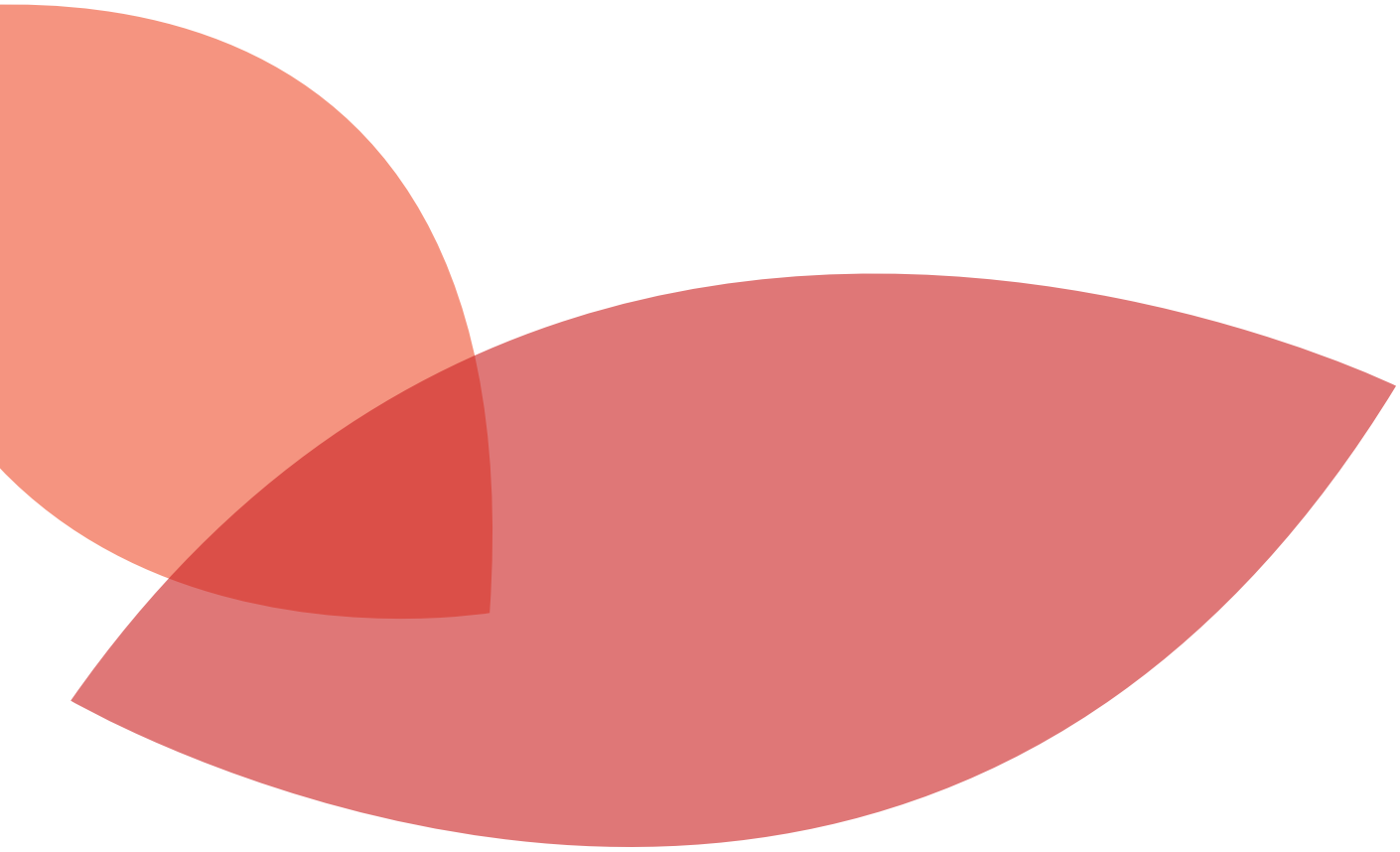
2018 New Hampshire Maternal, Infant, and Early Childhood Home Visiting Program Needs Assessment



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- Community Action Program of Belknap and Merrimack Counties
- Family Resource Center of Coös and Grafton Counties
- Goodwin Community Health Center
- Home Healthcare, Hospice & Community Services
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INTRODUCTION

In 2010 under the Affordable Care Act, the Health Resources and Services Administration (HRSA) initiated the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. In preparation for the release of funds, the NH Maternal and Child Health Section (MCHS) conducted the 2010 NH Home Visiting Needs Assessment that identified the at-risk communities in NH to be served by the MIECHV-funded home visiting services. In 2011, MCHS engaged stakeholders in a process that resulted in the NH Home Visiting State Plan in which Healthy Families America (HFA) was selected as the evidence-based home visiting program that would best serve the needs of the New Hampshire families targeted by the MIECHV grant. Today, MCHS contracts with seven community-based nonprofit organizations with 11 sites providing services statewide to provide HFA - a voluntary home visiting model that embodies the belief that early nurturing relationships are the foundation for lifelong healthy development. HFA is family-centered, culturally sensitive, strength-based, and proven effective in promoting healthy child development and preventing child abuse and neglect.

In 2017, MIECHV initiated an update to the 2010 needs assessment to (1) examine how the current system of home visitation services available in New Hampshire meets the needs of the community and (2) identify gaps in services. The data gleaned from this assessment will be used to support program planning, improvement, and decision making. It is critical to identifying and understanding how to meet the needs of eligible families living in at-risk communities. JSI Research & Training Institute, Inc./Community Health Institute (JSI/CHI) was contracted via competitive bid process.

This needs assessment update attempts to identify:

- Communities with elevated risk due to higher concentrations of factors such as: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health, poverty, crime, intimate partner violence, high rates of high-school dropouts, substance abuse, unemployment, or child maltreatment.
- The quality and capacity of existing programs or initiatives for early childhood home visitation in the state including: the number and types of individuals and families who are receiving services under such programs or, the gaps in early childhood home visitation; and the extent to which such programs or initiatives are meeting the needs of eligible families.
- The state's capacity for providing substance misuse treatment and counseling services to individuals and families in need of treatment and services.

This needs assessment update employed a non-experimental design and a mixed methods approach that relies upon a four-part assessment comprised of the following components, to inform the following areas of focus:

Research Component	Communities with Concentrations of Risk Identification	Quality and Capacity of Existing Programs	Substance Use Treatment Capacity
HRSA-prescribed and additional local indicator analysis	X		X
NH Family and Caregiver Survey	X	X	
NH Home Visitor Survey	X	X	
Photovoice Project		X	

JSI/CHI's Institutional Review Board determined that this assessment was exempt from human subjects oversight.

METHODS & FINDINGS

This section of the needs assessment update features a narrative describing the partnerships, data collection and analysis, and preliminary findings from each of the research components.

Coordination with Local, State, and Federal Maternal & Child Health Programs

Partnerships and collaborations are core components of the MIECHV federal grant requirements. In anticipation of the updated needs assessment process, NH MIECHV and JSI/CHI engaged in a thoughtful planning process built upon existing partnerships and growing new relationships with stakeholders to ensure a robust diversity of perspectives were represented. When engaging partners, JSI/CHI very intentionally encouraged partners to provide feedback and input so that any data or findings produced by the process would be applicable and meaningful to their work. JSI/CHI engaged a broad spectrum of maternal and child health- focused agencies and stakeholders, largely through the reinvigoration of the NH Home Visiting Task Force.

NH Home Visiting Task Force

In fall of 2017, NH MIECHV submitted an application to Spark NH, the Governor Appointed Early Childhood Advisory Council for the State of New Hampshire, to convene a NH Home Visiting Task Force (Task Force) as an official sub-group of Spark NH. As a recipient of a federal Maternal, Infant, and Early Childhood Home Visiting grant (MIECHV), NH MIECHV is charged with developing and implementing - in collaboration with other federal, state, territory, tribal, and local partners - a continuum of home visiting services to support eligible families and children prenatally through age three. NH MIECHV also aimed to convene the Task Force so that it might advise and inform the needs assessment update and anticipated updating of the statewide home visiting plan.

The mission of the NH Home Visiting Task Force is to promote, extend, and coordinate high quality home visiting services in New Hampshire as a cost-effective way to ensure the health and well-being of families with children. Long-term goals include:

- plan, offer, coordinate, and co-promote joint professional development opportunities for home visitors; develop and support the implementation of recommendations on common protocols, processes, and procedures, assessment and reporting within and across home visiting programs, wherever possible;
- support the development of educational and promotional materials for home visiting services that may be used with referral sources, the general public, policy makers, and funders;
- map the availability of home visiting services statewide, assess critical gaps, and develop strategies to meet unmet need;
- connect with state level institutions relative to the work of home visiting; and examine, on a regular basis, the joint ability of the home visiting system in New Hampshire to use evidence-based approaches, achieve shared outcomes, adopt sustainable practices, and implement system reforms.

During the spring of 2018, the NH MIECHV team requested the Task Force establish a data workgroup to advise the quantitative and qualitative assessment methods and approach of this needs assessment. The data workgroup was comprised of representatives from HFA, the Division for Children, Youth and Families (DCYF), family resource centers, funders, research agencies, and several other state-level agencies. In the absence of a centralized data system for home visiting in New Hampshire, they provided critical feedback on existing data sets, previous efforts to collect uniform data, and recommendations on how best to interpret and interweave the available data. In addition, the workgroup representatives reviewed and provided input on the development of the final versions of the *NH Family and Caregiver and Home Visitor surveys.* This input ensured that partners could meaningfully apply these data to their own program planning in the future.

