



**FFY 2020 Evaluation Report**

February 2021

******

Table of Contents

[Introduction 1](#_Toc64988238)

[Evaluation Questions 3](#_Toc64988239)

[Data Sources 4](#_Toc64988240)

[Process and Implementation 4](#_Toc64988241)

[Training Satisfaction 4](#_Toc64988242)

[Client-Level 4](#_Toc64988243)

[Site-Level 5](#_Toc64988244)

[Pilot Site Staff Roster 5](#_Toc64988245)

[Pilot Site Interviews 5](#_Toc64988246)

[State- and Sub-State-Level 5](#_Toc64988247)

[Process and Implementation Progress 7](#_Toc64988248)

[Core Activities 7](#_Toc64988249)

[Interagency Council and Its Subcommittees 8](#_Toc64988250)

[Interagency Council Member Survey 8](#_Toc64988251)

[Subcommittees and Workgroups 10](#_Toc64988252)

[Pilot Sites 11](#_Toc64988253)

[Greater Nashua Mental Health Center 11](#_Toc64988254)

[Granite Pathways 12](#_Toc64988255)

[Implementation Progress and Fidelity 12](#_Toc64988256)

[Training Satisfaction 13](#_Toc64988257)

[Client-Level Analysis Results 15](#_Toc64988258)

[Client Characteristics 15](#_Toc64988259)

[Planned Services 19](#_Toc64988260)

[Preliminary Outcome Analysis 22](#_Toc64988261)

[Sub-State-Level Analysis Results 26](#_Toc64988262)

[State-Level Analysis Results 30](#_Toc64988263)

[Substance Use 31](#_Toc64988264)

[Mental Health 35](#_Toc64988265)

[Drug- and Alcohol-Related Crime 38](#_Toc64988266)

[Opioid-Related Deaths 38](#_Toc64988267)

[Discussion 39](#_Toc64988268)

List of Exhibits

[Exhibit 1. Overview: Activities tracked 7](#_Toc64988269)

[Exhibit 2. Activity monitoring measures 7](#_Toc64988270)

[Exhibit 3. Planning assessment measures 8](#_Toc64988271)

[Exhibit 4. Evidence-based trainings received by GNMHC staff members 11](#_Toc64988272)

[Exhibit 5. Evidence-based training received by GP staff members 12](#_Toc64988273)

[Exhibit 6. Cumulative enrollment/intake interviews 15](#_Toc64988274)

[Exhibit 7. Interview type 15](#_Toc64988275)

[Exhibit 8a. Characteristics of clients served 16](#_Toc64988276)

[Exhibit 8b. Percentage of enrollments by race/ethnicity among New Hampshire public schools and CC-NH 17](#_Toc64988277)

[Exhibit 8c. Percentage of enrollments by sexual orientation among New Hampshire high school students and CC-NH 17](#_Toc64988278)

[Exhibit 9. Primary diagnosis 18](#_Toc64988279)

[Exhibit 10. Housing, education, and employment status 18](#_Toc64988280)

[Exhibit 11. Geographic distribution of program participants, by zip code area 19](#_Toc64988281)

[Exhibit 12. Planned Services – Modality 20](#_Toc64988282)

[Exhibit 13. Planned Services – Treatment Services 20](#_Toc64988283)

[Exhibit 14. Planned Services – Case Management Services 21](#_Toc64988284)

[Exhibit 15. Planned Services – Medical Services 21](#_Toc64988285)

[Exhibit 16. Planned Services – After Care Services 21](#_Toc64988286)

[Exhibit 17. Planned Services – Education Services 22](#_Toc64988287)

[Exhibit 18. Planned Services – Peer-to-Peer Recovery Services 22](#_Toc64988288)

[Exhibit 19. Average days of substance use during the past 30 days 23](#_Toc64988289)

[Exhibit 20. Average days of mental health symptoms during the past 30 days 24](#_Toc64988290)

[Exhibit 21. Days impact of alcohol or drug use during the past 30 days 24](#_Toc64988291)

[Exhibit 22. Percentage of program participants reporting their overall health is excellent, very good, or good 25](#_Toc64988292)

[Exhibit 23. Percentage of program participants reporting their quality of life is good or very good 25](#_Toc64988293)

[Exhibit 24. Percentage of program participants reporting they are satisfied or very satisfied with themselves 25](#_Toc64988294)

[Exhibit 25. Percentage of program participants having interaction with family and/or friends that are supportive of their recovery in the past 30 days 26](#_Toc64988295)

[Exhibit 26. Percentage of students who had at least one drink of alcohol during the past 30 days 27](#_Toc64988296)

[Exhibit 27. Percentage of students who binged\* on alcohol during the past 30 days 27](#_Toc64988297)

[Exhibit 28. Percentage of students who perceive slight or no risk from binge drinking 27](#_Toc64988298)

[Exhibit 29. Percentage of students who disapprove or strongly disapprove of alcohol use 28](#_Toc64988299)

[Exhibit 30. Percentage of students who used marijuana at least once during the past 30 days 28](#_Toc64988300)

[Exhibit 31. Percentage of students who perceive slight or no risk from marijuana use 28](#_Toc64988301)

[Exhibit 32. Percentage of students who used electronic vaping products in the past 30 days 29](#_Toc64988302)

[Exhibit 33. Percentage of students who took a prescription drug without a doctor’s prescription at least once during the past 30 days 29](#_Toc64988303)

[Exhibit 34. Percentage of students who felt sad or hopeless every day for 2 weeks in a row during the past 12 months 29](#_Toc64988304)

[Exhibit 35. Percentage of students who did something to purposely hurt themselves without wanting to die during the past 12 months 30](#_Toc64988305)

[Exhibit 36. Percentage of students who seriously considered attempting suicide during the past 12 months 30](#_Toc64988306)

[Exhibit 37. Percentage of youth aged 12 to 20 reporting alcohol use in the past month 31](#_Toc64988307)

[Exhibit 38. Percentage of youth ages 12 to 20 reporting binge alcohol use in the past month 31](#_Toc64988308)

[Exhibit 39. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Gender 31](#_Toc64988309)

[Exhibit 40. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Age 32](#_Toc64988310)

[Exhibit 41. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Race/Ethnicity 32](#_Toc64988311)

[Exhibit 42. Percentage reporting marijuana use in the past month among youth ages 12-17 32](#_Toc64988312)

[Exhibit 43. Percentage reporting marijuana use in past month among individuals ages 18-25 33](#_Toc64988313)

[Exhibit 44. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Gender 33](#_Toc64988314)

[Exhibit 45. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Age 33](#_Toc64988315)

[Exhibit 46. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Race/Ethnicity 34](#_Toc64988316)

[Exhibit 47. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Gender 34](#_Toc64988317)

[Exhibit 48. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Age 34](#_Toc64988318)

[Exhibit 49. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Race/Ethnicity 35](#_Toc64988319)

