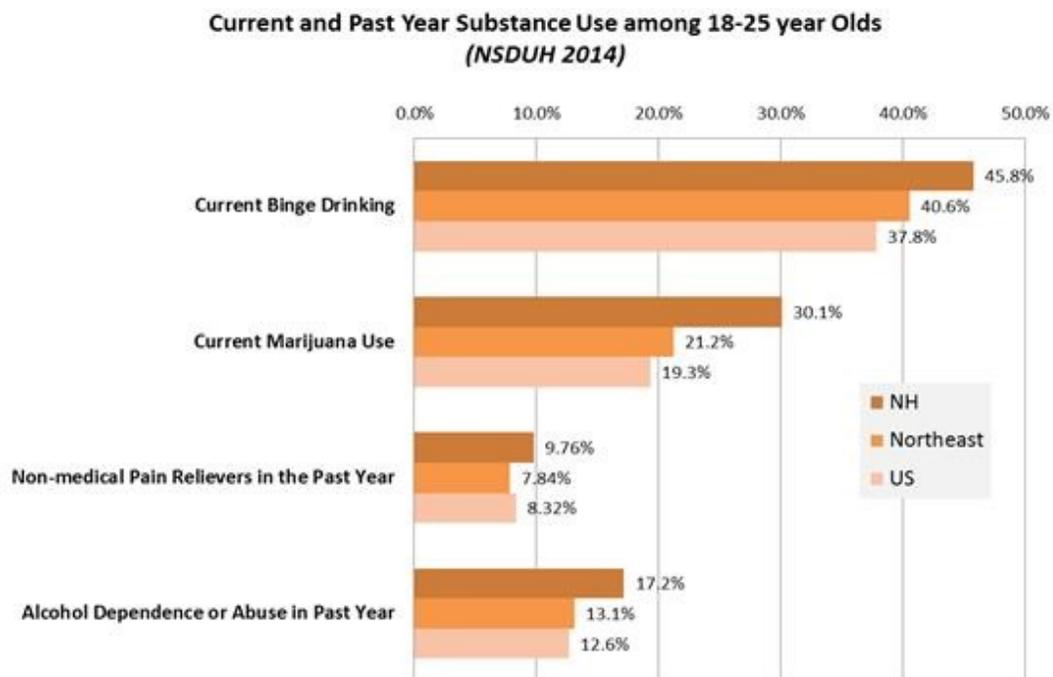
www.nhphn.org



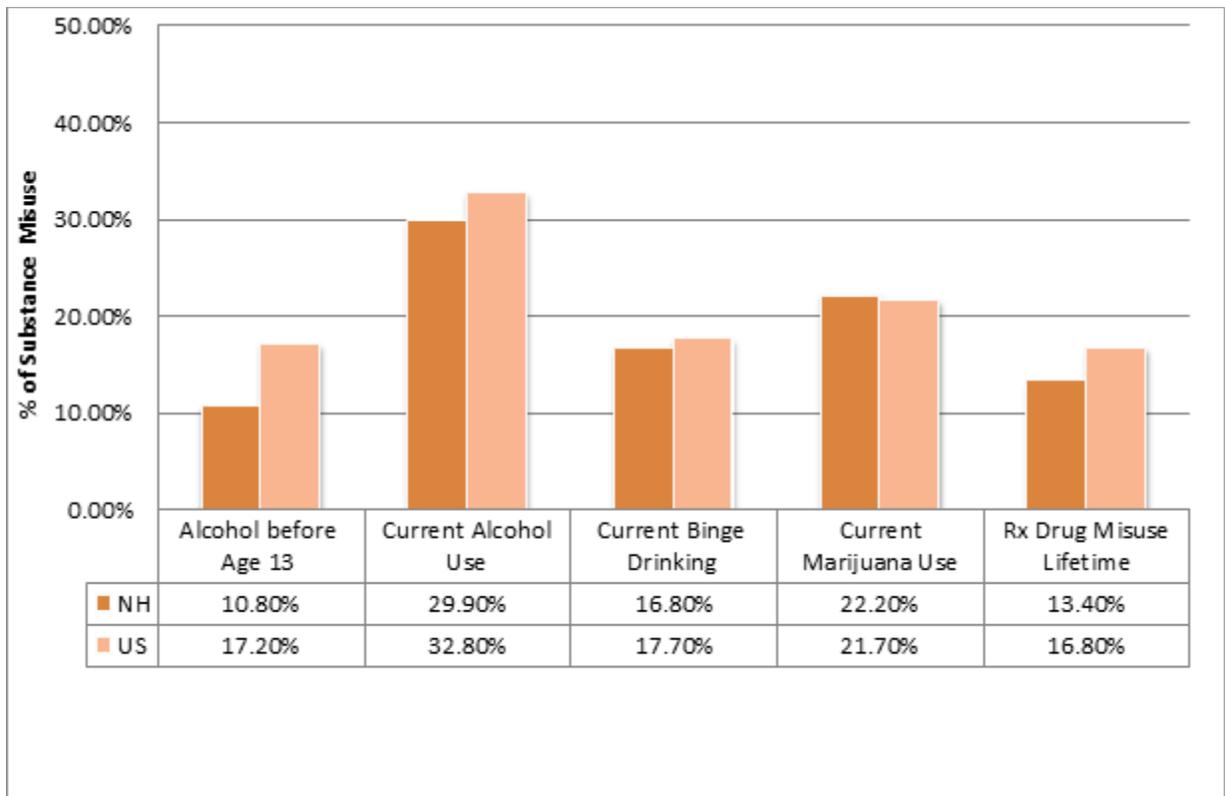
Appendix B: The Misuse of Alcohol and Other Drugs in New Hampshire

The misuse of alcohol and drugs is one of the most devastating public health issues faced by New Hampshire (NH) communities today. Substance misuse impacts all NH residents regardless of race, gender, class, zip code, age etc. According to the 2014 National Survey on Drug Use and Health, New Hampshire has some of the highest rates of substance misuse by youth and young adults in the country, and ranks in the top nine in the country for youth binge drinking among youth and young adults.

Below demonstrates how NH young adults' substance use rates compare to the average rates in the Northeast and the United States.

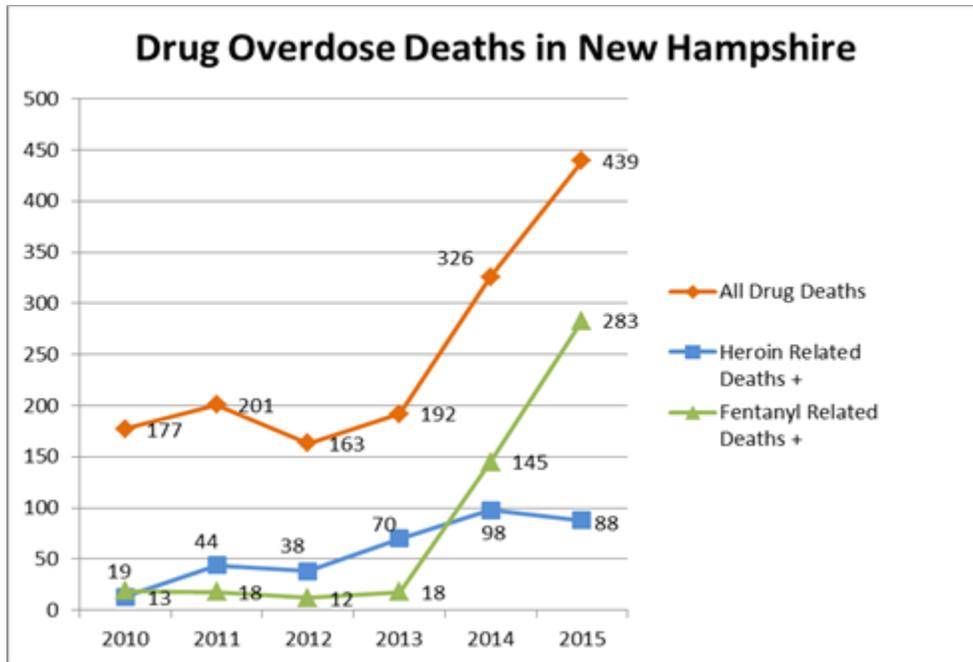


Similar rates of alcohol use, marijuana use, and prescription drug use are observed among the NH youth. The Youth Risk Behavioral Survey (YRBS) administered in 2015 indicated striking rates of substance misuse among New Hampshire Youth. New Hampshire youths have fairly comparable rates of substance misuse with the average U.S youth and considered one of the states with the highest rates of substance misuse among the youth (YRBS, 2015).