In September 2018, the Task Force engaged an expert facilitator to conduct a strategic planning meeting to assist them in the development and execution of a work plan with clear priorities and strategies to secure funding and advance their priorities. The group used boundary-spanning principles to engage in conversation and planning. These principles foster alignment and commitment within and across individuals, groups, and organizations in service of a higher vision or goal (Yip, Ernst, and Campbell, 2011). Through this strategic planning process, four major groups of priorities that will guide the Task Force's next steps were identified:

1. **ACCESS AND DELIVERY OF SERVICES:** Simplify and expand access to home visiting and other family supports so that families can reach their maximum potential through:
    - Centralized intake
    - Universal screening
    - Universal access to family support and strengthening programs, including home visiting
2. **DATA:** Prioritize the development and refinement of data collection and reporting processes in order to:
    - Determine baseline measures
    - Identify gaps in services/systems
    - Streamline data collection
    - Identify/develop shared metrics related to service delivery, outcomes, and cost analysis
    - Evaluate current and future efforts
3. **ADVOCACY:** Develop a public awareness campaign that defines family support and reduces stigma, emphasizes return on investment (ROI) and prevention, and uses a range of delivery methods targeted to a variety of audiences, including: TV, social media, elevator message, and radio, so that partners are speaking with a common "voice."
4. **INFRASTRUCTURE:** Articulate a system of family support and strengthening to further the reach of programs ensuring that family these programs are available to every family. The Task Force membership will reflect the communities it serves.

As summarized later in the Opportunity chapter, many of the findings of this needs assessment align with the activities to be undertaken by the Task Force in its future work.

CAPTA, Title V, and Head Start

The Task Force, through its data workgroup, actively engaged with the entities offering services through the Child Abuse Prevention and Treatment Act (CAPTA), Title V, and Head Start programs to broadly disseminate the two assessment surveys.

The needs assessment data collected through this process has been shared with local WIC agencies with whom the project team partnered to administer the *NH Family & Caregiver Survey*, the Title V grant partners, and partners working on the Child Development Block Grant. Additionally, the NH MIECHV team has shared the data with the Early Head Start partners beginning work on their needs assessments.

HRSA-PRESCRIBED AND OTHER INDICATOR REVIEW

In an effort to identify communities with the highest need for MIECHV home visiting services, JSI/CHI examined HRSA-prescribed indicators across five domains, in addition to locally available data indicators across several domains. The five HRSA-prescribed domains framing this needs assessment, and their relation to need for home visiting services are defined as follows:

1. **SOCIOECONOMIC STATUS (SES):** the social standing or class of an individual or group; reveals inequities in access to resources, plus issues related to privilege, power, and control. (American Psychological Association, n.d.) Research indicates that SES is a key factor influencing quality of life, related to psychological health, physical health, education, and family well-being across the life span for children, youth, and families. (American Psychological Association, n.d.).
2. **ADVERSE PERINATAL OUTCOMES:** while the effects of adverse perinatal outcomes vary, oftentimes these indicators cause health problems in a newborn baby, or require the baby to stay in the hospital longer than babies born without these outcomes. Additionally, these outcomes can cause problems for babies throughout their lives. (March of Dimes, 2013).
3. **CHILD MALTREATMENT:** beyond death, physical injury, and disability, child maltreatment and violence can lead to stress that impairs brain development and damages the nervous and immune systems; this is then associated with delayed cognitive development, poor school performance and dropout, mental health problems, suicide attempts, increased health-risk behaviors, re-victimization, and the perpetration of violence. (World Health Organization, n.d.).
4. **CRIME:** exposure to violence and crime in communities occurs at various levels including victimization, direct witnessing, or hearing about events from other community members. Repeated exposure to crime and violence may be linked to increase in negative health outcomes. (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, n.d.) Children and adolescents exposed to violence are at risk for poor long-term behavioral and mental health outcomes regardless of whether they are victims, direct witnesses, or hear about crime.
5. **SUBSTANCE MISUSE:** substance misuse affects children and families through a range of modalities including pre- and perinatal use of substances, parental substance misuse in the home, and through incarceration. (Calhoun, Conner, Miller, & Messina, 2015) Children impacted by substance misuse are at an increased risk for a variety of problems including abuse, neglect, and ongoing behavioral problems.

Within each domain, JSI/CHI examined a number of indicators to quantify areas of concern. These indicators are defined in **Figure 1.** Asterisks denote additional non-HRSA-prescribed data points added to the analysis, available from state sources. An indicator marked by italics indicates that it was available at a municipality level.

Figure 1: Quantitative Indicators Reviewed for Needs Assessment Update

Domain	Indicator	Definition	Source	Year(s)
Socioeconomic Status	Poverty	Persons in poverty	United States Census Bureau Quick Facts New Hampshire	2010-2016
	Unemployment	Unemployed persons in civilian labor force	New Hampshire Employment Security, Economic & Labor Market Information Bureau	2010-2016
	High School Dropout	9th – 12th graders who have dropped out of school Note: Subcategory "dropouts" are early exiters who, as of the report date, have not completed a GED or enrolled in college	State and County Level: National Center for Education Statistics / City Level: New Hampshire Department of Education	2010-2016
	Income Inequality	Gini Coefficient – measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution (Organisation for Economic Co-operation and Development, 2006)	American Community Survey	2016 / 2012- 2016 / 2012- 2016 OR 2016
	** Lack of health insurance	People under 19 years of age without health insurance People under 65 years of age without health insurance	United States Census Bureau Small Area Health Insurance Estimates (SAHIE) Program	2010-2016
Adverse Perinatal Outcomes	Premature Birth	Live births at less than 32 weeks	New Hampshire WISDOM	2012-2016
	Low Birthweight	Live births under 2,500 grams	New Hampshire WISDOM	2010-2014
	v ** Smoking During Pregnancy	Live births at less than 37 weeks where mother self- reported tobacco use	New Hampshire WISDOM	2012-2016
Child Maltreatment	** Domestic Violence	Victims of Domestic Violence seen at NH Crisis Centers Note: Data included for the following age categories: child, teen, adult, elderly, unknown age	New Hampshire Coalition Against Domestic and Sexual Violence	2011-2016
	** Sexual Violence	Victims of Sexual Violence seen at NH Crisis Centers Note: Data included for the following age categories: child, teen, adult, elderly, unknown age	New Hampshire Coalition Against Domestic and Sexual Violence	2011-2016
	Child Maltreatment	Victims aged <1-17 per 1,000 child (aged <1-17) residents	Administration of Children and Families	2016

Crime	Crime	Offenses known to law enforcement	The FBI Uniform Crime Reports, Table 6	2013-2016
	Juvenile Offenses	Arrests of individuals under 18 years of age	The FBI Uniform Crime Reports, Table 6	2010-2014

Substance Misuse	** Overdose Deaths	Drug overdose deaths where drug(s) is/are suspected to have been used	New Hampshire Medical Examiner's Office	2013-2017
	** Narcan Administration	Incidents where Narcan was administered by EMS	New Hampshire Bureau of Emergency Medical Services	2013-2017
	** Smoking	1+ days of smoking cigarettes in the past 30 days among high school students	New Hampshire Youth Risk Behavior Survey	2017
	Alcohol	1+ days of drinking alcohol in the past 30 days among high school students	New Hampshire Youth Risk Behavior Survey	2017
	** Binge Alcohol Use	Prevalence rate: binge alcohol use in past month At least 1 day with 5+ drinks of alcohol in a row among high school students	SAMHSA - National Survey of Drug Use and Health New Hampshire Youth Risk Behavior Survey	2012-2014 2017
	Marijuana	Prevalence rate: Marijuana use in past month 1+ days of using marijuana in the past 30 days among high school students	SAMHSA - National Survey of Drug Use and Health New Hampshire Youth Risk Behavior Survey	2012-2014 2017
	** Prescription Drugs	1+ times using prescription drugs (without a prescription) in the past 30 days among high school students	New Hampshire Youth Risk Behavior Survey	2017
	Pain Relievers	Prevalence rate: nonmedical use of pain medication in the past year	SAMHSA - National Survey of Drug Use and Health	2012-2014
	Illicit Drugs	Prevalence Rate: use of illicit drugs excluding marijuana, in the past month Note: Such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax without a doctor's prescription	SAMHSA - National Survey of Drug Use and Health	2012-2014
	** Heroin	1+ times using heroin in their lifetime among high school students	New Hampshire Youth Risk Behavior Survey	2017

Z-score Methodology

JSI/CHI examined data on a statewide level, as well as by county and by selected cities and towns. When possible, JSI/CHI presents these data as per capita rates in order to normalize the data presented across population differences. To adequately represent the needs of all areas of the state, including those with limited population mass, JSI/CHI normalized data to rates per 10,000, or rates per 100,000 depending on the size of the population group represented in a particular indicator. JSI/CHI then calculated the per capita rates for each indicator utilizing a mean of population data across a number of years. Following the calculation of the per capita rates, JSI/CHI calculated z-scores to inform prioritizing communities based on risk.

A z-score, otherwise known as a standard score, is a statistical tool used to indicate how many standard deviations an element is from the mean. The standard

deviation is a numerical value used to indicate how widely individual data in a group of data, vary. If data elements vary widely from the group mean, then the standard deviation will be larger. Simply stated, the larger the absolute value of a z-score, the further it is from the mean score.

For this analysis, z-scores were calculated utilizing a mean of all geographic areas represented in a particular analysis (e.g., county calculations were calculated using a mean of all ten counties and municipality calculations were calculated using a mean of all ten municipalities represented in this analysis). Given that a majority of NH is very rural, JSI/CHI wanted to conduct analysis that would highlight any disproportionate impact a large municipality might have on a county's data. To demonstrate this, JSI/CHI analyzed and created z-scores for local municipalities where the population exceeded 20% of the entire county population for indicators where data was available. Those cities and towns were selected if they had at least 20% of the county's residing population, and represent eight out of the ten New Hampshire counties:

- Berlin (Coos)
- Claremont (Sullivan)
- Concord (Merrimack)
- Conway (Carroll)
- Dover (Strafford)
- Keene (Cheshire)
- Manchester (Hillsborough)
- Laconia (Belknap)
- Nashua (Hillsborough)
- Rochester (Strafford)

Data tables showing the z-score analysis across all indicators at the county and local municipality level are available in their entirety in the data summary tables submitted to HRSA with this needs assessment update., available by request from NH MIECHV.

Figures 2, 3 and 4 are summary tables showing the number of flagged indicators (z-score ≥ 1.0), overall, and the total number of at-risk domains (≥ 50% of indicators within a particular domain that have z-scores ≥ 1.0).