[Exhibit 50. Percentage reporting mental illness in past year among individuals ages 18-25 35](#_Toc64988320)

[Exhibit 51. Percentage reporting major depressive episode in the past year among youth ages 12-17 35](#_Toc64988321)

[Exhibit 52. Percentage reporting major depressive episode in the past year among individuals ages 18-25 36](#_Toc64988322)

[Exhibit 53. Percentage who had serious thoughts of suicide among individuals ages 18-25 36](#_Toc64988323)

[Exhibit 54. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Gender 36](#_Toc64988324)

[Exhibit 55. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Age 37](#_Toc64988325)

[Exhibit 56. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Race/Ethnicity 37](#_Toc64988326)

[Exhibit 57. Crude suicide death rates per 100,000, by age group: 2014-2018 37](#_Toc64988327)

[Exhibit 58. Percentage of total arrests that are alcohol- or drug-related among youth under 18 38](#_Toc64988328)

[Exhibit 59. Opioid-Related Deaths 38](#_Toc64988329)

# Introduction

The *Creating Connections – NH* (CC-NH) initiative is funded through a Cooperative Agreement between the New Hampshire Department of Health and Human Services (NH DHHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Adolescent and Transitional Aged Youth Treatment Implementation (SYT-I) grant program. In accordance with the requirements of the grant, awarded in 2017, CC-NH seeks to strengthen statewide substance use disorder (SUD) treatment infrastructure and to increase access to integrated evidence-based assessments, treatment models, and recovery services and supports to youth ages 12-25 with SUD and/or co-occurring SUD and mental health disorders (SUD/COD) and their families throughout the state. The Department’s specific population of focus is youth of color and lesbian, gay, bisexual, and transgender (LGBT) youth.

Evidence-based practices implemented include:

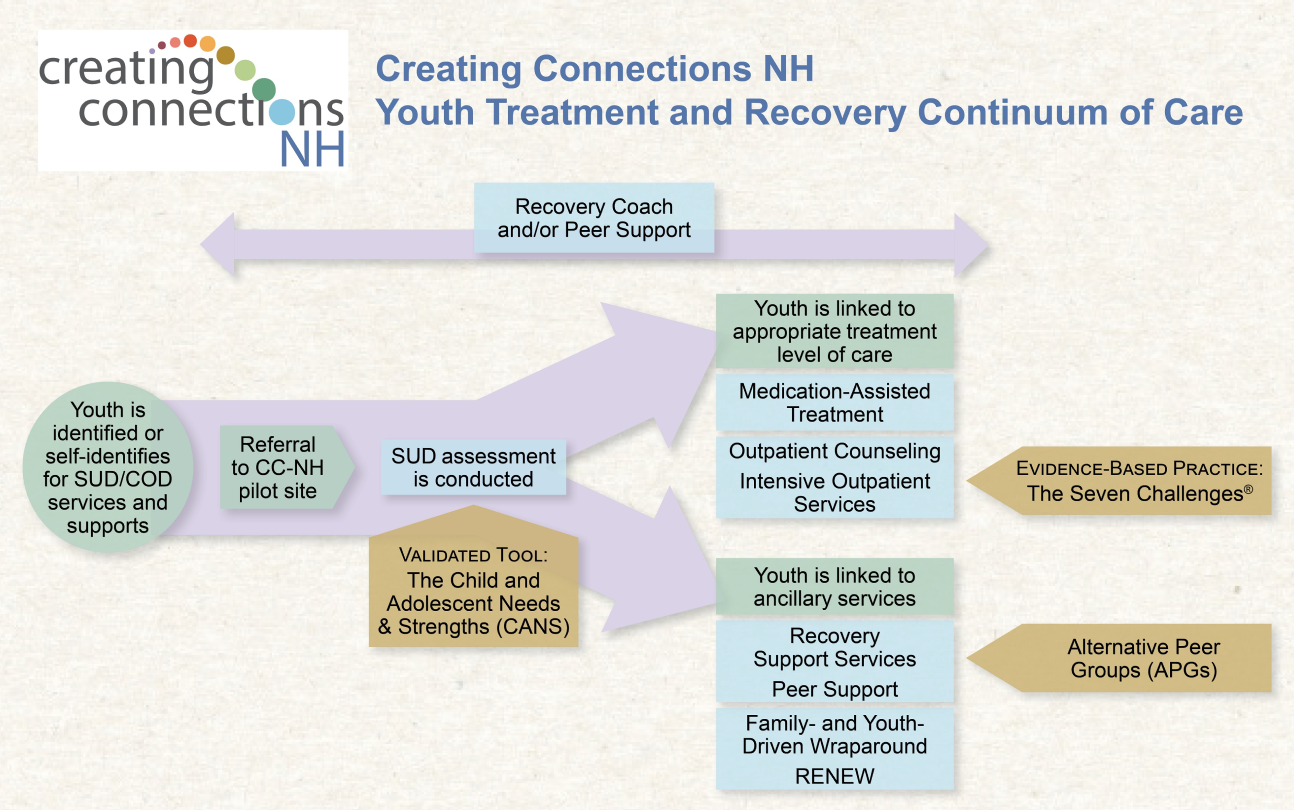
* Child and Adolescent Needs and Strengths (CANS) Assessment or Adult Needs and Strengths Assessment (ANSA), depending on the client’s age
* *The Seven Challenges*
* Medication-assisted treatment (MAT)

Two pilot sites, Greater Nashua Mental Health and Granite Pathways, were awarded the SYT-I Provider Site contract in 2019 and began implementing *The Seven Challenges* on August 1, 2019. Granite Pathways relinquished the SYT-I Provider Site contract on July 31, 2020 due to unexpected changes in its organizational and management structure and associated challenges in program implementation. NH DHHS is in the process of selecting replacement sites.

The CC-NH model of care for adolescents and transitional-age youth with SUD or SUD/COD, implemented solely by Greater Nashua Mental Health at the time of writing, is summarized in the flowchart on the following page.

The Human Services Research Institute (HSRI) has a contract with NH DHHS to evaluate the implementation of the SYT-I grant. The purpose of this annual report is to provide an update on the evaluation and summarize data collected during the grant period in order to inform NH DHHS and members of the Interagency Council (IAC) on the progress of the initiative as well as any barriers encountered by the initiative.

This report summarizes the progress made during the period covering **January 1, 2019 through December 31, 2019**.