By all accounts, the misuse of alcohol and drugs is a key concern of NH residents. According to a recent poll conducted in October 2015 by the University of NH Survey Center, 25% of NH adults now identify “drug abuse” as the most pressing issue facing the state, followed by jobs and the economy (21%), which has held the top position for the past eight years (WMUR Granite State Poll https://cola.unh.edu/sites/cola.unh.edu/files/research_publications/gsp2015_fall_heroin100715.pdf). In October of 2014, only 3% of NH adults identified “drug abuse” as the most important issue representing increasing concerns by NH residents.

This significant increase in community concern is likely connected to the growing number of overdose deaths attributed to the use of opioids, including heroin and fentanyl. Overdose deaths have surpassed traffic-related deaths in NH every year since 2008 (NH Information and Analysis Center, 2016). According to the NH Medical Examiner’s office, there were 439 drug-related overdose deaths in the state in 2015 (NH Medical Examiner’s Office, 2016). This indicates a 35% increase of OD deaths due to opioids and opiate-related deaths from 2014 to 2015. Furthermore, the number of heroin-related emergency department visits increased significantly in the recent years. In 2012 there were 106 visits while in 2015 had 427, demonstrating a 300% increase from 2012 (NH Information and Analysis Center, 2016).



Consequently, substance misuse negatively impacts all sectors of society, from individuals and families to government, law enforcement and businesses. The effects of substance misuse are widespread, with negative implications for public health and wellbeing, including an alarming cadre of medical, social, safety, and economic costs. According to a recent analysis, substance misuse cost the NH economy over \$1.84 billion dollars in 2012, an amount equal to about 2.8 percent of the state’s gross state product or \$1,393 dollars for every person in the state.^[1] These costs include lost productivity and earnings, increased expenditures for healthcare, and public safety costs. In the same report, it is stated that only about six percent (6%) of individuals who misuse alcohol or drugs in NH currently receive treatment for their substance misuse. In fact, PolEcon Research (2014) contends that doubling the substance abuse treatment rate in NH to 12% is estimated to result in net benefits to the state of between \$83 and \$196 million

^[1] PolEcon Research. November 2014. The Corrosive Effects of Alcohol and Drug Misuse on NH’s Workforce and Economy. Retrieved from http://www.new-futures.org/sites/default/files/Summary%20Report_0.pdf on September 30, 2015.

**The majority of baselines and targets have been determined for this priority area. This is because we have a better since of trend data related to the misuse of drugs and alcohol and also have a better understanding of expected scope/saturation of inputs/activities to impact the indicators.*

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), every dollar invested in treatment saves \$4 in healthcare costs and \$7 in law enforcement/judicial costs. Prevention efforts are even more cost-effective, with an estimated return on investment ranging between \$7.40 and \$36 per dollar invested, with a median estimate of \$18 (SAMHSA, 2008). Addressing substance misuse in our state will not only save lives, but also will save the state resources.

Appendix C: Continuum of Care Assets and Gaps Assessment Tool

Continuum of Care Assets and Gaps Assessment Tool

I. Introduction & Background

The development of a Continuum of Care (CoC) that fully integrates prevention, intervention, treatment and recovery support services must be embraced to effectively manage substance use disorders (SUDs). A well-coordinated CoC includes networks of organizations, agencies and community members that provide a wide spectrum of strategies and services. The diagram depicts the full Continuum of Care necessary for helping individuals experiencing problems with alcohol and drug use, including addiction. For more information, view the webinar in the following link: <http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm>.



Many benefits for linking services across the CoC exist for both the service provider and consumer. These include:

- increased communication;
- bi-directional referral networks;
- integrated billing and data systems; and
- increased knowledge and awareness across all services.

All of these benefits will help to increase the efficiency of care and produce better health outcomes for those people and families suffering from SUDs. When developing the CoC in your region, consider how primary healthcare and behavioral healthcare will be included, involved and integrated.

The first step in developing a more integrated behavioral health system is to assess the current system. In conducting this assessment, considerations should be made about what services are available, who are they available to, what are the barriers to service, can these barriers be overcome, how do service providers work together, and how can those communication pathways be improved. One of the primary deliverables for year one of regional CoC development is the assets and gaps assessment of substance misuse services (prevention, early identification and intervention, treatment and recovery). Utilizing a collaborative process by bringing together stakeholders from across the CoC each sharing different perspectives will help to define how each plays an integral role in the broader system of care approach to behavioral health and SUDs.

The following document will provide information for how a region can assess its ability to provide quality, comprehensive and coordinated SUD and behavioral health care with help from key stakeholders.

II. Identify Existing Service Providers

The first step to conducting an asset and gaps assessment is to identify what services are currently active in the region. Involvement of key stakeholders in each sector (law enforcement/safety, education institutions, businesses, local government, and family community support systems) will enhance credibility and accountability of the CoC development in your region. Many sources are available to assist in gathering this information including preliminary scans of regional assets that have taken place through the Substance Misuse Prevention Program and the Treatment Capacity Inventory Survey (see following chart of additional resources for identifying available services). Be sure to connect with the Substance Misuse Prevention Coordinator in your region and search for treatment service providers using the [NH Alcohol and Drug Treatment Locator](http://www.nhtreatment.org), www.nhtreatment.org. The [Substance Use Disorder Treatment Capacity Assessment](#) can be found here as well: (<http://www.dhhs.nh.gov/dcbcs/bdas/documents/nh-sud-treatment-capacity-report.pdf>). Additionally, consider other related resources that may or could fill gaps. For example, do subject matter experts exist in your region? If so, they should also be included in this assessment.

Resources to Identify Service Providers	Prevention	Treatment	Recovery
NH Alcohol and Drug Treatment Locator - http://nhtreatment.org/	X	X	X
Faces and Voices of Recovery http://www.facesandvoicesofrecovery.org/who/regions/new-england			X
NH 211 - http://www.211nh.org/	X	X	X
Health Systems(hospitals (ER, Ob/Gyn, Social Work)) http://www.nhha.org/index.php/nh-hospitals/map-of-hospitals		X	X
NH Board of Licensing for Alcohol and Other Drug Use Professionals http://www.dhhs.nh.gov/dcbcs/bdas/licensing.htm		X	X
NH Board of Mental Health Practice https://www.nh.gov/mhpb/	X	X	X
Bi-State Primary Care Association - http://www.bistatepca.org/find-a-health-center/nh	X	X	X
NH Medical Society and the Academy of Family Physicians https://www.nhms.org/specialty-societies		X	X
Medical Group Management Association http://www.nhmgma.com/	X	X	X
NH Center for Non-Profits (Community Social Service Agencies) http://www.nhnonprofits.org/	X	X	X
SAMHSA Behavioral Health Treatment Services Locator https://findtreatment.samhsa.gov/		X	

SAMHSA On-Line Locator (Buprenorphine-Certified Physicians) http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator		X	
Bureau of Drug and Alcohol Services (Opioid Treatment Programs) http://www.dhhs.nh.gov/DCBCS/bdas/documents/guide.pdf		X	
BDAS (State-Funded Treatment Programs, Access To Recovery Providers, Non-ATR Service Providers)		X	
Vivitrol Prescriber Locator - www.vivitrol.com		X	
Community health centers, Community Mental Health Centers	X	X	X

III. Inventory Existing Services

Once regional stakeholders across each sector has been identified, connect with them and introduce them to the process. Engaging these stakeholders will vary from region to region. This may be accomplished through periodic meetings of a leadership team, a workgroup convened specifically for this purpose and/or as an extension of existing substance misuse workgroups in your region. The information, ideas, feedback, recommendations and concerns of stakeholders will be instrumental in the development of the region’s Continuum of Care Assessment.

During this process gather factual information describing your regional CoC assets. Information such as location, services provided, capacity and referral network will help to guide this work by developing a high level perspective of how the continuum of care looks in your region. Please see Appendix A for a sample assessment that can be used to collect this information.