Figure 2 illustrates the HRSA indicators at the county level. Belknap, Strafford, and Coos County are the three counties with the greatest amount of flagged indicators (from greatest to least). HRSA indicators flag Belknap County as the most at-risk county, overall, with four of five domains noted, including Adverse Perinatal Outcomes, Substance Use Disorder, Crime and Child Maltreatment. The only not at-risk domain for Belknap County was Socioeconomic Status, which contained no flagged HRSA indicators. Strafford and Coos counties each had two at-risk domains.

Figure 2: Aggregated summary of z-score analyses showing how many HRSA indicators had z-scores of ≥ 1.0, and how many of the five domains were flagged as "at-risk" (county-level).

County	Population (2016)	Domain #1 Socioeconomic Status	Domain #2 Adverse Perinatal Outcomes	Domain #3 Substance Use Disorder	Domain #4 Crime	Domain #5 Child Maltreatment	> 1.0 SD indicators (Total =13)	# at-risk domains
Belknap	60,779	0.0%	**100.0%**	**75.0%**	**50.0%**	**100.0%**	7	4
Carroll	47,289	25.0%	0.0%	0.0%	**50.0%**	0.0%	2	1
Cheshire	75,774	0.0%	0.0%	25.0%	0.0%	**100.0%**	2	1
Coos	32,039	**75.0%**	**50.0%**	0.0%	0.0%	0.0%	4	2
Grafton	88,888	25.0%	0.0%	0.0%	0.0%	0.0%	1	0
Hillsborough	407,761	0.0%	0.0%	25.0%	0.0%	0.0%	1	0
Merrimack	303,251	0.0%	0.0%	0.0%	0.0%	0.0%	0	0
Rockingham	148,582	0.0%	0.0%	0.0%	0.0%	0.0%	0	0
Strafford	127,428	0.0%	0.0%	**75.0%**	**100.0%**	0.0%	5	2
Sullivan	43,004	25.0%	**50.0%**	0.0%	0.0%	0.0%	2	1

Figure 3 illustrates the findings from additional indicators JSI/CHI analyzed at the county level. This time, showing Coos County as the most at-risk county, overall, with four of five domains flagged. Sullivan County was another noteworthy county with three of five domains defined as at-risk.

Figure 3: Aggregated summary of z-score analyses showing how many additional local indicators had z-scores of ≥ 1.0, and how many of the five domains were flagged as "at-risk" (county-level).

County	Population (2016)	Domain #1 Socio-economic Status	Domain #2 Adverse Perinatal Outcomes	Domain #3 Substance Use Disorder	Domain #4 Crime	Domain #5 Child Maltreatment	# > 1.0 SD indicators (Total = 20)	# at-risk domains
Belknap	60,779	0.0%	33.3%	12.5%	**50.0%**	0.0%	3	**1**
Carroll	47,289	40.0%	0.0%	12.5%	0.0%	0.0%	3	**0**
Cheshire	75,774	0.0%	0.0%	25.0%	**50.0%**	0.0%	3	**1**
Coos	32,039	**60.0%**	**66.7%**	**50.0%**	0.0%	**100.0%**	11	**4**
Grafton	88,888	20.0%	0.0%	0.0%	0.0%	0.0%	1	0
Hillsborough	407,761	0.0%	0.0%	25.0%	0.0%	0.0%	2	0
Merrimack	303,251	20.0%	0.0%	0.0%	**50.0%**	0.0%	2	**1**
Rockingham	148,582	0.0%	0.0%	0.0%	0.0%	0.0%	0	0
Strafford	127,428	20.0%	0.0%	37.5%	0.0%	0.0%	4	**0**
Sullivan	43,004	0.0%	**66.7%**	12.5%	**50.0%**	**50.0%**	5	**3**

While there were some discrepancies between the HRSA and additional local indicators – with regard to at-risk domains and flagged indicators – there was consensus in identifying Grafton, Hillsborough, and Rockingham counties as the least at-risk.

Lastly, **Figure 4** illustrates the most at-risk towns (using the additional local indicators), showing Berlin (Coos County) as the most at-risk town, with two of four domains flagged as at-risk. With one at-risk domain between them, the following towns are also noteworthy: Conway (Carroll County), Manchester (Hillsborough County), Laconia (Belknap County), and Rochester (Strafford County).

Figure 4: Aggregated summary of the z-score analyses showing how many indicators had z-scores of ≥ 1.0, and how many of four domains were flagged as "at-risk" (municipality-level).

Town	Population (2016)	Domain #1 Socioeconomic Status Socioeconomic Status	Domain #2 Adverse Perinatal Outcomes	Domain #3 Substance Use Disorder	Domain #4 Crime	> 1.0 SD indicators (Total =13)	# at-risk domains
Berlin	9,241	**66.7%**	**66.7%**	0.0%	0.0%	4	2
Claremont	12,913	33.3%	0.0%	0.0%	0.0%	1	0
Concord	42,610	0.0%	0.0%	0.0%	0.0%	0	0
Conway	9,915	0.0%	**66.7%**	0.0%	0.0%	2	1
Dover	31,054	0.0%	0.0%	0.0%	0.0%	0	0
Keene	23,244	0.0%	0.0%	0.0%	0.0%	0	0
Laconia	16,300	33.3%	0.0%	**100.0%**	0.0%	3	1
Manchester	110,353	0.0%	33.3%	0.0%	**100.0%**	2	1
Nashua	88,252	0.0%	0.0%	0.0%	0.0%	0	0
Rochester	30,096	0.0%	0.0%	**50.0%**	0.0%	1	1

NH FAMILY & CAREGIVER SURVEY

JSI/CHI administered the *NH Family & Caregiver Survey* to explore the experiences of families who are pregnant or caring for a child under the age of eight years The survey – adapted from Oregon's 2010 MIECHV Needs Assessment - aimed to identify the experiences of potentially vulnerable families in accessing necessary resources, such as: health care, financial assistance, employment training, etc. The survey respondents who had received some type of home visiting service, answered an additional brief set of questions to understand their experience with these services. JSI/CHI vetted the survey tool and distribution methods with the NH MIECHV team and the Task Force data workgroup. The survey's inclusion criteria was: 1) Between the age of 18 – 44 years; 2) Pregnant or caring for a child under the age of eight years, and; 3) New Hampshire resident.

The survey results provide important information about the characteristics of NH families and how their needs may differ depending on such factors as: geographic location within the state, enrollment in a home visiting program, primary language spoken, and nativity status. The survey aimed to provide information on families' help-seeking behaviors and possible points of intervention. The survey assessed:

- basic demographic data such as age, gender, employment status, education attainment,
- current knowledge, attitudes and beliefs regarding home visiting services while pregnant and parenting,
- types of services needed,
- challenges or difficulties accessing services for those who were home-visited, and
- degree of satisfaction with services.

A full copy of the survey is available as an appendix.

JSI/CHI administered the *NH Family and Caregiver Survey* both electronically via SurveyGizmo.com and on paper. Partners from across the state, including Women, Infant, and Children Nutrition Program (WIC) sites, the Task Force, other family support agencies with home visiting programs, local Community Action Partnership/Programs, Child Care Aware and others distributed the survey both on paper in offices and via electronic communication channels. Additionally, JSI/CHI collaborated with programs in the Manchester area specifically working with refugee/immigrant populations, to ensure the survey results captured the diverse perspectives of New Hampshire families. New Hampshire WIC offices provided the greatest proportion of survey responses. In return for partner support in disseminating the surveys, JSI/CHI offered to provide summary data tables for the catchment areas of partners or populations of interest. In addition, respondents who completed the survey had the opportunity to enter a drawing to win one of three $100 Wal-Mart gift cards.

JSI/CHI calculated the desired sample of non-home-visited families to be approximately 400 completed surveys – based on U.S. Census Bureau 2012-2016 American Community Survey data showing the estimated number of households with children under the age of six years as 28,989. The desired sample of home-visited families was estimated at 300 completed surveys, based on an estimated 2,000 New Hampshire families enrolled in three major state or federally funded home visiting programs included in this assessment: Healthy Families America-NH, services provided through the Comprehensive Family Support Services contracts, and Early Head Start. Survey data were organized, cleaned, and analyzed using SPSS (v.18.0). JSI/CHI excluded data from respondents who did not meet the inclusion criteria, leaving 862 cases for analysis. Of those 862, 577 families reported that they had not received home visiting services, 257 families received home visiting services, and 29 were unsure.

Survey Respondent Demographics

Figure 5 shows the demographics of the overall sample of respondents. The majority of the sample were married or in a domestic partnership (47.7%); educated to high school-level (or equivalent) as the last level of formal education (31.0%); employed full-time (40+ hours per week – 26.0%); aged between 25 and 34 years old (56.7%); White (87.8%); female (94.6%); not Hispanic/Latino (89.4%), and had not relocated to the US within the past two years (97.2%).

Figure 5: Demographics of the Parent & Caregiver Survey

RELATIONSHIP STATUS	Single (never married)	40.3%
	Married or in a domestic partnership	47.7%
	Widowed	0.5%
	Divorced	7.9%
	Separated	2.5%
	Prefer not to say	1.1%

LAST LEVEL OF FORMAL EDUCATION	Any elementary school grade through 11th grade	11.8%
	High school degree or equivalent	31.0%
	Some college, no degree	27.6%
	College degree (Associate, Bachelor's)	21.6%
	Master's, Professional, or Doctorate degree	5.6%
	Prefer not to say	0.5%
	Other	1.8%

EMPLOYMENT STATUS	Employed full time (40 or more hours per week)	26.0%
	Employed part time (up to 39 hours per week)	22.8%
	Unemployed and currently looking for work	10.5%
	Unemployed and not currently looking for work	10.7%
	Student	1.6%
	Retired	1.3%
	Homemaker	15.6%
	Self-employed	3.2%
	Unable to work	7.2%
	Prefer not to say	1.1%

AGE	18-24 years old	17.0%
	25-34 years old	56.7%
	35-44 years old	20.2%
	45-54 years old	3.6%
	55 or older	2.0%
	Prefer not to say	0.3%

GENDER	Female	94.5%
	Male	5.2%
	Bi-gender	0.1%
	Gender-fluid	0.0%
	Transgender	0.1%
	Prefer not to say	0.0%
	Prefer to self-describe	0.0%

HISPANIC/LATINO?	Yes	17.0%
	No	56.7%
	Prefer not to say	0.5%

RACE SELF-IDENTIFICATION	Asian	3.3%
	Black or African American	3.2%
	Native American or Alaskan	1.2%
	Pacific Islander or Native Hawaiian	0.1%
	White	87.8%
	Prefer not to say	1.3%
	Other	3.1%

RELOCATED TO US (<2 YEARS)?	Yes	2.5%
	No	97.2%
	Prefer not to say	0.2%

CHILDREN IN THE FAMILY	# < 1 year old	263	13.8%
	# 1 to 2 years	366	19.2%
	# 3 to 5 years	581	30.5%
	# 6 to 8 years	287	15.1%
	# 9+ years	407	21.4%
	Total # of children	1,904	
	Average # of children	2.21	
	# of children (median)	2	
	# of children (mode)	2	

Access and Barriers to Supports and Services

The following tables and graphs illustrate the differences in responses to specific survey questions between those who received home visiting services in the past year and those who did not (n = 256; n = 577, respectively).