# Evaluation Questions

The evaluation of the implementation of the SYT-I grant is framed by the following questions:

* To what extent are the goals and objectives of the strategic plan and associated workplans being met?
  + Which action items are delayed and why?
  + What changes are made to the strategic plan and why?
* What is the program’s impact on workforce development?
  + How many practitioners were trained in evidence-based programs and practices?
  + What was the level of satisfaction with workforce trainings?
  + How many new practitioners were hired?
  + How many existing practitioners obtained new certification/accreditation?
* Are the structure and activities of the Interagency Council (IAC) in line with grant requirements and the strategic plan?
  + Which stakeholder groups are represented in the IAC?
  + What is the level of engagement of IAC members?
  + How do members assess the effectiveness of the IAC?
* What are the program’s outputs?
  + How many youth are served and what are their intake diagnoses and sociodemographic characteristics?
  + What services are planned and provided to youth enrolled in the program?
  + Are evidence-based assessments implemented consistently?
  + Is *The Seven Challenges* implemented consistently and with fidelity?
* What is the impact of the program on participating youth as measured by differences between intake and follow-up survey responses?
  + Are there improvements in assessment scores?
  + Are there reductions in substance use and mental health disorder symptoms?
  + Are there improvements in social determinants of mental health, such as the quality housing, relationships, overall wellbeing?
  + To what extent is the treatment plan implemented?
* What are the program-level factors associated with outcomes for youth (e.g., fidelity, staffing)?
* What are individual-level factors associated with outcomes (e.g., sociodemographic characteristics)?
* What are the state-level impacts of the initiative, including on health disparities within the population of focus?

Each evaluation report addresses a subset of the above questions—depending on data availability and the anticipated pace of change; however, all questions will be addressed by at least one report by the end of the grant period.

# Data Sources

## Process and Implementation

An activity tracker was created in 2018 to monitor and assess the progress of activities related to CC-NH goals. The database contains information on each activity including the person or group the activity was assigned to, the date it was introduced, the date it was completed, and the status of the activity (not started, underway, on time, completed, or delayed). The database also provides a qualitative summary of the activities based on measures of interest that can be used to identify barriers to activity completion. The following information is summarized in the activity tracker:

* Total number of activities and total number of activities by current status
* Percent of activities assigned to a person, percent that are clearly operationalized, and percent with a completion date
* Percent of activities that are completed, percent completed or on time, and percent delayed

## Training Satisfaction

A training satisfaction survey was drafted in 2018 and has been administered at all CC-NH-related trainings. An accompanying database was also created to house the collected data. The instrument was piloted by the IAC and revised based on the results of the pilot. Training satisfaction surveys provide the following information:

* Total number of training and technical assistance events provided to workforce professionals (including peer support specialists)
* Total number of workforce professionals trained, by practitioner category and topic
* Satisfaction outcomes for training and technical assistance events
* Issues and recommendations for improvement reported by the participants

## Client-Level

The SAMHSA/CSAT GPRA instrument was updated in 2019 based on feedback from NH DHHS, the IAC, and the Workforce Development Workgroup. The two original provider sites were trained on data collection by the evaluation team in June 2019 and began enrolling participants in August 2019. A secure file-share system was set up and is used to transfer data from the provider sites to the evaluation team. The evaluation team uploads the GPRA participant-level data to SAMHSA’s Performance Accountability and Reporting System (SPARS) as they are received from the pilot sites. Non-GPRA participant-level data (additional data collected on the instrument but not required by SAMHSA/CSAT) are entered into an SPSS dataset template and then merged with the GPRA data. Data on client characteristics is updated every month (or in response to ad hoc queries) to assist the pilot sites in meeting their reporting requirements. The SAMHSA/CSAT instrument provides the following information:

* Total number of clients served, by demographics, intervention, and level of care
* Type and level of services delivered
* Retention rates
* Client-level change in knowledge, attitudes, behaviors, and community integration between intake and 6-month follow-up (or discharge, whichever comes last)
* Sustainability of treatment effects

## Site-Level

### Pilot Site Staff Roster

A staff roster template was finalized in 2019, incorporating feedback from NH DHHS and the IAC. The roster collects information about all staff members associated with CC-NH in the pilot sites, including their training, certification/licensure, and the services they provide. The staff roster was administered to pilot sites in October 2019 to collect baseline data on their staff. The evaluation team will repeat the data collection at the close of the grant period to assess workforce development efforts of the pilot sites.

### Pilot Site Interviews

A pilot site interview guide was also finalized in 2019 following feedback from NH DHHS and the IAC. The interview guide framed semi-structured interviews with pilot sites to collect information on their structure and operations at baseline. Baseline interviews took place in October and December of 2019. The interviews will be repeated at the end of the pilot sites’ implementation to assess system changes in the pilot sites.

### State- and Sub-State-Level

Secondary data and archival data sources are used to examine the state- and sub-state-level impact of CC-NH by recording state-level trends for the target population. The state-level measures are presented as time series. It is not expected that implementation will have a noticeable impact on state-level prevalence rates right away, but we do monitor local data sources for any changes. Although such changes cannot be fully attributed to the CC-NH initiative, this time-series analysis will provide a useful context for evaluating the initiative. Data are collected annually from the following data sources:

* The New Hampshire Office of the Chief Medical Examiner
* The Federal Bureau of Investigation’s (FBI) Uniform Crime Reporting Program (UCR)
* The National Survey on Drug Use and Health (NSDUH)
* The New Hampshire Youth Risk Behavior Survey (NH YRBS)
* U.S. Census Bureau
* New Hampshire Department of Health & Human Services
* New Hampshire Department of Education
* Worldwide Refugee Admissions Processing Data System

Data from these sources are consolidated in a state-level database that are updated as new data become available.

# Process and Implementation Progress

## Core Activities

The measures in this section are used to monitor the initiative’s core activities and assess the quality of the planning process. The exhibits provide a timeline of activity tracking metrics. Exhibit 1 provides an overall summary of the core activities tracked from project start through the latest quarter.

Exhibit 1. Overview: Activities tracked

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | As of 12/31/2019 | As of 6/30/2020 | As of 9/30/2020 | As of 12/31/2020 |
| Total number tracked | 83 | 113 | 119 | 124 |
| Number not yet started | 10 | 7 | 4 | 6 |
| Number completed | 54 | 72 | 78 | 80 |
| Number delayed | 4 | 4 | 2 | 2 |
| Number ongoing & on time | 15 | 26 | 32 | 36 |

Exhibit 2 summarizes progress monitoring measures and shows that progress was made on all three: the two completion rates steadily increased and the rate of delays decreased throughout the tracking period. Please note that these measures assign equal importance to all activities whereas some are more critical than others. Therefore, the numbers should be used for monitoring only and not for performance assessment. The first measure (% completed) slightly decreased since the end of 2019, primarily due to the introduction of new and currently ongoing activities associated with standing up the New Hampshire Alternative Peer Group Model. The second (% completed or on time) and third (% delayed) improved steadily throughout 2020.