IV. Conduct Key Informant Interviews and Focus Groups

After the assessment data from step 2 have been analyzed it may be helpful to collect additional information from key informants either through 1:1 interviews or focus groups.

Key Informant (1:1) Interviews

Key informant interviews are qualitative in-depth interviews with people who know what is going on in the community. The purpose of key informant interviews is to collect information from a wide range of people—including community leaders, professionals, or residents—who have first-hand knowledge about the community. These community experts, with their particular knowledge and understanding, can provide insight on the nature of problems and give recommendations for solutions. Face-to-face interviews and over the telephone are two common ways to conduct key informant interviews.

Focus Groups

Focus groups help people learn more about group or community opinions and needs. Responses in a focus group are open-ended, relatively broad, and qualitative. They have more depth and variety. Nonverbal communications and group interactions can also be observed. Focus groups can therefore get closer to what people are really thinking and feeling. Similar to key informant interviews, focus groups can be helpful when you want to ask questions that can't easily be

asked or answered on a written survey. It is recommended to limit the number of people in a focus group to no more than twelve individuals participating at a time. Limiting number of attendees will allow each person to voice their opinion during the exercise.

Sample topics and questions that you may want to go into more depth with can be found in **Appendix B**.

V. Conduct a Self-Assessment Survey

For more quantifiable stakeholder input on some of the key concepts associated with a well-functioning system or continuum of care, a self-assessment stakeholder survey can be helpful. This type of stakeholder assessment can be useful for identifying point in time perceptions of the activities, values, and practices of the system, and can thus also be helpful for measuring change from baseline and various points in time along the process. A sample of this type of survey can be found in Appendix C. In the event that focus groups or 1:1 interviews cannot take place or to fill in gaps from the basic information survey, administration of a brief self-assessment such as the sample provided could also be used to fill in important information and perceptions.

Appendix A Inventory of Services General Information

Organization Name:
Provider Name:
Address:
With which sector would you affiliate your organization: <input type="checkbox"/> Business <input type="checkbox"/> Education <input type="checkbox"/> Government <input type="checkbox"/> Law Enforcement/Safety <input type="checkbox"/> Family Community Supports <input type="checkbox"/> Health/Medical
Service Area:
Phone Number:
Website:
Email:

In what area of the Continuum of Care do you provide services? (Check all that apply)

- Prevention
- Screening/Identification
- Treatment
- Recovery
- Other Service Area (e.g., employee assistance program, law enforcement activity), please specify:

Population Served

- Children
- Adolescents
- Young Adults
- Adults

Specialty Populations (programming available for specific population)

- Pregnant Women
- Parenting Women
- Injection Drug Users
- HIV/AIDS, Tuberculosis, Viral Hepatitis
- Adolescents (12-17)
- Young Adults (18-22)
- Men
- Women
- Lesbian, Gay, Bisexual, Transgender
- Military/Veterans
- Individuals on Psychotropic Medications
- Individuals on Other Medication-Assisted Treatment
- Co-Occurring SA/MH
- Co-Occurring for Severe and Persistent Mentally Ill
- Suicide Risk
- Recent Suicide Attempt
- History of Violence: Victims of Domestic Violence
- History of Violence: Perpetrators (including sexual assault)
- History of Trauma (including sexual assault)
- DWI Offenders
- Criminal Justice involved
- Immigrants/Refugees
- Other (please specify)

Capacity

How many clients (or program participants) is your organization/program able to serve?

How many clients (or program participants) is your organization/program currently serving?

Payment

Do you bill for services?

- Yes
- No

If you bill for services, what forms of payment are you able to accept for Substance Use Disorder Services?

(For the health insurance and managed care organizations listed below, being able to accept payments means you are currently an approved provider for the insurer.)

	Yes (Approved Provider)	No	Currently Negotiating
NH Health Families Health Plan/Cenpatico (MCO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well Sense Health Plan/Beacon Health Strategies (MCO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthem/Matthew Thornton Health Plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TriCare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harvard Pilgrim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Pay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State contract (BDAS, BBH, DPHS, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected "other" please specify

Services provided (check all that may apply):

Prevention

- Not providing prevention services
- Direct Services Prevention
- Environmental Prevention
- Parenting Programs
- Policy-related Prevention
- Prevention Training
- Suicide Prevention and Education
- Violence Prevention
- Other (Please Describe)

Intervention/ Early Identification

- Not providing intervention/early identification services
- Student Assistance Programs in schools and colleges
- Employee Assistance programs (formal or informal) in workplaces
- Screening and brief interventions for justice/court-involved youth, young adults, adults and families
- Community-based programs that encourage clients to self-refer for assessment and referral for services
- SBIRT (Screening, Brief Intervention and Referral to Treatment) in medical settings
 - Screening (Alcohol)
 - Screening (Other Drugs)
 - Screening (Mental Health)
 - Screening (Trauma)
- Integrated Screening and Assessment Processes
- Assessment
- Case Management
- Brief Intervention
- Cognitive-behavioral therapy
- Family interventions
- Individual or group counseling
- Motivational enhancement
- Psychopharmacology
- Skills training
- 12-Step recovery meetings
- Residential treatment
- Intensive Outpatient treatment
- Other (Please Describe)

Treatment Services (for substance use disorders or co-occurring substance use and mental health disorders)

- Not providing treatment services
- Evaluation
- Outpatient (OP) Counseling Services (Individual)
- Outpatient Counseling Services (Group)
- Intensive Outpatient Services (IOP)
- Partial Hospitalization
- Residential Services
- Medically Managed Inpatient Hospital-Based Services
- Transitional Living
- Opioid Treatment Programs (methadone)
- Office Based Medication Assisted Treatment (buprenorphine/Suboxone)
- Other Medication Maintenance
- Naltrexone (Vivitrol)
- Care Coordination
- Other (Please Describe)

Recovery Support Services (RSS)

- Not providing recovery support services
- Child Care
- Transportation
- Employment Services
- Anger Management
- Impaired Driving Program
- Job Training/Employment Counseling
- Personal Finance Skill Building
- Relationship Skill Building
- Stable Housing and Employment
- Volunteer Opportunities/Giving Back
- Recovery Mentoring/Relapse Prevention Management
- Peer Recovery Coaching
- Peer Support Groups
- Permanent Supportive Housing
- Sober Housing
- Care Coordination
- Substance Free Activities
- Recovery-supportive health care, employment, education, and community environments
- Other (Please Describe)

Other Services

- Employee Assistance Program
- Law Enforcement Activity
- Youth Mentoring Program
- Youth Group
- Housing Assistance
- Alternative Justice Program

Please indicate the number of full-time equivalent licensed practitioners you have on staff for substance use disorder related services?

LADC - Licensed Alcohol and Drug Counselor	<input type="text"/>
MLADC - Master Licensed Alcohol and Drug Counselor	<input type="text"/>
LICSW - Licensed Independent Clinical Social Worker	<input type="text"/>
LCMHC - Licensed Clinical Mental Health Counselor	<input type="text"/>
LMFT - Licensed Marriage and Family Therapist	<input type="text"/>
CRSW - Certified Recovery Support Worker	<input type="text"/>
RN - Registered Nurse	<input type="text"/>
APRN - Advanced Registered Nurse Practitioner	<input type="text"/>
PA - Physician Assistant	<input type="text"/>
MD - Doctor of Medicine	<input type="text"/>
DO - Doctor of Osteopathic Medicine	<input type="text"/>
LPP - Licensed Pastoral Psychotherapist	<input type="text"/>
Psychologist	<input type="text"/>
Psychiatrist	<input type="text"/>
Practitioner certified to prescribe buprenorphine/suboxone	<input type="text"/>
Other (please specify)	<input type="text"/>

Appendix B

Specific questions (Key Informant Interview or Focus Group)

Referral Network

1. What organizations are you currently working with to coordinate care for SUD clients?
2. What does the referral process look like?

3. What barriers exist to strengthening the referral process?
4. How would you describe your capacity to appropriately deliver services to clients (internally, through referral networks etc.)?

Systems Development

5. What gaps do you perceive in the array of services available in the region?
6. What services would you like to provide if you had the capacity?
7. What resources would be required to provide this service?
8. What do you anticipate are your needs going forward?

Capacity

9. What are the strengths of your program? What is working well?
10. What barriers exist for increasing capacities to implement new programs?
11. What barriers exist for people trying to access existing services?