Figure 6 details the types of support and services respondents sought during the past year. The bars on the left represent the responses of those who received home visiting services in the past year, with the bars on the right representing the responses of those who did not receive such services in the past year. As might be expected, those who received home visiting services accessed more types of support and services than those who did not receive home visiting services. The top three types of supports and services sought between both groups were the same, with slight differences in proportions for each group: food (64.6%, 55.8%, respectively); health care (59.2%, 53.9%, respectively), and; dental care (52.3%, 41.2%, respectively). When reviewing these data, the reader must consider that NH WIC offices were a primary survey dissemination partner, which may have an impact on data relevant to accessing food support.

Figure 6: "Please tell us which types of support or services you sought for your family during the past year (check all that apply). "Responses by those who did (left) and did not (right) receive home visiting services (n = 256; n - 577, respectively)

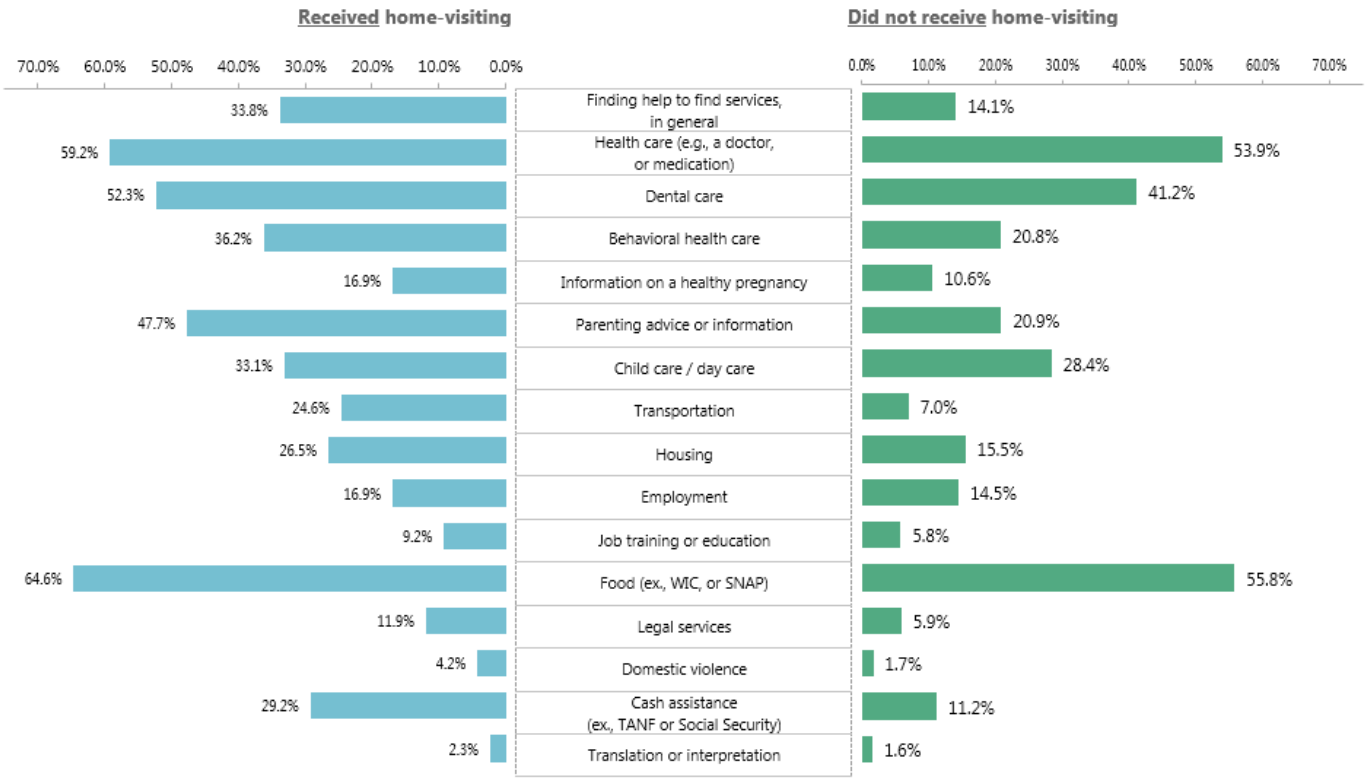


Figure 7 shows the distribution of the number of services/supports accessed by home visited and non-home visited families. Based on this data, those who received home visiting services accessed a greater number of services/types of support compared to those who did not receive home visiting services.

Figure 7: Distribution of the number of accessed services and types of support comparing those who did and did not receive home visiting services

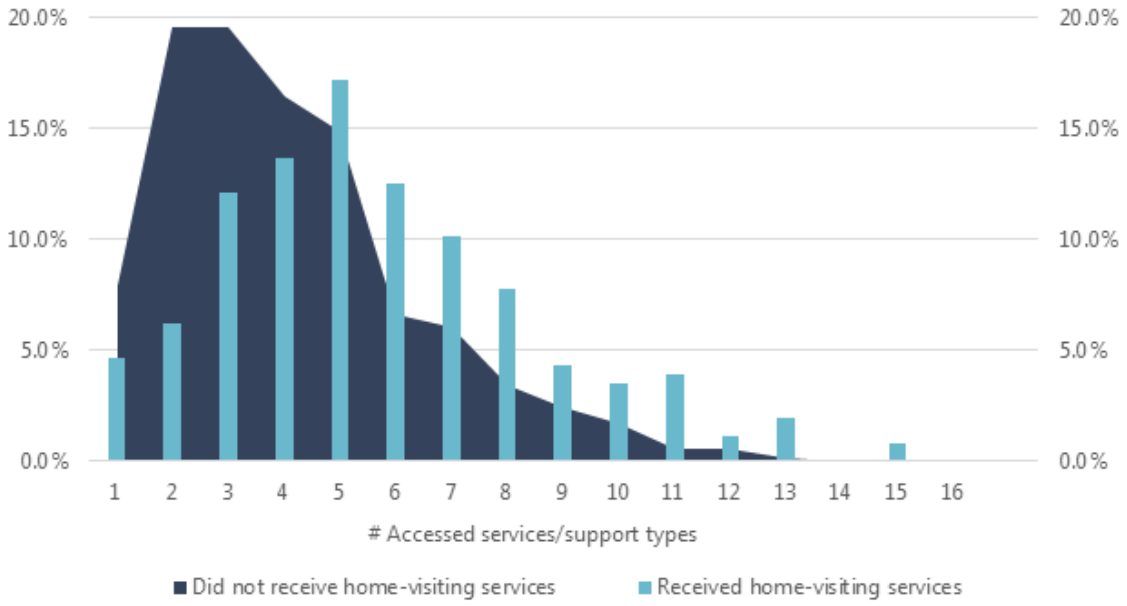


Figure 8 illustrates the rate by which survey respondents sought services by county. The last column of the table shows the percentages for New Hampshire as a whole, allowing for comparisons to be made between state and county data. Directional arrows indicate whether the percentage is higher or lower than the state rate. Highlighted cells indicate a statistically significant difference in services needed; red indicates a higher frequency of services needed (a negative), green denotes less (a positive). One asterisk denotes an alpha value of less than .05 ($p < .05$) and two asterisks denoting an alpha value of less than .001 ($p < .001$).

Figure 8: Frequency of services sought, by county (when compared to the state as a whole)

Type of service/ support	Belknap	Carroll	Cheshire	Coos	Grafton	Hillsborough	Merrimack	Rockingham	Strafford	Sullivan	NH
Finding help to find services, in general	22.5%	25.0%	25.6%	⬇10.4%*	11.8%	26.4%	17.8%	25.0%	14.0%	⬆37.5%*	20.2%
Health care (e.g., a doctor, or medication)	⬆67.6%*	50.0%	46.2%	50.0%	59.2%	51.4%	58.9%	50.0%	57.0%	58.3%	55.1%
Dental care	50.7%	45.0%	⬆61.5%*	37.5%	44.7%	41.4%	42.3%	50.0%	49.5%	37.5%	44.5%
Behavioral health care	26.8%	35.0%	28.2%	25.0%	25.0%	30.0%	20.2%	30.0%	18.3%	29.2%	25.8%
Information on a healthy pregnancy	⬆21.1%*	15.0%	20.5%	13.5%	9.2%	10.5%	9.8%	5.0%	11.8%	⬆29.2%*	12.3%
Parenting information	35.2%	⬆50.0%*	35.9%	25.0%	21.1%	30.0%	27.0%	31.7%	21.5%	⬆54.2%*	29.1%
Child care / day care	33.8%	⬆60.0%*	23.1%	21.9%	22.4%	30.9%	26.4%	⬆46.7%*	30.1%	16.7%	29.5%
Transportation	11.3%	5.0%	⬆23.1%*	6.3%	⬇5.3%*	⬆18.2%*	9.2%	8.3%	12.9%	20.8%	12.2%
Housing	19.7%	25.0%	23.1%	14.6%	11.8%	18.6%	17.8%	23.3%	22.6%	⬆41.7%*	19.3%
Employment	15.5%	15.0%	17.9%	9.4%	17.1%	18.2%	14.1%	8.3%	14.0%	25.0%	15.1%
Job training or education	8.5%	15.0%	7.7%	5.2%	5.3%	6.8%	6.7%	3.3%	8.6%	4.2%	6.7%
Food (e.g., WIC or SNAP)	62.0%	50.0%	59.0%	55.2%	65.8%	⬇47.3%*	63.8%	51.7%	⬆71.0%*	⬆79.2%*	58.5%
Legal services	4.2%	10.0%	15.4%	5.2%	3.9%	10.0%	10.4%	5.0%	3.2%	12.5%	7.8%
Domestic violence	2.8%	0.0%	2.6%	1.0%	5.3%	2.7%	1.8%	5.0%	2.2%	0.0%	2.6%
Cash assistance (e.g., TANF or Social Security)	23.9%	25.0%	20.5%	12.5%	13.2%	17.7%	12.3%	16.7%	17.2%	⬆33.3%*	17.1%
Translation or interpretation	0.0%	0.0%	0.0%	1.0%	1.3%	⬆5.0%*	0.6%	0.0%	1.1%	0.0%	1.7%