Exhibit 2. Activity monitoring measures

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | As of 12/31/2019 | As of 6/30/2020 | As of 9/30/2020 | As of 12/31/2020 |
| % of started activities that are completed | 74.0% | 67.9% | 69.6% | 67.8% |
| % of started activities that are either completed or on time (activities with known completion date only) | 94.3% | 96.1% | 98.1% | 98.3% |
| % of started activities that are delayed (activities with known completion date only) | 5.7% | 3.9% | 1.9% | 1.7% |

Exhibit 3 shows the change in three measures of planning quality. The first two that measure clarity of operationalization and task assignment were already at a ceiling (maximum score=100%) with not much room for improvement. The third, measuring timeline specificity, increased from 88.0% at the end of 2019 to 96.8% by the end of 2020, a 12% improvement.

Exhibit 3. Planning assessment measures

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | As of 12/31/2019 | As of 6/30/2020 | As of 9/30/2020 | As of 12/31/2020 |
| % of activities assigned to a specific person or group | 98.8% | 99.1% | 99.2% | 99.2% |
| % activities that are clearly operationalized | 98.8% | 99.1% | 99.2% | 99.2% |
| % activities with completion dates specified | 88.0% | 96.5% | 96.6% | 96.8% |

## Interagency Council and Its Subcommittees

Initially IAC meetings were held monthly in 2018, but meeting frequency changed to every other month beginning in 2019. Additionally, meetings were moved from the first Thursday of every other month from 1-3 pm to the first Tuesday of every other month from 2-4 pm starting in April 2020 to allow greater flexibility for youth to attend.

In July 2019, NH DHHS established a Children’s System of Care (CSoC) Advisory Council to oversee the multiple initiatives focusing on behavioral healthcare for children, youth, and young adults. The IAC now operates as a sub-council within this umbrella organization and continues to act as the governing body for the CC-NH initiative, in coordination with this broader state initiative. The CSoC Advisory Council meets every other month with CC-NH IAC business incorporated into its agenda. CSoC meetings were held in July, September, and November 2019 and in January, May, July, September, and November 2020. The March 2020 meeting was cancelled due to competing priorities and scheduling logistics. During the months that do not have a CSoC meeting, the IAC meets on its own. IAC meetings were held monthly in 2018 and in January, March, May, August, and December 2019 and February, April, June, August, October, and December 2020. Starting in July and August 2019, program directors and service providers from the two pilot sites also began attending CSoC and IAC meetings, respectively.

### Interagency Council Member Survey

An online IAC member survey was administered in June 2019. Council members were informed in advance of the upcoming survey effort and received links to the instrument via email. A reminder email was sent to all IAC members one week prior to the close of the survey. While 43 IAC members were sent a link to the survey, only 11 members responded, resulting in a response rate of 25.6%. Survey responses were extracted and analyzed in Excel.

#### Member Characteristics

Among the 11 IAC members who responded to the survey:

* 78% were female, out of 9 members who provided information on gender;
* all but one of the members who provided information on race identified as white; one member identified as Hispanic or Latino;
* 91% were age 35 or older, 9% (one member) was between the age of 25 and 34; and
* 64% had a graduate degree; the remaining 36% had a bachelor’s degree or some college.

Almost half of respondents (48%) of the survey were members of the CC-NH management team. Due to this and the low survey response rate, results of the survey may not be generalizable to the entire council. One reason the response rate might have been low is that the survey was administered before the pilot sites had started implementation. We expect the next survey of the council to have more respondents including staff from the pilot sites.

Survey respondents represented the following service systems:

* Education
* Criminal/juvenile justice
* Substance use disorder (prevention and/or treatment)
* Wraparound provider
* Care Management Entity
* LGBTQ+ education, advocacy, and support
* Policy & Advocacy organization

Missing from the council were representatives from the State Medicaid agency and the mental health, child welfare, labor/employment, and housing sectors. While 73% of members thought that the council was representative of the varied groups/citizens of the community, some members thought the youth and family voice could be stronger, including youth and families from a broader range of racial and ethnic groups, from LGBTQ populations, and those who are new Americans. Some members thought law enforcement/emergency responders and SUD treatment organizations serving youth were also missing from the council.

Only two respondents (18%) indicated that they were a youth or family member representative. Sixty-four percent of members did not think there was sufficient input from youth service users and their families in the planning process. The issue of the lack of involvement from youth and families was also raised when IAC members were asked about the challenges to CC-NH. Four of seven respondents thought that the IAC could be improved by getting more input from youth and families. Multiple council members thought more recruitment and outreach to youth and families was needed, while others suggested offering financial compensation or paying mileage for meeting attendance, alternating meeting times, or ensuring access to video conferencing would improve efforts to involve youth and their families.

During the year and a half following this baseline survey, the CC-NH management team made efforts to increase youth participation and to reach out to the underrepresented sectors to garner their involvement in the program.

Sixty-four percent of respondents were involved in other councils or workgroups in NH that focus on behavioral health systems integration or services for adolescents and transitional age youth. These include:

* NH Children's Behavioral Health Collaborative (including the policy, workforce, and peer support workgroup)
* Wraparound
* Behavioral Health Equity Workgroup
* Youth Suicide Prevention Assembly
* Integrated Team for Bureau of Developmental Services
* Community Mental Health Center Children's Directors
* DCYF Case Transition Workgroup
* Anti-Human Trafficking Workgroup
* NH State Rehab Council
* System of Care
* Integrated Delivery Network
* Small group CME
* Large group CME

### Subcommittees and Workgroups

There are three IAC subcommittees: the Workforce Development Workgroup (WDW), the Peer-to-Peer Workgroup, and the Policy Workgroup. The WDW oversees all workforce development and implementation activities of the CC-NH project. The WDW has engaged with *The Seven Challenges* developer, organized provider and leader trainings in implementing the EBP, trained the pilot sites in CANS and ANSA assessment, established a Community of Practice (CoP) for pilot sites, and facilitated CoP meetings. The WDW has also contacted area colleges and universities to identify degree programs and other training resources relevant to the project and is working with a university to expand the range of training resources available to area providers.

The Peer-to-Peer Support workgroup, organized by the WDW with Youth MOVE taking a key role in activities, developed an Alternative Peer Group model for the state, including practice profile, fidelity checklist, and training curriculum for peer leaders. With input from a broad range of stakeholders, the Evaluation Team developed a plan for assessing the impact of Alternative Peer Groups, including tools for intake and follow-up data collection.

The Policy Workgroup has reviewed state policies related to the treatment of adolescents and transition-age youth with SUD and SUD/COD, identified barriers through stakeholder interviews and by reviewing existing policy documents, and drafted a report of their findings and recommendations for policy change. The draft report was reviewed by the IAC and revised based on their feedback.

## Pilot Sites

Two pilot sites, Greater Nashua Mental Health Center and Granite Pathways were contracted in June 2019, then onboarded and trained in the CC-NH care model and data collection procedures. Both sites were trained in the CANS assessment tool and *The Seven Challenges* and began implementing *The Seven Challenges* treatment model on Aug. 1, 2019.