Integration of Primary Care/Behavioral Health/SUD

12. What would the successful integration of Primary Care and Behavioral Health or SUD care look like at your organization?
13. What do you see as the greatest benefit of integrating primary care with behavioral health/SUD care?
14. Some people have observed that the worlds of primary care and behavioral health services, as well as mental health and SUD services, have been in separate silos for many years, with key differences not only in financing, payment structures, data requirements, training, and staffing, but also in “cultures.” “How can we best create a shared culture that allows staff and programs to develop needed common values and understanding?”

Workforce Development

15. What kinds of dissemination, training/education, and workforce initiatives are needed to ensure support for the vision and practices of integrated services?
16. How can training for both MH and SUD, and health care staff help promote effective business and service practices, as well as to enhance collaboration and team approaches at agency and provider levels?

Information Sharing

17. What are the possible barriers and supports needed in the area of information technology, data systems and current data reporting requirements (such as...)?
18. How might these be reduced, consolidated, or used more efficiently for better care coordination and integration?
19. How might current limitations on exchange of information (e.g. federal HIPAA limits regarding SUD information) best be addressed to enhance treatment coordination in real time, as well as health planning?

Financial Considerations

20. What are the key financial barriers that need to be overcome to promote integration?
21. How might financing incentives and supports best be identified and developed for true integrated care that reinforces outcomes, not just visit volume?

Appendix C: System of Care Self-Assessment – Stakeholder Assessment

(Adapted from: http://www.oacbha.org/docs/ROSC_Stakeholder_Assessment.pdf)

System of Care Self-Assessment STAKEHOLDER ASSESSMENT

Please indicate the degree to which you feel the following statements reflect the activities, values, and practices of your community.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
	1	2	3	4	5	D/K
Focusing on Clients and Families						
1. Service providers are trained regularly in relevant Substance Use Disorder topics and Continuum of Care assessments.	1	2	3	4	5	D/K
2. Barriers (e.g., childcare, transportation) are addressed for participants.	1	2	3	4	5	D/K
3. Multi-disciplinary teams (e.g., clinician, peer support, family members, other cross-system partners) work together with the goal of recovery.	1	2	3	4	5	D/K
4. Age appropriate services are offered to children, adolescents, young adults, and seniors.	1	2	3	4	5	D/K
Ensuring Timely Access to Care						
5. Individuals have timely access to the services and supports that are most helpful for them.	1	2	3	4	5	D/K
6. Partnerships exist for all ages in a variety of health care settings that will facilitate the use of evidenced-based behavioral health screenings, on-site assessments, early intervention and referral strategies, as well as wellness checks.	1	2	3	4	5	D/K
7. Co-occurring behavioral and physical health are addressed in integrated ways, including assertive referral to and coordination with primary care providers, with an aim to address co-occurring issues through integrated rather than consecutive care.	1	2	3	4	5	D/K
8. Connections with key community partners (e.g., housing and food shelters, halfway houses, church-based meal programs, community corrections facilities, recreation centers) exist for at-risk individuals.	1	2	3	4	5	D/K

9. Partnerships exist with peer support recovery programs, recovery community organizations and other support groups.	1	2	3	4	5	D/K
10. Partnerships exist with treatment programs at varying levels (assertive community treatment, individual outpatient treatment, group outpatient treatment, medication assisted treatment and other treatment methods)	1	2	3	4	5	D/K
11. Partnerships exist with organizations that provide other resources (e.g., housing, childcare, employment services, and transportation) that may benefit the individuals and families served.	1	2	3	4	5	D/K
12. Partnerships and learning exchanges exist with first responders to help stabilize individuals by providing education on: mental health and substance abuse issues, common responses to trauma, and facilitation of referrals.	1	2	3	4	5	D/K
13. Cross training and referrals are in place.	1	2	3	4	5	D/K
14. A no-wrong-door policy exists in the community for children, adolescents, and adults to engage individuals at whatever point they enter the system and determine the most appropriate type and level of care at that time.	1	2	3	4	5	D/K
15. Interim services are available for people on waiting lists and/or who are not ready to commit to treatment.	1	2	3	4	5	D/K
16. Assertive linkages exist during transitions using peer-based support staff and volunteers through levels of care.	1	2	3	4	5	D/K
17. Intake and engagement strategies use evidenced-based practices (e.g., motivational interviewing, contingency management and cognitive behavioral techniques).	1	2	3	4	5	D/K

Promoting Healthy, Safe and Drug-Free Communities

18. Helping people build connections with their neighborhoods and communities is a priority.	1	2	3	4	5	D/K
19. The community receives education about mental illness and addictions.	1	2	3	4	5	D/K
20. Persons in recovery are involved with facilitating trainings and education programs.	1	2	3	4	5	D/K
21. Coordination exists to link people in recovery with other persons in recovery who can serve as role models or mentors.	1	2	3	4	5	D/K
22. Strategies to decrease stigma are conveyed to all partners and are consistently implemented in communities.	1	2	3	4	5	D/K
23. Partnerships and learning exchanges exist with first responders and others in the community to provide education on mental health and substance	1	2	3	4	5	D/K

abuse disorders, and common responses to trauma, facilitate referrals and alter them to types of situations you may be able to help them stabilize (e.g., Crisis Intervention Training, Mental Health First Aid).						
---	--	--	--	--	--	--

Prioritizing Accountable and Outcome-Driven Financing

24. Criteria for completing and exiting treatment are clearly defined and discussed with participants upon entry to services.	1	2	3	4	5	D/K
25. The success of community-based screening processes is monitored regularly.	1	2	3	4	5	D/K
26. Indicators of initial treatment engagement (e.g., “no shows,” frequency with which people come back for return appointments) are monitored regularly.	1	2	3	4	5	D/K
27. Focus groups and other formats (e.g. surveys) are used regularly to seek feedback about participant satisfaction and improvement strategies from adults, youth and families receiving services and supports.	1	2	3	4	5	D/K
28. Peer leaders are developed and promoted to affect program development, evaluation and improvement.	1	2	3	4	5	D/K
29. Quantitative and qualitative evaluation approaches are used to prevent barriers to program participation and satisfaction.	1	2	3	4	5	D/K
30. Outcomes are connected to community plan priorities.	1	2	3	4	5	D/K

Locally Managing Systems of Care

31. Procedures are clear about the options for referrals to other programs and services if a provider cannot meet the needs of a participant.	1	2	3	4	5	D/K
32. Primary care and behavioral health follow-ups are integrated and coordinated.	1	2	3	4	5	D/K
33. Communities are proactively addressing emerging issues.	1	2	3	4	5	D/K
34. Partnerships exist with local businesses to increase opportunities for employment.	1	2	3	4	5	D/K

Continuum of Care

			Yes	No	Don't Know
35. Prevention and wellness management services are available in the community.			Y	N	D/K
36. People in recovery work alongside providers to develop and provide new programs and services.			Y	N	D/K
37. Prevention, Screening/Early Intervention/Referral, Treatment and Support services are					

available in the community.			
38. Treatment services are available in the community, including outpatient, residential, partial hospitalization and withdrawal management.	Y	N	D/K
39. Recovery supports are available in the community, including peer support, housing, and transportation.	Y	N	D/K
40. Workforce programs and supports are available to help individuals get back to work.	Y	N	D/K
Do you have additional questions pertaining to the assessment? Is there anything that we should have asked but did not?			
Additional Comments			

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Appendix D: Results of Assets Inventory Scan and Regional Summaries of Assets

The following table represents a scan of regional assessments.

KEY: By component - # SU = number of substance use agencies providing service, #PH = number of primary health agencies providing service, # BH = number of behavioral health agencies providing service, # CBO = number of other community based organizations providing services, # Safety/Gov = number of police, fire or other government agencies providing service, # Schools = number of academic facilities providing services.