[1] *JSI/CHI conducted multiple chi-square tests of independence for each test of significance across the needs assessment update. Any statistically significant relationships throughout this report are emphasized with one asterisk denoting an alpha value of less than .05 ($p < .05$) and two asterisks denoting an alpha value of less than .001 ($p < .001$).*

A caveat exists when reviewing the data for both Carroll and Sullivan County given the total number of respondents from these counties were 20 and 24, respectively, constituting 2.3% and 2.8% of the overall sample. Despite JSI/CHI performing non- parametric chi-square tests of independence to account for the non-normal distributions and lack of variance for these counties, the small sample sizes still have the potential to affect the sensitivity of the performed analyses, when comparing these counties with the state.

Within health care, the access rate for Belknap County was significantly higher than the overall state access rate (67.6% vs. 55.1%, respectively). Within dental care, the access rate for Cheshire County was significantly higher than the overall state access rate (61.5% vs. 44.5%, respectively). Within food, the access rate was significantly lower for Hillsborough County (47.3% vs. 58.5%, respectively), and was significantly higher for Strafford and Sullivan County, when compared with the state access rate (71.0% vs. 58.5%, respectively; and 79.2% vs. 58.5%, respectively).

Figure 9 describes the difficulty in accessing services, by county. The last column of the table shows the average number of barriers for each type of support or service for New Hampshire as a whole. The barriers included in the analyses were: Too expensive; Too far away; No room/waiting list; Couldn't find help; Staff didn't understand my family's needs, and; Language barriers. Thus, the maximum number of barriers for types of support/services that any participant could have selected was six. For this analysis, JSI/CHI calculated an average number of barriers using the total numbers of barriers specified by each participant, per county. Asterisks denote a statistically significant difference between the county and state average. Highlighted cells indicate a statistically significant difference in barriers experienced; red indicates more barriers (a negative), green denotes fewer (a positive).

Figure 9: "Please tell us about any barriers you experienced accessing services. " Average number of barriers experienced by county (when compared to the state as a whole)

Type of service/ support ⬇	Belknap	Carroll	Cheshire	Coos	Grafton	Hillsborough	Merrimack	Rockingham	Strafford	Sullivan	NH
Finding help to find services, in general	.103	.102	.103	.098	.103	.116 ⬆*	.094	.095	.107	.105	.103
Health care (e.g., a doctor, or medication)	.190	.183	.185	.183	.184	.189	.182	.178	.181	.188	.184
Dental care	.226	.226	.235 ⬆**	.223	.228	.218	.219	.220	.229	.228	.225
Behavioral health care	.139	.139 ⬆*	.141	.140	.140	.139	.129	.136	.131	.137	.137
Information on a healthy pregnancy	.019 ⬆*	.015	.014	.016	.015	.016	.013	.014	.015	.015	.015
Parenting information	.060	.057	.059	.057	.058	.059	.057	.056	.059	.059	.058
Child care / day care	.250	.249	.248	.234 ⬇*	.242	.246	.246	.251	.250	.245	.246
Transportation	.084	.084	.085	.076	.077	.088	.077	.078	.081	.082	.081
Housing	.151	.155	.159	.153	.154	.153	.150	.161	.153	.167 ⬆*	.155
Employment	.051	.050	.055	.050	.048	.053	.048	.051	.050	.054 ⬆*	.051
Job training or education	.049	.048	.050	.050	.048	.052	.043	.050	.048	.050	.049
Food (e.g., WIC or SNAP)	.083	.086	.091 ⬆*	.088	.082	.090	.086	.082	.089	.094 ⬆*	.087
Legal services	.036	.039	.039	.038	.038	.043	.036	.037	.038	.038	.038
Domestic violence	.016	.015	.014	.017	.014	.015	.013	.014	.019	.015	.015
Cash assistance (e.g., TANF or Social Security)	.044	.049 ⬆*	.049	.046	.044	.044	.043	.046	.049	.052 ⬆*	.046
Translation or interpretation	.016	.015	.016	.018	.015	.015	.014	.014	.015	.015	.015

Eleven statistically significant differences were identified altogether (10 higher than the state average, and one lower than the state average). The greatest difference was observed in the average number of barriers in accessing dental care for Cheshire County, when compared to the state average (0.235 vs. 0.225, respectively; $p < .001$). The remainder of the statistically significant differences all had alpha values of $p < .05$. As mentioned previously, the reader should exercise caution when considering the analyses for both Carroll and Sullivan County because of the small sample size from those regions.

JSI/CHI analyzed the volume of those seeking services and barriers to access by several key demographic groups to further identify potential areas of disparity: home visiting participation status, ethnicity, relocation status, native language, and race. **Figure 10** shows how often survey respondents reported seeking out services, broken out by these demographics. Cells highlighted in green indicate a statistically significant higher access rate than the comparison group.

Figure 10: Percentages of those who accessed services/types of support, broken out by specific demographics.

Type of service/ support	Home-visited (n = 256)	Not home-visited (n = 577)	Hispanic/ Latino (n = 80)	Not Hispanic/ Latino (n = 739)	Has relocated to US (n = 21)	Has not relocated to US (n = 812)	Non-English speaking (n = 84)	English-speaking (n = 749)	Non-White (n = 100)	White (n = 717)
Finding help to find services, in general	**33.8% ⬆***	14.1%	23.8%	19.8%	23.8%	19.7%	21.4%	19.8%	**27.0% ⬆***	18.1%
Health care (e.g., a doctor, or medication)	59.2%	53.9%	46.3%	56.2%	66.7%	54.6%	52.4%	55.4%	44.0%	**57.0% ⬆***
Dental care	**52.3% ⬆***	41.2%	36.3%	45.6%	57.1%	43.8%	45.2%	44.3%	46.0%	44.2%
Behavioral health care	**36.2% ⬆****	20.8%	10.0%	**27.7% ⬆****	4.8%	**26.4% ⬆***	9.5%	**27.6% ⬆****	20.0%	27.1%
Information on a healthy pregnancy	**16.9% ⬆***	10.6%	7.5%	13.1%	14.3%	12.4%	10.7%	12.8%	16.0%	12.1%
Parenting information	**47.7% ⬆****	20.9%	16.3%	**31.4% ⬆***	23.8%	29.6%	22.6%	30.4%	33.0%	29.0%
Child care / day care	33.1%	28.4%	21.3%	30.6%	23.8%	29.4%	21.4%	30.2%	27.0%	29.6%
Transportation	**24.6% ⬆****	7.0%	11.3%	12.6%	**28.6% ⬆***	11.8%	**20.2% ⬆***	11.6%	**18.0% ⬆***	11.4%
Housing	**26.5% ⬆****	15.5%	12.5%	20.0%	9.5%	19.6%	15.5%	19.9%	13.0%	**20.4% ⬆***
Employment	16.9%	14.5%	18.8%	15.2%	19.0%	15.1%	16.7%	15.2%	14.0%	15.1%
Job training or education	**9.2% ⬆***	5.8%	7.5%	6.9%	4.8%	7.0%	8.3%	6.8%	10.0%	6.4%
Food (e.g., WIC or SNAP)	**64.6% ⬆***	55.8%	50.0%	60.1%	42.9%	59.4%	47.6%	60.3%	52.0%	59.8%
Legal services	**11.9% ⬆***	5.9%	2.5%	**8.1% ⬆***	0.0%	7.9%	2.4%	**8.3% ⬆***	6.0%	7.9%
Domestic violence	**4.2% ⬆***	1.7%	2.5%	2.6%	0.0%	2.7%	3.6%	2.5%	4.0%	2.5%
Cash assistance (e.g., TANF or Social Security)	29.2% ⬆**	11.2%	11.3%	18.1%	23.8%	17.0%	14.3%	17.6%	18.0%	17.2%
Translation or interpretation	2.3%	1.6%	**7.5% ⬆***	0.9%	**14.3% ⬆***	1.2%	**14.3% ⬆****	0.3%	**5.0% ⬆***	1.0%

The data broken out by home visiting status mirrors the findings from **Figure 6**, in that higher proportions of those who received home visiting services accessed services/types of support than those who did not receive home visiting services. Of the 12 statistically significant relationships, four had alpha values of less than .001 ($p < .001$): behavioral health care, parenting information, transportation, housing, and cash assistance support/services.

Looking at the data by Hispanic/Latino status, the most notable differences were the higher percentage of non-Hispanic/Latino respondents accessing behavioral health care services, parenting information, and legal services (27.7%, 31.4%, and 8.1%, respectively) compared to Hispanic/Latino respondents (10.0%, 16.3%, and 2.5%, respectively). Also, significantly more Hispanic/Latino respondents sought translation/interpretation services than non-Hispanic/Latino respondents (7.5% and 0.9%, respectively).

JSI/CHI also found statistically significant differences when assessing the data by relocation status. For example, significantly more relocated respondents sought transportation and translation/interpretation services than non-relocated respondents (28.6% vs. 11.8%, and 14.3% vs. 1.2%, respectively). There was also a significantly higher percentage of non-relocated respondents accessing behavioral health care services compared to relocated respondents (26.4% vs. 4.8%, respectively).