As mentioned earlier, one of the sites, Granite Pathways, ended its CC-NH contract as of July 31, 2020. At the time of this report, Greater Nashua Mental Health Center is the only active pilot site. Efforts are underway to contract with additional pilot sites.

### Greater Nashua Mental Health Center

The Greater Nashua Mental Health Center (GNMHC) is a community mental health center established 100 years ago. It delivers services across four sites to a catchment area of 11 surrounding towns in the Greater Nashua area. The GNMHC serves everyone from children to the elderly and offers services ranging from case management, functional support services, mobile crisis for adults, medication-based programs (MAT) to community and school outreach. It also works with the court system on the drug court program; has an integrated health care program, and housing and supported employment programs. GNMHC also has a team that serves people who live with hearing disorders statewide. The two sites serving the CC-NH project are the Child, Adolescent & Family Services site and the Adult Substance Misuse Services site.

The GNMHC collaborates with the CC-NH Partners Group made up of stakeholders and organizations that are directly connected to the project. GNMHC also has liaisons with the child advocacy center, the Division for Children, Youth, and Families (DCYF), and with the juvenile justice system.

At the beginning of its contract, the Greater Nashua Mental Health Center allocated 20 staff members, 7 of whom were peer support specialists, to the CC-NH program. All staff members were trained in least one form of evidenced-based practice (EBP). Exhibit 4 shows the types of training and proportion of staff who received EBP training prior to or at the onset of the site’s contract.

Exhibit 4. Evidence-based trainings received by GNMHC staff members

Source: Baseline GNMHC CC-NH staff roster

\*Other EBP trainings include EMDR, TF-CBT, MATCH, HNC, DBT, CPP, Theraplay, CBT, Seeking Safety, CBI-SA, MI, RENEW

### Granite Pathways

Granite Pathways targets adolescents (12-17) and young adults (18-25) with a primary substance use diagnosis. It provides assessments and outpatient and intensive outpatient counseling services for individuals with substance use disorders and/or co-occurring mental health disorders. It also provides case management, referrals to MAT, peer support, parent psychoeducation (focusing on *The Seven Challenges* as well as parenting techniques and education about substance use disorders), and peer-led parent support groups. Granite Pathways works closely with DCYF, Juvenile Probation and Parole Officers (JPPOs), and school systems. It gets referrals from families, schools, JPPOs, DCYF, and insurance companies.

Eight staff members, none of whom were peer support specialists, worked to provide services in the CC-NH program at the Granite Pathways pilot site. Five staff members were trained in at least one form of EBP. Exhibit 5 shows the types of training and proportion of staff who received EBP training prior to or at the onset of the site’s contract.

Exhibit 5. Evidence-based training received by GP staff members

Source: Baseline GP CC-NH staff roster

\*Other EBP training include CBT, DBT, MI

### Implementation Progress and Fidelity

The pilot sites began enrolling clients into *The Seven Challenges* in August 2019, after attending an in-person, two-day training provided by the organization that developed the EBP. Supervisors at the sites also attended a leader training that qualified them to supervise the group leaders, ensure fidelity, and train new staff. A further training was conducted to familiarize the sites with the EBP’s fidelity checklist. The sites have been conducting regular phone check-ins with the developer to discuss cases and smooth out challenges. The CoP has also provided a platform for the sites to discuss their cases and problem-solve in in-person meetings.

Until March 2020, the most notable barrier to fidelity was the treatment of youth referred to the pilot sites by juvenile justice authorities. For these youth, abstinence from substances is typically a condition of their parole. *The Seven Challenges* approach, on the other hand, is a harm reduction program. The counselor’s role is defined as facilitating healthy decisions while refraining from “policing” abstinence. This challenge was discussed at one of the check-in meetings with the developer. One resolution that was recommended was for the counselor to emphasize that abiding by the terms of their parole was one of the important life decisions that faced these youth and that the counselor would help their clients make good decisions in this area.

The COVID-19 pandemic posed serious challenges for the program. Collaborative journaling, one of the program’s core elements, requires the participant to keep a physical journal in a prespecified format. The counselor regularly reviews and comments on the journal and returns it to the participant. Until the pandemic, there were no virtual journaling procedures designed by the developer. Although the group and individual sessions could be conducted remotely, the journaling function was disrupted at the beginning of the pandemic. This issue is being addressed in consultation with the developer; a new digital version of the journal template was developed to enable virtual collaboration and feedback between the participant and the counselor. At the time of this writing, the developer was working through the copyright implications of this version to enable its use in the field.

The pilot sites were scheduled to have in-person site visits by the developer of *The Seven Challenges* in March.Due to the pandemic, however, the developer instead held virtual site visits in June 2020. The evaluation team is working with pilot sites to obtain the documentation prepared for the visit (fidelity checklists and client satisfaction forms) and will quantify the fidelity checklist to obtain fidelity scores for the sites.

## Training Satisfaction

The training satisfaction survey was administered at six trainings, one of which occurred in 2020:

* the CANS training on July 17, 2019;
* *The Seven Challenges* training, held July 24-26, 2019;
* the CLAS training on September 12, 2019;
* *The Seven Challenges* Leader Training, held October 10-11, 2019;
* the ANSA training on November 26, 2019; and
* the R1 Discovery Card training on January 14, 2020.

The following are selected results from the satisfaction surveys:

* 8 clinical staff members from the pilot sites were trained and are now proficient in administering the evidence-based CANS assessment tool. Of the 8 people who attended this training, 100% were ‘Very Satisfied’ with the overall training experience and 62.5% rated the information received from the instructor as ‘Very Useful’, while the remaining 37.5% rated the information as ‘Useful’.
* Of the total 33 people who took *The Seven Challenges* training, 87.9% were ‘Satisfied’ or ‘Very Satisfied’ with the overall training experience. Almost 10% of participants thought the information received was ‘Somewhat Useful’, while almost 84% of participants found the information ‘Very Useful’.
* Of the 9 people who participated in the CLAS training, 89% were ‘Very Satisfied’ with the overall training experience, while the remaining 11% were ‘Satisfied’ with their experience. Similarly, 11% thought the information was ‘Somewhat Useful’ and 89% thought the information was ‘Very Useful’.
* Of the 17 people who took *The Seven Challenges* Leader training, 82.4% were ‘Very Satisfied’ with their overall training experience and 94.1% found the information they received from the instructor ‘Very Useful’. As part of CC-NH’s contract with the distributor, CC-NH has access to *The Seven Challenges* online training materials, which can be used by newly hired staff to further train themselves in implementing the EBP.
* 6 members of the CC-NH project team, including 4 clinical staff, attended the training for the evidence-based ANSA assessment tool. All trainees were ‘Satisfied’ or ‘Very Satisfied’ with the overall training experience, and 80.0% found the information they received from the instructor ‘Very Useful’, while 20.0% found the information ‘Somewhat Useful’.
* 17 attendees took part in the R1 Discovery Cards training but only 6 completed the training satisfaction survey. All 6 attendees were ‘Satisfied’ or ‘Very Satisfied’ with the overall training experience and found the information they received from the instructor to be ‘Useful’ or ‘Very Useful’.