PREVENTION

REGION	Component	# SU	# PH	# BH	# CBO	# Safety/Govt.	# Schools
Capital Region	Prevention		1	1	2	4	2
Carroll	Prevention	6	4	6			2
Central NH	Prevention			2	8	3	5
Gtr. Manc.	Prevention						
Grt. Monad.	Prevention	4	8	10	4	5	10
Gtr. Nashua	Prevention						
Gtr. Sullivan	Prevention				2		1
Nrt. Country	Prevention	3			6		
Seacoast	Prevention		3		7	1	4
Sth. Central	Prevention						
Stafford.	Prevention			1	5	1	4
Upper Val.	Prevention	16	1	2	4	11	11
Winne.	Prevention				1	3	2

EARLY IDENTIFICATION AND INTERVENTION

REGION	Component	# SU	# PH	# BH	# CBO	# Safety/Govt.	# Schools
Capital Region	Early ID and Interven.		1		1	1	3
Carroll	Early ID and Interven.	11	6	3	7	1	2
Central NH	Early ID and Interven.		2	1	2	3	
Gtr. Manc.	Early ID and Interven.						
Grt. Monad.	Early ID and Interven.		3	1	8	4	2
Gtr. Nashua	Early ID and Interven.						
Gtr. Sullivan	Early ID and Interven.		3	1	3		1
Nrt. Country	Early ID and Interven.	1	9	1	12	1	
Seacoast	Early ID and Interven.	5	5	1			1
Sth. Central	Early ID and Interven.						
Strafford.	Early ID and Interven.	4	3	4	4	2	4
Upper Val.	Early ID and Interven.	17	1	1	2	12	11
Winne.	Early ID and Interven.						

TREATMENT

REGION	Component	# SU	# PH	# BH	# CBO	# Safety	# Schools
Capital Region	Treatment	18					
Carroll	Treatment	7	3	1			
Central NH	Treatment	5		2	1	5	
Gtr. Manc.	Treatment						
Grt. Monad.	Treatment	8	3	9		1	6
Gtr. Nashua	Treatment						
Gtr. Sullivan	Treatment	2	1		2		
Nrt. Country	Treatment	2	4	1	5	1	
Seacoast	Treatment	5	3	1	3		
Sth. Central	Treatment						
Strafford.	Treatment	4	2	2			
Upper Val.	Treatment	15	1		1		1
Winne.	Treatment	4	4				
Total							

RECOVERY SUPPORT SERVICES

REGION	Component	# SU	# PH	# BH	# CBO	# Safety/Govt	# Schools
Capital Region	RSS	7			6		
Carroll	RSS	7		2	8	7	1
Central NH	RSS			1	4	1	
Gtr. Manc.	RSS						
Grt. Monad.	RSS	6	3	8	10	1	6
Gtr. Nashua	RSS						
Gtr. Sullivan	RSS				6	1	
Nrt. Country	RSS	2	2		5	1	
Seacoast	RSS	5	2	1	7		
Sth. Central	RSS						
Strafford.	RSS	2		1	6		
Upper Val.	RSS	10	1	1	6		
Winne.	RSS			3	1		

Individual Asset Summaries:

Capitol Area Public Health Network (CAPHN) Assets Summary

Prevention Assets

The Capital Region Substance Misuse Prevention Network has been convening area prevention providers since 2007. Efforts that have stemmed from the efforts of the network include permanent prescription drop boxes, Life of an Athlete and youth councils. These strategies target communities and youth and cover a broad geographical range in the area. Second Start's Student Assistance Programs also have broad reach in the region. Another asset in the prevention system includes the variety of sectors engaged in the provision of prevention on some level including Concord Hospital Family Health Center, the police department and Riverbend Community Mental Health Center. The communities of Bow and Pittsfield have active prevention coalitions.

Early Intervention Assets

Merrimack County residents have access to mental health, drug court and diversion programs offered by the District Court and Diversion Center. The Concord Hospital Family Health Center currently implements Screening, Brief Intervention and Referral to Treatment with one clinical team and will be expanding to the whole clinic soon. Again, Second Start's Student Assistance Programs, which include an early intervention component, also have broad reach in the region.

Treatment Assets

There are many SUD treatment providers in the Concord area providing evaluation, outpatient treatment services for adults, including many that specialize in treating young adults. There are a small number of treatment providers serving the outlying areas of the region as well.

Recovery Assets

HOPE for NH Recovery (HOPE) has recently expanded services to the Capital Area. HOPE will be opening a recovery center in Concord in May 2016 following a sustainability model which includes the engagement of local businesses. New Futures provides Recovery Coach Academy trainings regularly and Families Sharing without Shame offers a well-known and well-attended family support group. Several treatment providers offer recovery support services and there is a sober living facility for men in Boscawen.

Ancillary Recovery Supports Assets

The capitol city has many service providers including those that provide transitional housing support services and offer services for those seeking employment. There are food pantries in most towns.

Carroll County Coalition for Public Health Assets Summary

Prevention Assets

Carroll County listed a number of assets in substance misuse prevention. Many prevention efforts are spearheaded by health centers and clinics in the area. Ossipee Family Planning & Teen Clinic provides health care and counseling. Several schools were also listed as assets for prevention in the community, due to Student Assistance Programs, at-risk groups, Life of an Athlete, general prevention education.

Early Intervention Assets

Schools were also listed as an asset for early intervention by connecting at-risk youth and young adults to services. Health centers and clinics, including White Mountain CHC and Memorial Hospital also provide early intervention services to Carroll County Residents.

Treatment Assets

There are substance use disorder (SUD) treatment providers in Carroll County providing evaluation, outpatient treatment services for adults, including many that specialize in treating young adults. Many health centers and treatment centers were listed, including Northern Human Services CHC, Green Mountain Treatment Center, Road to a Better Life, Saco River Medical Group, Memorial Hospital, White Mountain CHC, and several individual providers throughout the county.

Recovery Assets

Recovery services available in the Carroll County network provide assistance to families and mothers in recovery by offering parent support, education, and child care. Organizations providing these services include MWV Supports Recovery, Children's Unlimited, and Wolfeboro Visiting Nurses. Other community wide recovery services include Narcotics Anonymous and Alcohol Anonymous, which provide a forum for group recovery meetings. Town offices throughout the county provide welfare supports and resources.

Ancillary Recovery Supports Assets

Carroll County reported several services that provide ancillary recovery supports, including Books on Wheels in Wakefield and food pantries throughout the county. Volunteer support groups were also listed in Ossipee and county wide, providing an array of goods and services such as transportation, clothing, and stewardship. Other services available in the county include provide transitional housing support services and offer support for finding employment.

Central Regional Public Health Network Assets Summary

Prevention Assets

Prevention assets listed by Central Region Public Health Network (RPHN) ranged from informal community activities to coordinated initiatives by organizations throughout the region. Outdoor recreation by the Parks and Recreation departments in several towns were listed as prevention efforts, for pro-social engagement among children, young adults, and families in the community. Project Promise in the Newfound region provides a safe after school learning environment where students can grow academically and socially. Life of an Athlete was listed as another school based prevention program that is active throughout the region. Other notable prevention efforts included initiatives led by schools, healthcare providers, law enforcement, and restorative juvenile justice in the Central RPHN.

Early Intervention Assets

Community-based organizations were listed as early intervention assets for Central RPHN. Becket Family Services provides comprehensive services include home and community based treatment and supports, as well as residential treatment and schools serving students and individuals struggling with behavioral challenges and disabilities throughout Central and northern New England. Naloxone distribution and permanent prescription drug boxes in the Central region were also notable intervention assets, as these provide active ways to prevent & intervene if there is misuse of prescription drugs. Mid-State Health Center and pediatricians throughout the region implementing Screening, Brief Intervention and Referral to Treatment in their services were also notable intervention assets.

Treatment Assets

There are substance use disorder (SUD) treatment providers in Central RPHN providing evaluation, outpatient treatment services for adults, including many that specialize in treating young adults. These organizations include Genesis Behavioral Health, Horizons Counseling Center, PainCare, Plakes Region Senior Psychology Center, and Riverbank House, among others. LADCS and individual providers throughout the county were also included.

Recovery Assets

Peer-to-peer recovery support programs are provided by Families Advocating Substance Treatment, Education, Recovery (FASTER) and Self-Management and Recovery Training (SMART) Recovery in the Central and Newfound regions, respectively. Alanon was also listed as a peer-to-peer support program in the Central region. Recovery centers are also available assets in the region.

Ancillary Recovery Supports Assets

Recovery coaches and centers were also listed as ancillary recovery support assets in Central RPHN. Specifically, HOPE for NH recovery is available and provides telephone support, recovery coaching, and community recovery.