The most notable differences between English and non-English speakers were the higher percentage of English speakers accessing behavioral health care ($p < .001$) and legal services (27.6% and 8.3%, respectively) compared to non-English speakers (9.5% and 2.4%, respectively). However, significantly more non-English speakers sought transportation and translation/interpretation services than English speakers (20.2% and 14.3%, respectively).

With regard to race, JSI/CHI observed statistically significant differences when looking at the percentage of White respondents accessing health care services and housing support (57.0% and 20.4%, respectively) compared to non-White respondents (41.0% and 13.0%, respectively). However, significantly more non-White respondents sought help to find services, transportation, and translation/interpretation services than White respondents (27.0%, 18.0% and 5.0%, respectively), and these differences were statistically significant ($p < .05$).

Figure 11 illustrates the level of difficulty respondents experienced in attempting to access support services. For this analysis, JSI/CHI calculated an average number of barriers using the total number of barriers specified by each participant. Highlighted cells indicate a statistically significant difference in barriers experienced between comparison groups with red indicating more barriers.

Figure 11: Average number of barriers experienced, broken out by specific demographics

Type of service/ support	Home-visited (n = 256)	Not home-visited (n = 577)	Hispanic/ Latino (n = 80)	Not Hispanic/ Latino (n = 739)	Has relocated to US (n = 21)	Has not relocated to US (n = 812)	Non-White (n = 100)	White (n = 717)
Finding help to find services, in general	**0.152 ⬆***	0.081	0.063	0.097 ⬆	0.095 ⬆	0.091	0.110 ⬆	0.088
Health care (for example, a doctor, or medication)	0.191 ⬆	0.185	0.063	**0.198 ⬆***	0.286 ⬆	0.181	0.160	0.184 ⬆
Dental care	0.266 ⬆	0.210	0.175	0.234	0.333 ⬆	0.224	0.250 ⬆	0.222
Behavioral health care	**0.211 ⬆***	0.107	0.050	**0.143 ⬆***	0.048	0.135 ⬆	0.070	0.144 ⬆
Information on a healthy pregnancy	0.020 ⬆	0.014	0.000	0.018 ⬆	0.048 ⬆	0.015	0.010	0.015 ⬆
Parenting information	**0.113 ⬆***	0.033	0.013	0.062 ⬆	0.000	0.058 ⬆	0.040	0.060 ⬆
Child care / day care	0.277 ⬆	0.237	0.163	0.250 ⬆	0.381 ⬆	0.240	0.290 ⬆	0.238
Transportation	**0.137 ⬆***	0.057	0.038	0.087 ⬆	**0.238 ⬆***	0.079	**0.150 ⬆***	0.074
Housing	**0.230 ⬆***	0.120	0.063	0.157 ⬆	0.095	0.154 ⬆	0.070	0.165 ⬆*
Employment	0.082 ⬆	0.035	0.013	0.057 ⬆	0.048	0.053 ⬆	0.060 ⬆	0.052
Job training or education	0.059 ⬆	0.043	0.050 ⬆	0.046	0.048 ⬆	0.046	**0.080 ⬆***	0.042
Food (e.g., WIC or SNAP)	0.109 ⬆	0.081	0.050	0.088 ⬆	0.143 ⬆	0.084	**0.140 ⬆***	0.075
Legal services	**0.070 ⬆***	0.024	0.025	0.042 ⬆	0.000	0.041 ⬆	0.040 ⬆	0.039
Domestic violence	0.023 ⬆	0.012	0.000	0.016 ⬆	0.000	0.015 ⬆	0.000	0.015 ⬆
Cash assistance (e.g., TANF or Social Security)	0.070 ⬆	0.036	0.013	0.053 ⬆	0.000	0.049 ⬆	0.060 ⬆	0.047
Translation or interpretation	0.008	0.019 ⬆	0.000	0.016 ⬆	0.000	0.015 ⬆	0.010	0.015 ⬆

The first two columns of **Figure 11** show the average number of barriers experienced by those who did and did not receive home visiting services. The averages were higher for all but one of the services/types of support, in favor of those who received home visiting services (the exception being translation/interpretation services). Of those higher averages, six of the differences were statistically significant ($p < .05$). One interpretation of this finding is that as home visiting participants engage more in services, they naturally are exposed to barriers associated with a particular service.

When assessing the average number of barriers experienced by Hispanic/Latino and non-Hispanic/ Latino respondents, the most notable (and statistically significant) differences were the higher average number of barriers experienced by non- Hispanic/Latino respondents accessing health care and behavioral health care services (0.198 and 0.143, respectively; both $p < .05$) compared to Hispanic/Latino respondents (0.063 and 0.050, respectively). The only type of support/service with a marginally higher average number of barriers experienced by Hispanic/Latino

(compared to non-Hispanic/Latino) respondents was job training or education (0.050 vs. 0.046, respectively) – but this difference was not statistically significant ($p > .05$). For relocated (to U.S.) respondents, the only statistically significant difference observed was the higher average number of barriers experienced by relocated-to-U.S. respondents accessing transportation services (0.238 vs. 0.079).

While not shown in the table, no statistically significant differences were identified when assessing the barriers for English and non-English speakers.

The most notable (and statistically significant) differences when assessing race were the higher average number of barriers experienced by non-White respondents in accessing transportation, job training or education, and food (e.g., WIC or SNAP) services/ support (0.150, 0.080, and 0.140, respectively). However, significantly more White respondents reported a higher average number of barriers in accessing housing support than non-White respondents (0.165 and 0.070, respectively), and this difference was statistically significant ($p < .05$).

Assessment of home visiting services

Two hundred fifty two respondents reported being involved in at least one home visiting program (**Figure 12**). **Figure 13** shows the breakdown of responses to the following question: "How long have you been/were you involved with the home visiting program?" (n = 225). Of those who did receive home visiting services, most were involved between one and two years (27.2%), with a majority of home-visited respondents involved for at least seven months.

Figure 12: Survey Respondents, by home visiting program

	n	%
Family Centered Early Supports and Services (aka Early Intervention)	**54**	**17.5%**
Early Head Start	**53**	**17.2%**
Healthy Families America	**44**	**14.2%**
Other (e.g., a family resource center)	**43**	**13.9%**
Head Start	**40**	**12.9%**
Comprehensive Family Support Services	**30**	**9.7%**
Post partum visiting nurse	**30**	**9.7%**
Home Visiting NH	**8**	**2.6%**
Project LAUNCH	**7**	**2.3%**

Figure 13: "How long were you involved with your home visiting program?"

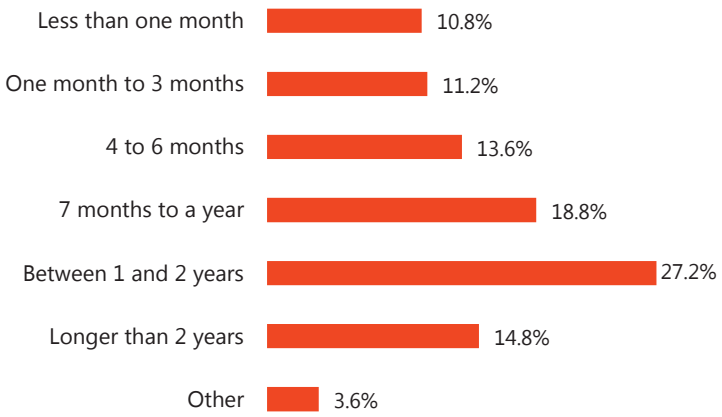
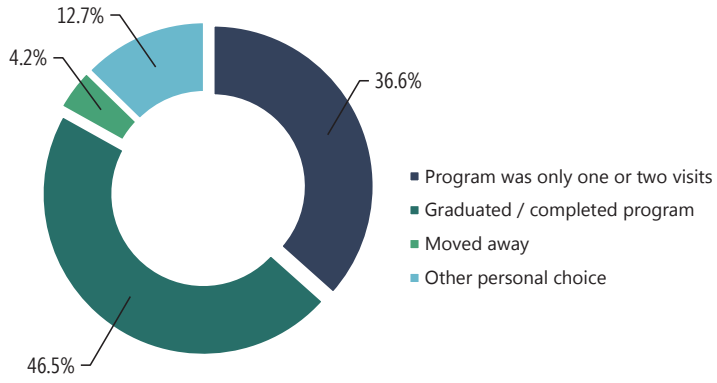


Figure 14 illustrates reasons why respondents are no longer in a home visiting program. Of those who did receive home visiting services, a majority graduated or completed their program (46.5%); or their program was only one or two visits (36.6%). Personal reasons cited included timing/scheduling challenges, choosing to self-teach parenting skills, and a general belief that the respondent no longer needed services.

Figure 14: "Please tell us why you are no longer in the home visiting program?"



For respondents who were never involved with a home visiting program, the most common reason was "I didn't need a home visiting program" (79.4%). "Other" reasons included that the children were not the right age, families did not know about home visiting programs, scheduling conflicts, and families were already receiving support from other non-home visiting programs. **Figure 15** shows the full breakdown of responses to this question.

Figure 15: "Why didn't you participate in a home visiting program?"

Not offered	**16.2%**
Couldn't find a program	**1.1%**
I didn't need a home-visiting program	**79.4%**
I wanted to, but the available programs didn't meet my family's needs	**2.4%**
Other	**0.9%**

The overwhelming "I didn't need a home visiting program" response, in particular, points to a strategic opportunity for the home visiting community in terms of messaging and framing home visiting and family strengthening supports as a universal benefit for all families – not just something to support families in times of need or "deficit".

Figures 16a and 16b illustrate the general satisfaction of home-visited respondents with the services they received, by program. For the "The home visiting services were helpful" statement, the majority of the responses are weighted toward "Strongly agree" or "Agree" domains. For the "My family was comfortable talking to my home visitor about things my family needed" statement, the "Strongly agree" responses ranged from 93.2% to 73.1%.

For the "The frequency of the home visits were sufficient" question, the majority of respondents "Strongly agreed". Of the "Strongly agree" responses, the proportion of responses ranged from 96.6% (Comprehensive Family Support Services) to 69.0% (postpartum visiting nurse). The most prominent "Strongly disagree" responses came from those who received services from a postpartum visiting nurse (6.9%).