# Client-Level Analysis Results

Exhibits 6 and 7 display the enrollment progress and type of available data, respectively. Enrollments showed a steep increase through January 2020, slightly slowed down through February 2020, and at a plateau between March and June 2020. As the sites worked through the challenges posed by the pandemic, enrollments slowly but gradually increased between June and November.

Exhibit 6. Cumulative enrollment/intake interviews

Source: Participant-level data received through November 30, 2020

Exhibit 7. Interview type

Source: Participant-level data received through November 30, 2020

## Client Characteristics

Exhibits 8a through 11 show the sociodemographic characteristics, clinical diagnoses, housing, employment and educational status, and location of the participants at intake. Among the enrolled youth, 57% are male, 93% are between ages 13 and 17, 82% are non-Hispanic/Latinx, 88% are white, and 70% identify as heterosexual (Exhibit 8a).

Exhibit 8a. Characteristics of clients served

|  |  |  |
| --- | --- | --- |
|  | N | % |
| Program |  |  |
| Granite Pathways | 8 | 18.2% |
| Greater Nashua Mental Health | 36 | 81.8% |
| Gender |  |  |
| Female | 17 | 38.6% |
| Male | 25 | 56.8% |
| Non-binary | 2 | 4.5% |
| Age |  |  |
| 13 to 17 years old | 41 | 93.2% |
| 18 to 24 years old | 2 | 4.5% |
| 25 years old and older | 1 | 2.3% |
| Ethnicity |  |  |
| Hispanic/Latinx | 8 | 18.2% |
| Non-Hispanic/Latinx | 36 | 81.8% |
| Race |  |  |
| African American/Black | 2 | 4.8% |
| American Indian or Alaska Native | 1 | 2.4% |
| White | 37 | 88.1% |
| Two or more races | 2 | 4.8% |
| Sexual Orientation |  |  |
| Heterosexual | 30 | 69.8% |
| Gay or Lesbian | 2 | 4.7% |
| Bisexual | 9 | 20.9% |
| Not sure | 2 | 4.7% |

Source: Participant-level data received through November 30, 2020

As noted earlier, CC-NH has a special focus on youth of color and youth who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ). To assess the level of success in recruiting youth from these two underserved communities, we compared the race/ethnicity and sexual orientation of youth enrolled in the CC-NH program with New Hampshire’s youth population. Looking at Exhibit 8b, we find that 24% of CC-NH participants identified with a racial/ethnic category other than non-Hispanic White, compared to 16% among the state’s population of public school students. This indicates that minority youth are *over*represented among program participants, suggesting that the program has been successful in reaching out to this community.

Exhibit 8b. Percentage of enrollments by race/ethnicity among New Hampshire public schools and CC-NH

Source: Participant-level data received through November 30, 2020 and data from the New Hampshire Department of Education, Division of Education Analytics and Resources, accessed on June 24, 2020 from <https://www.education.nh.gov/who-we-are/division-of-educator-and-analytic-resources/bureau-of-education-statistics/demographic-data>

Although we do not have data on program participants’ transgender status, we were able to compare their sexual orientation to the state’s population in the same age range. Exhibit 8c shows that 16% of New Hampshire’s high school students identified their sexual orientation as LGBQ, compared to 30% of program participants. This difference indicates the program’s success in providing services to LGBQ youth.

Exhibit 8c. Percentage of enrollments by sexual orientation among New Hampshire high school students and CC-NH

\* LGBQ = Lesbian, Gay, Bisexual, or Questioning (“not sure”)

Source: Participant-level data received through November 30, 2020 and 2019 New Hampshire YRBS.

Exhibit 9 shows primary diagnoses of participants at intake. The majority of participants (69%) presented with an SUD-related primary diagnosis. The most prevalent substance use diagnoses were those associated with cannabis use (collectively, 45%) followed by alcohol-related diagnoses (collectively, 12%). Disorders associated with psychoactive drugs other than cannabis constituted 7% of diagnoses. Participants with a mental health diagnosis accounted for 31% of intakes.

Exhibit 9. Primary diagnosis

|  |  |  |
| --- | --- | --- |
|  | N | % |
| F10.10 – Alcohol use disorder, uncomplicated, mild | 1 | 2.4% |
| F10.20 – Alcohol use disorder, uncomplicated, moderate/severe | 4 | 9.5% |
| F11.20 – Opioid use disorder, uncomplicated, moderate/severe | 1 | 2.4% |
| F12.10 – Cannabis use disorder, uncomplicated, mild | 6 | 14.3% |
| F12.20 – Cannabis use disorder, uncomplicated, moderate/severe | 10 | 23.8% |
| F12.9 – Cannabis use, unspecified | 3 | 7.1% |
| F14.20 – Cocaine use disorder, uncomplicated, moderate/severe | 1 | 2.4% |
| F15.21 – Other stimulant use disorder, moderate/severe, in remission | 1 | 2.4% |
| F19.10 – Other psychoactive substance use disorder, uncomplicated, mild | 1 | 2.4% |
| F17.20 – Tobacco use disorder, mild/moderate/severe | 1 | 2.4% |
| F21 – Schizotypal disorder | 1 | 2.4% |
| F32 – Major depressive disorder, single episode | 3 | 7.1% |
| F33 – Major depressive disorder, recurrent | 1 | 2.4% |
| F34 – Persistent mood [affective] disorders | 2 | 4.8% |
| F40-F48 – Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders | 4 | 9.5% |
| F90 – Attention-deficit hyperactivity disorders | 1 | 2.4% |
| F91 – Conduct disorders | 1 | 2.4% |
| Total | **42** | **100.0%** |

Source: Participant-level data received through November 30, 2020

Exhibit 10 summarizes the participants’ housing, education, and employment status. Ninety-one percent of participants were stably housed while 9% lived in a shelter or institution at intake; 48% lived in their own apartment, room or house and 41% lived in someone else’s apartment, room, or house. Ninety-one percent of participants were enrolled full- or part-time in school or job training and 45% had a full- or part-time job.