Greater Manchester Region Assets Summary

Prevention Assets

Makin It Happen for Resilient Youth, Inc. was noted as the regional substance misuse disorder network, which provides prevention messaging throughout the Greater Manchester area. Outdoor recreation by the Parks and Recreation departments in Auburn, Bedford, Deerfield, Goffstown and others were listed as prevention efforts, for pro-social engagement among children, young adults, and families in the community. Up Reach was listed for the Greater Manchester area, as this non-profit offers year round therapeutic riding and driving sessions, as well as equine assisted learning programming for those with behavioral health issues. The Be BOLD Coalition in the Bedford community is a newly formed grassroots Substance Abuse Prevention Coalition. Other organizations listed included New Horizons for NH, the YWCA, Families in Transition and Harbor Homes Veterans FIRST.

Early Intervention Assets

Greater Manchester Region listed New Horizons for NH as an intervention resource that provides primary medical care, addiction counseling, mental healthcare, dental care, eye care and specialty care as well as mental health services. The YWCA was listed as an asset that provides advocacy and support services for domestic violence, sexual assault and substance use disorders in the Greater Manchester community. Other organizations also providing intervention services included, Families in Transition, Harbor Homes Veterans FIRST, and the YWCA. Police departments and law enforcement officials in several towns were listed for various initiatives, including drug take back days, permanent drop boxes for prescription drugs, and roles as School Resource Officers.

Treatment Assets

Hospital and treatment facilities were the primary assets listed for treatment in the Greater Manchester area. Some organizations included were the VA Hospital, Farnum Center, Serenity Place, OPCO Habit, and Healthcare for the Homeless in Manchester. Treatment services available through these entities include methadone assisted treatment, inpatient and group outpatient counseling, detoxification, case management, and more. Helping Hands Outreach Center in the Greater Manchester area provides 24/7 alcohol and drug related recovery transitional housing to men aged 18 and older.

Recovery Assets

There were several recovery assets listed by the Greater Manchester Region. Teen Challenge is a Manchester chapter of a Christian residential drug recovery program that faith-based for 18+ year old males. Another recovery organization, Live Free Recovery Consultants, provides family recovery services, as well as recovery support services in Hillsboro County. Community support groups, such as NAR-ANON, Granite State Area Narcotics Anonymous, and Cocaine Anonymous, are also available assets in the Greater Manchester Region.

Ancillary Recovery Supports Assets

Ancillary recovery support assets in the Greater Manchester area were intertwined with

recovery assets. Organizations, such as Families Sharing Without Shame and Families Advocating for Substance Education and Treatment (FASTER) provide recovery support services to peers and family members of those in recovery.

Greater Monadnock Region Assets Summary

Prevention Assets

Many school-based programs were listed as prevention assets in the Monadnock Region. Middle and High school resources and programs included: Life of an Athlete, student counseling and treatment services, Student Assistance Programs, Students Against Destructive Decisions (SADD), and after school programming. Universities in the region were also listed as having prevention programs, including “Under the Influence,” Brief Alcohol Screening and Intervention for College Students (BASICS) and the Alcohol Wise program. These resources are seen as providing both strategic prevention messaging related to alcohol and other drugs, as well as providing the youth in the community with opportunities to spend free time in a safe, drug-free environment. The Monadnock Alcohol & Drug Abuse Coalition (MADAC) was listed as a drug free coalition working to reduce misuse, build partnerships, advocate for policy change and prevention funding, and offer prevention trainings for parents and schools. Police and fire departments in Keene were also listed as prevention and intervention assets.

Early Intervention Assets

The Monadnock Region listed several juvenile justice and court diversion programs available to youth and young adults, which provides structured programs that hold young offenders accountable for their illegal behavior while addressing possible underlying substance use disorders. Many of the school programs listed as prevention also qualify as early intervention assets, as these programs identify risky behavior and provides tools and education to those potentially at risk for alcohol or other drug misuse. Cheshire Medical Center and other community health centers were identified as early intervention assets for screening and referral processes embedded in their primary care practices. Keene Police Department and the Cheshire County Sheriff Department were listed for various initiatives, including drug take back days and permanent drop boxes for prescription drugs. A partnership between Keene Fire Department, Keene Police Department, the Cheshire County Sherriff, Southwestern Community Services and the Cheshire Hospital Emergency Department. The initiative, modeled after PAARI (Police Assisted Addiction and Recovery Initiative), will use Recovery Coaches to be dispatched to the ER, or jail when one of these entities has encountered an individual struggling with substance misuse and/or addiction and/or overdose.

Treatment Assets

Hospital and treatment facilities were the primary assets listed for treatment in the Monadnock region. Of note, Cheshire County Medical Center provides free one-on-one counseling for tobacco addiction, provides assistance with nicotine replacement therapies, and local support group for individuals who are maintaining a tobacco-free lifestyle. The Controlled Substance Management Network (CSMN) is working to develop a region-wide infrastructure to support the effective communication and cooperative relationships necessary to coordinate the implementation of comprehensive, best-practice controlled substance prescribing, monitoring, and management, with linkages to community-based behavioral health interventions and addiction treatment. Drug courts, alternative sentencing programs, and many treatment

organizations and individual providers were also highlighted as treatment assets in the Monadnock region.

Recovery Assets

There were several recovery assets listed by the Monadnock Region. Community support groups, such as the River Center, Peterborough Peers, Catholic Charities, and NAR-ANON, among others, are available assets in the Monadnock Region.

Ancillary Recovery Supports Assets

The Monadnock Region listed several available ancillary recovery support assets in their region. Transitional residence and treatment centers are available for specific populations, including veterans, homeless population, women, and families. Southwestern Community Services was listed as also providing transitional housing and emergency shelter options for those in need. Food pantries, community kitchens, and the Salvation Army were listed as resources that can provide food, clothes, and other life necessities. Other recovery support assets included: transportation services, healthy start programs, Service Link and other resource centers.

Greater Nashua Region Public Health Network Assets Summary

Prevention Assets

Community organizations were the primary prevention assets listed by the Greater Nashua Region Public Health Network. Community programs such as, “Beyond influence,” and, “Community Action for Safe Teens,” were specifically noted as providing direct prevention services to the Amherst, Brookline, Hollis, Lyndeborough, Mason, Milford, Mont Vernon, and Wilton communities. Other prevention assets include: DEA Takeback Events, the Hudson Police Department, Milford Police Department, and the Nashua Police Department for their work in communities to provide emergency services, drug take back boxes, education, and referral for support services. The “Awareness is Healing,” walk was also noted as a prevention resource, as this is a community walk created to bring awareness to those affected by heroin.

Early Intervention Assets

Early intervention assets listed by the Greater Nashua Region PHN included emergency intervention services provided by AMR and local police departments, while also including Naloxone distribution opportunities. Other intervention assets include community organizations and community health centers, where early screening and brief intervention is available. Drug courts that serve as an 18 to 24 month drug rehabilitation program and are used as an alternative to incarceration in county jails or state prisons were also listed as available in the Greater Nashua Region PHN. Several treatment organizations and hospitals were identified as early intervention assets for screening and referral processes embedded in their primary care practices. ‘F.A.S.T.E.R.’ was also listed as a community intervention service that provides support groups for parents of children, teens, and young adults with substance use issues.

Treatment Assets

Hospital and treatment facilities were the primary assets listed for treatment in the Greater Nashua region. Organizations and treatment facilities, such as Harbor Homes, Merrimack River Medical Services, Southern New Hampshire Medical Center, and the Nashua Treatment Center, among others provide various treatment services to Nashua residents. Treatment options include medication-assisted treatment, inpatient treatment, and outpatient treatment to those in need of such services.

Recovery Assets

There were several recovery assets listed by the Greater Nashua Region PHN. Organizations such as Another Way, Compass Counseling, Recovery Together, Process Recovery, and others provide support groups, outpatient therapy, transitional housing opportunities, relapse prevention, and dual diagnosis services. New Futures was also listed as a recovery asset, which advocates for recovery services in the legislature and provides recovery training statewide.

Ancillary Recovery Supports Assets

There were several assets that overlapped as both recovery and ancillary recovery support assets in the Greater Nashua Region PHN. Community organizations like Another Way, Compass

Counseling and F.A.S.T.E.R were reported as providing ancillary recovery support assets, such as transportation, aftercare programs, anger management programs, and support groups.