A similar pattern of responses was observed for the "I was satisfied with the home visiting services" statement, albeit with more overall weighting in the "Strongly agree/Agree" domain. Of the "Strongly agree" responses, the proportion of responses ranged from 96.6% to 69.0%.

Figures 16a: Perceptions of home visiting services, Part 1

	The home visiting services were helpful				My family was comfortable talking to my home visitor about things my family needed			
	Strongly agree	**Agree**	**Disagree**	**Strongly Disagree**	**Strongly agree**	**Agree**	**Disagree**	**Strongly Disagree**
Comprehensive Family Support Services (*n* = 29)	93.1%	6.9%	0.0%	0.0%	93.1%	6.9%	0.0%	0.0%
Early Head Start (*n* = 49)	79.6%	20.4%	0.0%	0.0%	83.7%	16.3%	0.0%	0.0%
Family Centered Early Supports and Services (*n* = 49)	88.0%	12.0%	0.0%	0.0%	81.6%	16.3%	2.0%	0.0%
Head Start (*n* = 38)	76.3%	15.8%	5.3%	2.6%	81.6%	18.4%	0.0%	0.0%
Healthy Families America (*n* = 44)	90.9%	9.1%	0.0%	0.0%	93.2%	6.8%	0.0%	0.0%
Home Visiting NH (*n* = 8)	87.5%	12.5%	0.0%	0.0%	87.5%	12.5%	0.0%	0.0%
Project LAUNCH (*n* = 7)	85.7%	14.3%	0.0%	0.0%	85.7%	14.3%	0.0%	0.0%
Postpartum visiting nurse (*n* = 29)	75.9%	20.7%	0.0%	3.4%	75.9%	20.7%	0.0%	3.4%
Other (e.g., a family resource center; *n* = 42)	83.3%	14.3%	0.0%	2.4%	87.5%	7.5%	5.0%	0.0%

Figures 16b: Perceptions of home visiting services, Part 2

	The frequency of the home visits were sufficient				I was satisfied with the home visiting services			
	Strongly agree	Agree	Disagree	Strongly Disagree	Strongly agree	Agree	Disagree	Strongly Disagree
Comprehensive Family Support Services (*n* = 29)	96.6%	3.4%	0.0%	0.0%	96.6%	3.4%	0.0%	0.0%
Early Head Start (*n* = 49)	75.5%	16.3%	8.2%	0.0%	79.6%	20.4%	0.0%	0.0%
Family Centered Early Supports and Services (*n* = 49)	74.0%	20.0%	4.0%	2.0%	80.0%	18.0%	0.0%	2.0%
Head Start (*n* = 38)	78.9%	15.8%	5.3%	0.0%	78.9%	21.1%	0.0%	0.0%
Healthy Families America (*n* = 44)	81.8%	13.6%	4.5%	0.0%	93.0%	7.0%	0.0%	0.0%
Home Visiting NH (*n* = 8)	87.5%	0.0%	12.5%	0.0%	75.0%	25.0%	0.0%	0.0%
Project LAUNCH (*n* = 7)	85.7%	14.3%	0.0%	0.0%	71.4%	28.6%	0.0%	0.0%
Postpartum visiting nurse (*n* = 29)	69.0%	24.1%	0.0%	6.9%	69.0%	27.6%	0.0%	3.4%
Other (e.g., a family resource center; *n* = 42)	82.9%	12.2%	4.9%	0.0%	81.0%	19.0%	0.0%	0.0%

NH Home Visitor Survey

The *NH Home Visitor Survey* was also adapted from the *2010 Oregon MIECHV Needs Assessment.* Following a similar approach and methods as the family survey, the *NH Home Visitor Survey* aimed to capture the perspective of home visitors regarding the needs of New Hampshire families, as well as understand the home visitors' perceived attitudes regarding the benefits and challenges of working in the field. The full survey is available as an appendix.

JSI/CHI distributed the survey across the same channels as the *NH Family and Caregiver Survey*, with responses also remaining anonymous, and respondents having an opportunity to win a gift card for their participation. JSI/CHI based a goal sample size of 75 on a rough estimate of 300 home visitors across the state. Fifty-two home visitors completed the survey, representing agencies and home visiting programs from all counties.

Home Visitor Demographics

Survey respondents represented agencies and programs from across the state from a broad range of backgrounds and experience **(Figure 18).**

Respondents were overwhelmingly female (98%), white (92%), non-Hispanic/Latino (94%), and almost exclusively spoke English primarily at home (98%). Age ranges were almost equally distributed across all categories beyond 25 years old **(Figure 19).**

Home visitors in New Hampshire experience in the field ranges from less than a year to 20 years, with average experience around nine years.

Further, nearly three-quarters (73%)of the respondents report having an associate or bachelor's degree, and 15% have a Master's Doctorate, or other higher degree. Almost one-third (29%) have special certifications in teaching or education, 11% have certifications in behavioral health, and 9% have certifications in social work. A small percentage report having nursing licenses (2%).

Home visitors were working with families and providing services (either directly or through a translator) in Spanish (19.2%), Arabic (9.6%), Nepali (9.6%), and in an African language (9.6%).

Figure 18: For which home visiting programs do you provide services?

Program Name	%
Comprehensive Family Support Services	38.50%
Healthy Families America	26.90%
Early Head Start	23.10%
Head Start	9.60%
Home Visiting NH	9.60%
Other*	7.70%
Family Center Early Supports and Services (aka Early Interventions)	7.70%
Parenting Plus	3.80%
**"Other" responses included "Family Resource Center", "mental health", "Partners in Health", and "Supervised visits".*	

Figure 19: How old are you?

Home Visitor Age	%
18-24	1.90%
25-34	25.00%
35-44	23.10%
45-54	25.00%
55 or older	25.00%

Benefits and Challenges to Working in Home Visiting

In the survey, home visitors shared what were the most impactful benefits and challenges to their roles as home visitors (**Figures 20 and 21**). Interestingly, but perhaps not surprisingly, the most challenging aspects reported were almost identically flipped to the impactful benefits reported. The most impactful benefits to being a home visitor were reported as the training and development opportunities available to staff, having manageable caseloads, direct supervision, and feeling supported within their organization. The most challenging aspects to the role of a home visitor included insufficient salary, a lack of available services to refer families, lack of systems-coordination to support families, and not enough opportunities to support self-care. The benefits may be attributed to inter-agency overlapping of home visiting and family strengthening programs sharing training resources, and evidence-based programs implementing case limits and supervision requirements. These challenges are commonly cited as reasons for compassion fatigue and high-staff turnover in many home visiting programs.

Figure 20: Greatest benefits of being a home visitor (average based on top 10 ranking, 10=high impact)

	Average ranking	N=# of people ranked in top 10
Sufficient training and development opportunities	**7.13**	45
Manageable caseload	**7.00**	45
Direct supervision	**6.43**	44
Support structure within organization	**5.98**	43
Availability of services to refer families	5.71	45
Salary	5.59	46
Broad, coordinated efforts to support families at county/town/state level	5.02	45
Reimbursement of mileage and other out of pocket expenses	4.85	46
Personal safety	4.71	41
Access to self-care supports/ opportunities	4.59	44

Figure 21: Most challenging aspects of being a home visitor (average based on top 10 ranking, 10=most challenging)

	Average ranking	N=# of people ranked in top 10
Insufficient salary	9.03	37
Unavailability of services to refer families	8.15	33
Lack of coordinated efforts to support families at county/ town/state level	7.61	28
Not enough opportunities to support self-care	6.07	27
Lack of organizational support	5.74	23
Caseloads too large	5.54	22
Personal safety	4.82	22
Lack of direct supervision	4.55	22
No reimbursement for mileage/ out of pocket expenses	4.45	22
Lack of available training and development opportunities	3.86	22

Home Visitor Perceptions of Family Challenges

Home visitors identified housing, transportation, and behavioral health needs as the most pressing challenges facing the families they serve. Not surprisingly, when asked to rate how often these needs of New Hampshire families are met, these three topics were identified as poorly-met needs. The most well-met needs included: access to parenting information, access to health care, information on a healthy pregnancy, food security, and support for navigating how to access resources. Conversely, poorly-met needs included: access to legal services, transportation, job training/ education, employment, and housing. **Figure 22** uses color gradations to show the ranking of the home visitors' perspective on the challenges facing families they serve and the degree to which these needs are met by area agencies.

Figure 22: Most common issues facing families (NH Home Visitor Survey responses)

	Average Ranking (scale 1-10, 10=high need)	How often are the needs met? (scale 0-3, 0=needs never met)
Housing	7.57	1.45
Transportation	7.49	1.39
Behavioral health care	7.44	1.67
Parenting information	6.26	2.73
Finding somewhere to go for help	6.03	2.33
Child care / day care	5.62	1.67
Dental care	5.2	1.53
Employment	5.05	1.43
Translation or interpretation	4.9	1.54
Job training or education	4.83	1.43
Information on a healthy pregnancy	4.67	2.47
Food (ex., WIC or SNAP)	4.41	2.43
Legal services	4.2	1.20
Health care	4.1	2.49
Domestic violence	3.7	1.88
Cash assistance	3.65	1.98

PhotoVoice Project

JSI/CHI selected the PhotoVoice approach as a component of the needs assessment update as a way to include the experiences, values, and insights of those served by the NH MIECHV-funded home visiting program. PhotoVoice is a participatory action research process in which individual participants take photos to capture their everyday realities and thereby focus on those things of greatest importance to them. Seeing these issues through the eyes of the families that are served by home visiting programs is a way for planners, policy makers, and program administrators to understand how to improve and change their services. The PhotoVoice component of this research sought to understand the factors that help or hinder clients' full participation in home visiting services.

JSI/CHI reached out to seven agencies to participate in the PhotoVoice project, with two agreeing to participate: TLC Family Resource Center and Home Healthcare Hospice & Community Service. Twelve participants met two times across both sites to complete the PhotoVoice project.

The PhotoVoice project was framed around three research questions:

1. What factors help you be involved with home visiting?
2. What factors make it hard to be involved with home visiting?
3. What keeps you motivated to stay in the home visiting program?