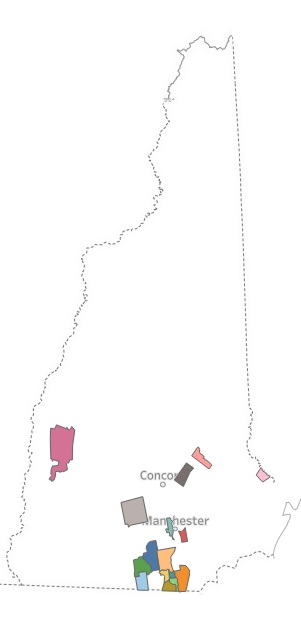
Exhibit 10. Housing, education, and employment status

|  |  |  |
| --- | --- | --- |
|  | N | % |
| Past 30-Day Housing Status |  |  |
| Living in a shelter | 1 | 2.3% |
| Living in an institution | 3 | 6.8% |
| Housed | 40 | 90.9% |
| Own/rent apartment, room, or house | 21 | 47.7% |
| Someone else’s apartment, room, or house | 18 | 40.9% |
| Halfway house | 1 | 2.3% |
| Education or Job Training Status |  |  |
| Not enrolled | 4 | 9.3% |
| Enrolled, full time | 37 | 86.0% |
| Enrolled, part time | 2 | 4.7% |
| Employment Status |  |  |
| Employed full or part time | 19 | 45.2% |
| Unemployed | 23 | 54.8% |

Source: Participant-level data received through November 30, 2020

Exhibit 11 maps the zip code areas of the participants. The majority live in and around Greater Nashua, Concord, and Manchester.

Exhibit 11. Geographic distribution of program participants, by zip code area



Source: Participant-level data received through November 30, 2020

## Planned Services

The GPRA intake survey asks provider site staff to indicate, for each participant, the services *planned* for the participant throughout his or her engagement in the program. These services are part of the participant’s treatment plan. Exhibits 12 through 18 present the planned services for the 44 participants for whom intake data were available by the end of November 2020. At discharge, program staff record the services each participant actually received. Currently, we do not have a sufficient number of discharge surveys to assess the degree to which the treatment plan was implemented. As more participants are discharged and the sample size becomes sufficient for analysis, we will compare the treatment plans developed at intake to services provided as reported at discharge.

Exhibit 12. Planned Services – Modality

Source: Participant-level data received through November 30, 2020

Exhibit 13. Planned Services – Treatment Services

Source: Participant-level data received through November 30, 2020

Exhibit 14. Planned Services – Case Management Services

Source: Participant-level data received through November 30, 2020

Exhibit 15. Planned Services – Medical Services

Source: Participant-level data received through November 30, 2020

Exhibit 16. Planned Services – After Care Services

Source: Participant-level data received through November 30, 2020

Exhibit 17. Planned Services – Education Services

Source: Participant-level data received through November 30, 2020

Exhibit 18. Planned Services – Peer-to-Peer Recovery Services

Source: Participant-level data received through November 30, 2020

## Preliminary Outcome Analysis

To answer the question “What is the impact of *The Seven Challenges* after 6 months of exposure?” we conducted pre-post outcome analysis on the GPRA data. Of the 44 participants with intake data, 17 have at least one post-intake interview: 8 have a 6-month follow-up survey and no discharge survey, 8 have a discharge survey and no 6-month follow-up survey, and 1 participant has both a 6-month follow-up survey and a discharge survey. To conduct pre-post analysis, we assigned the “pre” period as the intake survey and the “post” period as the available post-intake survey; if a client had two post-intake surveys, we used the survey where the pre-post period was closest to 6 months, where the definition of “pre-post period” is the time between the post-intake interview and the intake interview.

Prior to analysis, we confirmed that there were at least 30 days between each participant’s pre and post time points, restructured the dataset to facilitate outcome analysis, dichotomized variables of interest, and created matched versions of variables so only clients who had valid responses at both pre- and post-intake time points would be included in analysis. Because this analysis was conducted on fewer than 20 clients, we are considering the findings to be preliminary rather than conclusive. For the same reason, no significance testing was conducted.

Exhibits 19 through 25 show the preliminary results of this outcome analysis. Looking at Exhibit 19, we find that the average number of days of engaging in substance use related behaviors during the past 30 days decreased for the following:

* alcohol use
* binge alcohol use
* marijuana use
* any illicit drug use (including marijuana use)

Exhibit 19. Average days of substance use during the past 30 days

Source: Participant-level data received through November 30, 2020

Exhibit 20 shows declines in the incidence of the following mental health issues during the past 30 days:

* serious depression
* serious anxiety or tension
* hallucinations
* trouble understanding, concentrating, or remembering
* having trouble controlling violent behavior

According to Exhibit 20, almost 9% of clients were prescribed a medication for a psychological or emotional problem at intake; this increased to 19% at post-intake.

Exhibit 20. Average days of mental health symptoms during the past 30 days

Source: Participant-level data received through November 30, 2020

The GPRA instruments include three questions about the extent to which alcohol or drug use impacted the participant during the past 30 days, with response options, “not at all,” “somewhat,” “considerably,” and “extremely.” The three areas of impact referenced in the three questions are stress, reducing or giving up important daily activities, and experiencing emotional problems. Exhibit 21 shows the percentages of participants who responded either “considerably” or “extremely” to the three questions; the results show that the adverse effects of substance use decreased in all three areas between intake and post-intake.

Exhibit 21. Days impact of alcohol or drug use during the past 30 days

Source: Participant-level data received through November 30, 2020

The above results indicate declines in risky behaviors and negative mental health symptoms. Exhibits 22 through 25 show increases in protective factors.

The percentage of participants describing their overall health as ‘excellent,’ ‘very good,’ or ‘good’ increased from 44% at intake to 67% at post-intake (Exhibit 22); the percentage of participants who described their quality of life as ‘good’ or ‘very good’ increased from 50% to 80%.

Thirty-six percent of participants reported that they were ‘satisfied’ or ‘very satisfied’ with themselves at intake; this increased to 64% at the post-intake interview.

Participants’ report of interactions with family and/or friends supportive of their recovery in the past 30 days was at a ceiling at intake (91%) and remained at that level through the post-intake interview.

Exhibit 22. Percentage of program participants reporting their   
overall health is excellent, very good, or good

Source: Participant-level data received through November 30, 2020

Exhibit 23. Percentage of program participants reporting their   
quality of life is good or very good

Source: Participant-level data received through November 30, 2020

Exhibit 24. Percentage of program participants reporting they are  
satisfied or very satisfied with themselves

Source: Participant-level data received through November 30, 2020

Exhibit 25. Percentage of program participants having interaction with family  
and/or friends that are supportive of their recovery in the past 30 days

Source: Participant-level data received through November 30, 2020

# Sub-State-Level Analysis Results

As seen in Exhibit 11, most of the participants live in the Greater Nashua area. Although the program has not been implemented on a sufficient number of youth for a long enough time to have an impact in that region, it is informative to look at trends in relevant indicators in Greater Nashua compared to the state as a whole, to provide a context for this evaluation.

The 2017 YRBS results were compared to the 2019 results for both Greater Nashua and New Hampshire high schools. In this section, we present key indicators of students’ substance use (alcohol, marijuana, vaping products and prescription drugs) and mental health. This analysis is intended to assess overall trends in these key indicators in the CC-NH catchment area. Exhibits 26 through 36 show the results of this comparative trend analysis.