North Country Region Assets Summary

Prevention Assets

The North Country Health Consortium is listed as the coordinating entity for the regional public health network in the North Country region. Prevention assets provided by the Health Consortium include prevention education, individual and group intervention, awareness and outreach activities, parent programs, coordination of regional network. The Health Consortium is also a partner with local schools to implement school-based programs like 'Project: Success.' Other school-based prevention assets available in North Country middle and high schools include: Life of an Athlete, Project AWARE, and Educational Learning Center (ELC). The Haverhill, Littleton and Berlin Police Departments were also listed as prevention and intervention assets for their prescription drug take back initiatives. Community recreation organizations were noted as prevention assets for the opportunities they provide to community members for safe and drug-free activities.

Early Intervention Assets

Student Assistance Programs (SAPs) were mentioned several times as early intervention assets in the North Country region. Other early intervention assets listed included many community-based organizations and health centers, such as Weeks Medical Center, Indian Stream Health Center, Upper Connecticut Valley Hospital, Ammonoosuc Community Health Services and others, which incorporate screening and brief interventions in their primary care services. Other intervention assets overlap with services provided by treatment centers in the North Country region.

Treatment Assets

Hospital and treatment facilities were the primary assets listed for treatment in the North Country region. Many of the hospitals and health centers in the region provide varying treatment services, such as inpatient treatment, outpatient treatment, and counseling. Other treatment facilities listed as assets included: Northern Human Services/ White Mountains Mental Health Services, R.O.A.D. To A Better Life, Tri Community Action Program (CAP), and Connecticut River Services, among others. Prisons were also noted as treatment assets, as there are several county treatment programs that work with non-violent offenders to get time off of sentence for participation in treatment.

Recovery Assets

Recovery assets reported in the North Country region include support groups, such as Narcotics Anonymous, Alcoholics Anonymous, HOPE for NH Recovery, and North Country Serenity Center. Other recovery assets reported were in conjunction with treatment services provided by hospitals and community health centers identified as treatment assets.

Ancillary Recovery Supports Assets

Tri Country CAP Friendship House was listed as an ancillary recovery supports asset, as they provide Short-term residential, transitional living, peer recovery support services to North Country residents in need of these services. Other ancillary recovery supports assets reported

include Narcotics Anonymous and Alcoholics Anonymous meetings, as well as The Haven Peer Support Center and North Country Serenity Center, both of which provide peer recovery support services.

Seacoast Public Health Network Assets Summary

Prevention Assets

The Seacoast Public Health Network was listed as a prevention asset providing network development, technical assistance with community coalition development, information and referral, education, advocacy, and naloxone distribution to twenty-three towns in the seacoast region. Other prevention assets listed included several drug free coalition grantees, community coalitions, and school-based initiative in the region. The Raymond Coalition for Youth and SoRockNH are drug free coalition grantees who implement prevention messages and strategies throughout the Raymond, Fremont, Kingston, Sandown communities. Health service delivery sites, such as VNAs and community health centers in the region were listed as providing prevention services through Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Local schools were also listed as assets for programs they have implemented, including Life of an Athlete and Project Safety.

Early Intervention Assets

Families First Health and Support Center and their VNA program were listed as early intervention assets in the Seacoast Public Health Network for their screening and identification efforts through SBIRT implementation.

Treatment Assets

Hospital and treatment facilities were the primary assets listed for treatment in the Seacoast Public Health Network. Many of the hospitals and health centers in the region provide varying treatment services, such as substance use disorder assessments and evaluations, inpatient treatment, outpatient treatment, medically supervised detoxification, medication-assisted treatment, and counseling. Hospitals, health centers, and treatment facilities that provide such services include: Addiction Recovery Services, Endurance Behavioral Health, Families First Health and Support Center and Lamprey Health Care. Portsmouth Hospital provides medically supervised detoxification; and therapeutic inpatient treatment. Seacoast Mental Health Center, Inc. provides mental health counseling, referral education assistance, home & community-based counseling, and education for substance misuse. Other treatment facilities listed as assets included: Seacoast Youth Services, ROAD to a Better Life, and One Sky Community Services, among others. Rockingham Superior Court was also noted as treatment assets, as it provides a treatment program that works with non-violent offenders to get time off of sentence for participation in treatment.

Recovery Assets

Recovery assets reported in the Seacoast region overlapped with many treatment assets in the region, as recovery services are provided in conjunction with treatment services. Assets already listed include: Families First Health and Support Center, ROAD to a Better Life, Portsmouth Hospital, and Seacoast Mental Health Center, Inc. Other recovery assets reported were Safe Harbor Recovery Center and FEDCAP, which are organizations that provide peer recovery centers and peer recovery coach training in the Seacoast region. Alcoholics Anonymous, Heroin Anonymous, and Narcotics Anonymous meetings are included as treatment assets in the

Seacoast, Seabrook, and Newmarket areas. The organization, F.A.S.T.E.R. was listed as providing family support groups.

Ancillary Recovery Supports Assets

Zebra Crossings was listed as an ancillary recovery supports asset in the Greater Seacoast area, as they provide family support and advocacy for children with chronic health conditions in seacoast region. Other ancillary recovery supports assets reported include Narcotics Anonymous and Alcoholics Anonymous meetings, as well as Families First Health and Support Center and One Sky Community Services , both of which provide mental health counseling and peer recovery support services.

South Central Public Health Network Assets Summary

Prevention Assets

The South Central Public Health Network listed school districts, youth organizations, and community organizations as the primary prevention assets in the region. Schools in Derry, Londonderry, Windham, Salem, Chester, and the SAU 55 school district were identified for their youth education programs around alcohol and other drug use. Derry and Salem have youth organizations that provide opportunities for organized children's activities in the community. Community organizations, such as Community Alliance for Teen Safety, the Southern Rockingham Coalition for Healthy Youth, Stand Up Salem, and the Upper Room were all listed as prevention assets.

Early Intervention Assets

The main intervention assets identified in the South Central Public Health Network were hospitals and community health centers in the region. Derry Medical Center and Parkland Medical Center were specifically identified for their substance use disorder screening and identification efforts through SBIRT implementation.

Treatment & Recovery Assets

Hospital, treatment facilities, and individual providers were the primary assets listed for both treatment and recovery in the South Central Public Health Network. Many of the hospitals and health centers in the region provide varying treatment services, such as substance use disorder assessments and evaluations, group and individual therapy, inpatient treatment, outpatient treatment, medication-assisted treatment, and counseling. The recovery services and assets are reported as being provided in conjunction with treatment services.

Ancillary Recovery Supports Assets

Granite House was listed as an ancillary recovery supports asset in Derry, as they provide Sober living, group and individual therapy, and job assistance to individuals in recovery. Hampstead Hospital was also reported as having sober living opportunities for individuals in recovery. Several churches and community centers provide opportunities for individuals in recovery to participate in 12 step recovery programs and engage in peer recovery support services.

Strafford County Public Health Network Assets Summary

Prevention Assets

The Strafford County Public Health Network listed school programs, and drug free coalitions, and community organizations as the primary prevention assets in the region. Rochester schools are the recipient of a “Safe schools/healthy student” grant, which provides funding for early supports, prevention, and early intervention for grades 8-9. There are also social workers working in Rochester, Farmington Somersworth, Durham, and Milton schools to lead student groups and provide referrals to resources outside of the school, as appropriate. Rochester, Somersworth, and Dover all have active drug free coalition grantees in their area, that are providing substance misuse prevention messaging and initiatives at the community level. Community organizations, such as the Strafford County Prevention Board, were all listed as prevention assets that provide networking opportunities for educators and community based programs to coordinate prevention and intervention efforts.

Early Intervention Assets

Several early intervention assets were reported as available in the Strafford County region. Social workers in schools and in primary care were reported as assets for coordinating “warm handoffs” for patients identified as “at-risk.” Hospitals and health centers in Strafford County provide early identification through Screening, Brief Intervention, and Referral to Treatment protocols. These hospitals, in conjunction with regional EMS services, are also able to act in emergency situations with access to naloxone. Community-based organizations, such as NH Employment Program, REAP, and CAP home visiting, provide referrals to SUD counseling and early intervention services for families at risk in Strafford County.

Treatment Assets

Hospital, treatment facilities, and individual providers were the primary assets listed for both treatment and recovery in the Strafford County Public Health Network. Many of the hospitals and health centers in the region provide varying treatment services, such as substance use disorder assessments and evaluations, group and individual therapy, inpatient treatment, outpatient treatment, medication-assisted treatment, and counseling. Court and Law enforcement were also highlighted for their treatment assets, with programs such as the Strafford County Drug Court and the Therapeutic Community at Strafford County jail. These programs provide high level interventions, as well as treatment for incarcerated individuals.

Recovery Assets

Several recovery centers were identified as assets in the Strafford County Public Health Network. Bonfire was identified as an organization that provides sober living for males for up to twelve months. Alcoholics Anonymous, Narcotics Anonymous, and Heroin Anonymous are available in multiple locations throughout Strafford County, and offer a 12 step program along with peer recovery support. Families Hoping and Coping and Circle of Hope were identified as support groups for families and allies suffering with a loved one who is addicted. Several MLADCS were also reported as providing Addiction Recovery Services and IOP alumni groups in Portsmouth.

Ancillary Recovery Supports Assets

Tri City Co-Op was listed as an ancillary recovery supports asset in the Rochester and greater Strafford County areas, as they provide mental health peer to peer support to individuals in recovery. Hampstead Hospital was also reported as having sober living opportunities for individuals in recovery. Other recovery assets reported previously, including AA, NA, HA, and family & ally supports, can also be considered ancillary recovery support assets.

Sullivan County Public Health Network Assets Summary

Prevention Assets

The Sullivan County Public Health Network listed school prevention programs as the primary prevention asset in the region. The Newport School District has implemented several prevention programs, including Student Assistance Professional (SAP) and RENEW with West Central Behavioral Health.

Early Intervention Assets

The main intervention assets identified in the Sullivan County Public Health Network were hospitals and community health centers in the region. Valley Regional Hospital, Newport Health Clinic, and New London Hospital were reported as early intervention assets for their substance use disorder screening and identification efforts through SBIRT implementation.

Treatment Assets

Regional hospitals, treatment facilities, and individual providers were the primary assets listed as treatment assets in Sullivan County Public Health Network. West Central Behavioral Health was identified as providing Assertive Crises Team (ACT), ENT intensive Mental Health services, 20-person Mental Health Temporary Housing, one part time LADC to work with ACT team and TRAILS services in Sullivan and Grafton County.

Recovery Assets

Regional hospitals and treatment facilities were identified as primary recovery assets in the Sullivan County Public Health Network. HOPE Recovery Center in Newport, Celebrate Recovery, FASTER Peer Support, and Keady Family Practice provide peer recovery support services for individuals and families, as well as wellness programming. TLC Family Service Center provides recovery support to pregnant and parenting young families for positive development.

Ancillary Recovery Supports Assets

Many of the ancillary recovery supports assets reported by Sullivan County Public Health Network overlap with the recovery assets listed. Stepping Stones, Tranquility House and HOPE Recovery centers in Claremont and Newport provide services such as sober living, transitional housing support, and peer recovery supports. TRAILS Corrections Rehabilitation and Reentry Program in Sullivan County provides mental & behavioral health supports, parenting programs, and SUD support for the corrections population. Alcoholics Anonymous programs were also reported as ancillary recovery supports assets available in Newport, Claremont, New London and the greater Sullivan County Region.

Upper Valley Public Health Network Assets Summary

Prevention Assets

The Upper Valley Public Health Network listed schools, law enforcement, as health care providers as the primary prevention asset in the region. Middle schools, high schools, and colleges were reported as having prevention messages and education programs integrated in their system, with programs such as Student Assistance Counselors and Life of an Athlete. Law enforcement, fire departments, and EMTs throughout the region were identified as both prevention and early intervention assets, due to their involvement in prevention messaging, naloxone distribution, and response to emergency situations. Individual health care providers and larger health organizations in the region were also identified as prevention assets.

Early Intervention Assets

As noted above, law enforcement, fire departments and EMTs were also identified as early intervention assets, due to their response to emergency situations and their activities around addressing alcohol and drug misuse in Upper Valley communities. Other intervention assets identified in the Upper Valley Public Health Network were hospitals and community health centers, through their efforts to implement substance use disorder screening and identification efforts by incorporating Screening, Brief Intervention, and Referral to Treatment in their practices. Notable health care organizations and providers listed were Dartmouth Hitchcock services in primary care, OB/GYN, and pediatrics.

Treatment Assets

Regional hospitals, treatment facilities, and individual providers were the primary assets listed as treatment assets in Upper Valley Public Health Network. Treatment services offered include social detoxification, IOP, medication assisted treatment, mental health services, residential treatment, and outpatient counseling, among others. Treatment services are available to various populations, such as pregnant women, young adults, and pediatric populations.

Recovery Assets

Regional hospitals, treatment facilities, and community recovery centers were identified as primary recovery assets in the Upper Valley Public Health Network. Turning Point Recovery Centers, West Central Behavioral Health, Farnum Center, Friendship House, Plymouth House, ROAD to a Better Life, and Recovery Together provide peer recovery support services for individuals and families, as well as wellness programming.

Ancillary Recovery Supports Assets

Many of the ancillary recovery supports assets reported by Upper Valley Public Health Network overlap with the recovery assets listed. Friendship House, Headrest, HIS Mansion, and the Haven provide services such as sober living, transitional housing support, and peer recovery supports. Wits for Parents provides peer support for parents with children who are using drugs. Narcotics Anonymous and Cocaine Anonymous programs were also reported as ancillary recovery supports assets available in the Upper Valley Region.

Winnepesaukee Region Public Health Network Assets Summary

Prevention Assets

The Winnepesaukee Public Health Network listed schools, law enforcement, and the regional Substance Misuse Prevention Coordinator as the primary prevention asset in the region. Middle schools, high schools, and colleges were reported as having prevention messages and education programs integrated in their system, with programs such as Student Assistance Programs in two high schools and Life of an Athlete in four high schools. Law enforcement and fire departments in the region were also identified as both prevention and early intervention assets, due to their involvement in reducing access to prescription drugs through “Lock it Up” campaign, prescription drug “Take Back” days, and secure prescription drop boxes. The Substance Misuse Prevention (SMP) Coordinator was also identified as a prevention asset, as they provide technical assistance to four community coalitions in the region.

Early Intervention Assets

Health care organizations providing assessments to Winnepesaukee residents were identified as early intervention assets for the region. Horizons Counseling Center provides assessment and counseling services for the Winnepesaukee residents in need. HealthFirst Family Care Center has implemented substance use disorder screening and identification by incorporating Screening, Brief Intervention, and Referral to Treatment in their practice. HealthFirst is also helping other LRGHealthcare affiliates implement this in their practice, allowing for expansion throughout the region. As noted above, law enforcement, fire departments and EMTs were also identified as early intervention assets, due to their response to emergency situations and their activities around addressing alcohol and drug misuse in Winnepesaukee communities through programs like “Prevention, Enforcement and Treatment (PET)” a local program implemented by the Laconia Police Department. Other law enforcement and corrections programs include Corrections Opportunity for Recovery & Education (CORE) and specialty court programs for non-violent offenders.

Treatment Assets

Regional hospitals, treatment facilities, and individual providers were the primary assets listed as treatment assets in Winnepesaukee Public Health Network. Treatment services offered include emergency withdrawal treatment, methadone clinics, outpatient treatment, inpatient treatment, and medication assisted treatment. Treatment services are available to various populations, such as women only, men only, young adults, and veterans.

Recovery Assets

Recovery houses, community recovery centers, and recovery coaches were identified as primary recovery assets in the Winnepesaukee Public Health Network. The region reported experiencing an increase capacity in recovery houses, particularly increasing access for young men. Specifically, Riverbank in Laconia has 20 beds for young men age 18-25. While no recovery centers currently exist in the Winnepesaukee region, there is an active recovery planning group that is spearheading the development of recovery centers in the region, and is coordinating

efforts with pending statewide funding for recovery centers. Two certified recovery social workers were reported as available in the Winnepesauke region.

Ancillary Recovery Supports Assets

No specific ancillary recovery supports assets were reported by the Winnepesauke Public Health Network.