The results can be summarized as follows: In 2019, there was a decline in past-30-day alcohol and prescription drug use with a complementary increase in disapproval of alcohol use when compared to 2017. However, there is an increase in the proportion of students who perceive slight or no risk from binge drinking, an important risk factor for alcohol misuse. The past-30-day use of marijuana and vaping products increased between 2017 and 2019 along with the proportion of students who perceive slight or no risk from marijuana use. When compared to 2017, a higher proportion of students in 2019 felt sad/hopeless daily, purposely caused non-fatal self-injury, and seriously considered suicide in the past 12 months.

In comparison to the state as a whole, Greater Nashua students appear to have slightly lower risk for and higher protection against behavioral health problems, though the indicators for the group are trending in the same direction as the state as a whole.

Exhibit 26. Percentage of students who had at least one drink of alcohol during the past 30 days

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 27. Percentage of students who binged\* on alcohol during the past 30 days

\*In 2017, binging is defined as having 5 or more alcoholic drinks in a row; in 2019, it is defined   
as having 4 (females) or 5 (males) drinks in a row in 2019.

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 28. Percentage of students who perceive slight or no risk from binge drinking

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 29. Percentage of students who disapprove or strongly disapprove of alcohol use

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 30. Percentage of students who used marijuana at least once during the past 30 days

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 31. Percentage of students who perceive slight or no risk from marijuana use

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 32. Percentage of students who used electronic vaping products in the past 30 days

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 33. Percentage of students who took a prescription drug without a doctor’s prescription at least once during the past 30 days

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 34. Percentage of students who felt sad or hopeless every day for 2 weeks in a row during the past 12 months

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 35. Percentage of students who did something to purposely hurt themselves without wanting to die during the past 12 months

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

Exhibit 36. Percentage of students who seriously considered attempting suicide during the past 12 months

Source: 2017 & 2019 YRBS data for New Hampshire and Greater Nashua

# State-Level Analysis Results

Given that CC-NH is a pilot program with a somewhat limited catchment area, there is no expectation that its impact will be reflected in state-level indicators. However, we monitor state-level trends as part of establishing the context for the program and in identifying areas of strength and need at the state level. The following figures show key measures being tracked from state-level data sources.

### Substance Use

Exhibit 37. Percentage of youth aged 12 to 20 reporting alcohol use in the past month

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 38. Percentage of youth ages 12 to 20 reporting binge alcohol use in the past month

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015, 2016, 2017, 2018, and 2019.

Exhibit 39. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Gender

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 40. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Age

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 41. Percentage of students in New Hampshire who had at least one drink of alcohol during the past 30 days: Race/Ethnicity

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 42. Percentage reporting marijuana use in the past month among youth ages 12-17

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 43. Percentage reporting marijuana use in past month among individuals ages 18-25

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 44. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Gender

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 45. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Age

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 46. Percentage of students in New Hampshire who used marijuana at least once during the past 30 days: Race/Ethnicity

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 47. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Gender

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 48. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Age

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 49. Percentage of students in New Hampshire who took a prescription drug without a doctor’s prescription at least once during the past 30 days: Race/Ethnicity

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

### Mental Health

Exhibit 50. Percentage reporting mental illness in past year among individuals ages 18-25

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 51. Percentage reporting major depressive episode in the past year among youth ages 12-17

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018 and 2019.

Exhibit 52. Percentage reporting major depressive episode in the past year among individuals ages 18-25

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 53. Percentage who had serious thoughts of suicide among individuals ages 18-25

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014, 2015, 2016, 2017, 2018, and 2019.

Exhibit 54. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Gender

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 55. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Age

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 56. Percentage of students in New Hampshire who seriously considered attempting suicide during the past 12 months: Race/Ethnicity

Source: New Hampshire Youth Risk Behavior Survey, 2015, 2017, and 2019

Exhibit 57. Crude suicide death rates per 100,000, by age group: 2014-2018

|  |  |  |
| --- | --- | --- |
|  | **United States** | **New Hampshire** |
| All Ages | 14.09 | 18.8 |
| Youth 10-17 | 4.72 | 4.55 |
| Young Adults 18-24 | 15.08 | 20.86 |
| Youth and Young Adults 10-24 | 9.71 | 12.73 |

Source: New Hampshire Suicide Prevention Annual Report, 2019

### Drug- and Alcohol-Related Crime

Exhibit 58. Percentage of total arrests that are alcohol- or drug-related among   
youth under 18

Source: Data derived from the Federal Bureau of Investigation's Uniform Crime Reporting (UCR) Program. Measure calculation: Percent of arrests that are alcohol or drug-related = Number of alcohol or drug-related arrests divided by the total number of arrests and multiplied by 100.

### Opioid-Related Deaths

Exhibit 59. Opioid-Related Deaths

(Note: 2018 and 2020 numbers do not cover the entire year)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Opiate/ Opioid** | **2015** | **2016** | **2017** | **2018\*** | **2019** | **2020†** |
| Fentanyl (no other drugs) | 24 | 34 | 33 | 10 | 12 | 8 |
| Fentanyl and Other Drugs (excluding heroin) | 9 | 9 | 16 | 2 | 19 | 6 |
| Heroin (no other drugs) | 6 | 0 | 0 | 0 | 0 | 0 |
| Heroin and Other Drugs (excluding fentanyl) | 0 | 0 | 0 | 0 | 0 | 0 |
| Heroin and Fentanyl | 9 | 2 | 2 | 0 | 0 | 0 |
| Unknown Opioids | 1 | 0 | 0 | 0 | 0 | 0 |
| Other Opiates/Opioids | 7 | 1 | 3 | 1 | 0 | 1 |
| **Total Deaths Caused By Opiates/Opioids** | **56** | **46** | **54** | **13** | **31** | **15** |
| Other Drugs | 1 | 0 | 1 | 1 | 0 | 4 |
| Unknown Drugs | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Drug Deaths** | **57** | **46** | **55** | **14** | **31** | **19** |

Note: \*Data collected through summer; †Data collected through 11/16/2020

Source: New Hampshire Office of the Chief Medical Examiner

# Discussion

This report summarizes evaluation results for the Creating Connections NH project from the start of *The Seven Challenges* implementation in August 2019 through November 2020. The results indicate that the project has been successful in reaching out to the two priority populations of focus, that is, youth of color and LGBQ youth: The representation of these groups among the youth who received services is higher than their representation in the state’s population within the comparable age range. Outcome analysis compared participating youth’s responses to the intake interview with their responses to the same questions at either 6-month follow-up or discharge, whichever was closest to six months following intake. The results show reductions in substance use behaviors and mental health symptoms and improvements in overall health, quality of life, and social relationships. These results, although suggestive of program success, should not be viewed as conclusive due to the small number of youth for whom data were available. Our confidence in outcome analysis results will increase as additional youth are enrolled in the program and further data become available.