Participants were asked to take photos of their daily lives as they relate to the research questions, and reflect on what those photos represented through worksheet prompts and during the facilitated discussion in the second project meeting. A summary of themes is discussed below.

Positive Attributes to Participation in Home Visiting

Four themes surfaced during discussions regarding the positive attributes of home visiting: 1) creating happy families, 2) consistent, reliable support for any situation, 3) encouraging healthy child development, and 4) fostering increased social connections. Photographs included in this section belong to the project participants, who gave permission for the photos to be released for the purposes of this report.

CREATING HAPPY FAMILIES

Participants described the importance of their children and their families as a significant factor that keeps them motivated to be involved in the home visiting program. They expressed appreciation for the family-centered approach that home visiting practices, in which the entire family receives support from the system – services and home visiting staff do not just focus on the one child enrolled in the program. Home visitors treat all children in the family as clients of the program – not just those officially enrolled. For example, one participant added how grateful she was when her 15-year-old child received gifts at a holiday party.

Additionally, participants value that the home visiting program provides information, resources, and support to help parents feel like they are doing the best job they can. Participants strive to create childhoods for their children full of good memories, opportunity, and structure, and the home visiting program has been a backbone in facilitating that to become their reality.

There is a sense that the home visiting experience not only helps the children, but also helps the parent develop into a better parent. Participants appreciate the effort home visiting staff continuously put into helping them build a stronger and happier family unit; specifically, encouraging self-care activities for the parents, activities to foster sibling relationships, and introducing the family to new outdoor activities in the area.

"I want people to know that home visiting isn't just for the one specific client; they really do help everyone become a stronger family unit.

I don't know what I would have done without my home visitor."

CONSISTENT, RELIABLE SUPPORT FOR ANY SITUATION

Another dominant theme that emerged from the discussion was the importance of having a source of support for the range of issues participants face. That support ranged from emotional support to more tangible support with problems such as transportation and health care support. Regarding emotional support, participants appreciated help they receive to reinforce their parenting skills, struggles with low self-esteem/ confidence, and strategies to cope with stress and anxiety. Many families involved with home visiting feel isolated and they like knowing there is someone to coach them with their decisions and to talk with at any time. One mom described feeling reassured knowing she could text the home visiting nurse with her doubts or concerns about her child's well-being.

"Our home visiting nurse was able to come to our house to check on our baby when we needed her the most. I can text the nurse at any point during the day to get advice. It's really useful as a paranoid mom. The HFA nurses are so helpful."

"My home visitor is always saying things to me about how great I am or wonderfully I am doing as a parent. It's amazing to hear because I struggle with self-esteem."

Other common supports participants cited include their home visitors attending doctor's appointment or other important meetings related to their child, and support and education around routine tasks such as bathing and naptime. Participants also value support with rides to appointments and rides for their children, mentioning that they would have never been able to make it to certain appointments if it was not for the home visiting staff. In addition, participants were grateful for tangible support such as bus passes and donated clothes and toys.

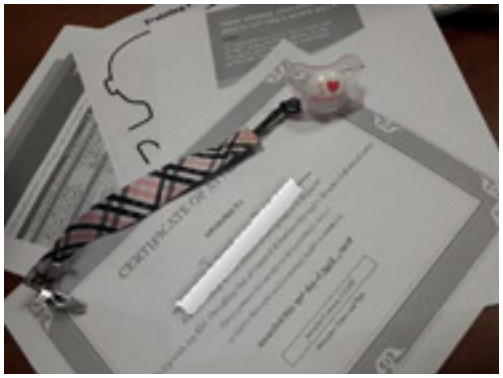
They also value the support they receive related to problem-solving issues such as learning to schedule and keep appointments. One participant described the help she received when looking for a job, noting the appreciation she had that the home visiting staff picked up her applications.

"My home visitor goes in with me every time my kids have an appointment.

There is always support when you need it through this program."

"My home visitor has helped me with bus passes for the city bus which is important for me to get my child to school."

Another important type of support cited was for behavioral health issues across a continuum. Women talked about support they receive from the home visiting program dealing with depression, intimate partner violence, and substance misuse. From the discussion, it was clear the home visitor supports parents at whatever stage of change they are in related



to coping with these issues by offering strategies to reduce harm, maintain safety, cope with stress, and expand their personal resources while increasing their opportunities for therapy.

"After many years of therapy I have learned coping mechanisms and how to set boundaries so I can stay healthy. Boundaries are a big struggle. Boundary setting is something I work on with my home visitor because it's extremely important."

ENCOURAGING HEALTHY CHILD DEVELOPMENT

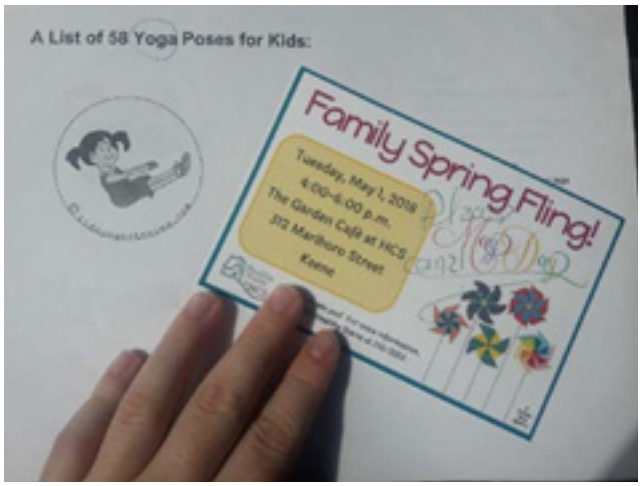
Participants are very satisfied with the information and guidance they receive on their baby's growth and development. Home visiting excels in meeting parents and children where they are on their continuum of parenting needs. Home visiting shares activities to promote social connections, encourage motor skill

development or give simple ideas to have fun. Home visitors share low or no-cost, fun activities to engage the children and keep them connected socially. They bring books and encourage book sharing between caregivers and children. One mom shared that she likes the low-cost ideas for stimulating toys for her children. When asked for an example, she said her home visitor showed her how to make a toy from an old prescription bottle and rice. Another participant described help with a scavenger hunt as a fun family activity.

Some families face more challenging situations with their children such as developmental, intellectual, and physical delays or disabilities. Having a home visitor helps the families face these challenges and find the resources they need to address them proactively. Participants were thankful for the encouragement and support to teach their children colors, animals, and shapes. They were also thankful these developmental delays were identified early so they could intervene appropriately.

FOSTERING INCREASED SOCIAL CONNECTIONS

Another prominent theme in the PhotoVoice discussions was the added benefit of social connection



with the home visitors and other parents in the community. Parents talked about how difficult it can be to get out and how helpful it is for the home visitor to come into their home. They also referenced the opportunity that home visiting provided in terms of connecting socially with other families. Many families noted that the home visiting program introduced them to many free social activities and services in the community they would not have otherwise known about. Specific services and activities mentioned include local farms, yoga classes, parks, and women's recovery groups.

"It validated a lot of what I am going through being connected to this parent group through my home visitor."

Challenging Attributes of Participation in Home Visiting

The main challenge discussed was the anxiety participants feel as they approach the end of their experience with home visiting as their child is

approaching their third birthday. Families feel a sense of loss about losing the services and social network and are anticipating their children will suffer a loss as well. They have come to rely on the home visitor for emotional support and connection and they grieve the end of the relationship. They talked about ways to prepare for the transition but felt the alternative services were not as meaningful and robust as what they had been receiving through their intimate home visiting experience.

"I don't like having to take people out of my son's life. I wish the program went longer so he could continue to benefit. It is a wonderful program and I'm so glad we've been able to be a part of it for the last three years."

Specific to their participation in HFA, another noted challenge was the mandatory paperwork throughout the experience; specifically the *Ages and Stages Questionnaire* (ASQ) and other screenings and surveys that are required. Participants feel this paperwork is redundant and does not benefit their families or enhance their experience. They would like to see some of this paperwork made optional.

The last challenge of participating was considered a "blessing and a curse." On the one hand, families like the fact they are given a choice about the location of the appointment. Most schedule in their home for the convenience. They do not need to pack up their children or drive someplace. On the other hand, they feel stress and anxiety about someone coming into their home. They feel pressure to clean and tidy up.

DISCUSSION

Identifying Communities with Risk

New Hampshire currently maintains a population estimated at 1,327,503 residents, with approximately 65,000 under the age of five. Eighteen percent of the total population are women between the ages of 15 and 44 (U.S. Census Bureau). A largely rural state with few urban centers, the state - as a whole - is fairly racially and ethnically homogenous with almost 94% of the population identifying as white, and almost 97% non-Hispanic (U.S. Census Bureau). A high school graduation rate of 93%, bachelor's degree attainment rate of 35.5%, and an unemployment rate of only 2.6% (as of May 2018) paints a picture of a strong economy and a stable workforce.

While New Hampshire is perennially ranked by many national organizations as one of the top states to live and raise children, various public health and social service professionals can attest to a more challenged outlook for many young families. As demonstrated later in this report, disparity and social vulnerability abound in geographic pockets of the state, particularly in many of the domains critical to the planning of home visiting services: socioeconomic status, adverse perinatal outcomes, substance use, crime, and child maltreatment.

Below, several key statewide statistics are highlighted within these domains, demonstrating risk factors which may make families eligible to receive home visiting services.

According to the *2012-2016 American Community Survey 5-Year Estimates,* 8.6% of children under the age of 18 (23,145) are living with non-biological parents (e.g., grandparents, other relatives, or foster parents). For families with children only under the age of five, single-women households experience the highest rate of poverty, at 35.8%, compared to 3.4% of married couples, and 11.1% of all families (U.S. Census Bureau). Similarly, single mothers of children of all ages have the lowest educational attainment compared to their married counterparts - 39.3% and 4.9%, respectively - putting them at high risk to experience economic and housing insecurity (U.S. Census Bureau). In 2016, 6.4% of infants were born of low birth weight; and 10.8% of mothers smoked during pregnancy (NH Vital Records Birth Certificate Data).

Related to family strength and resilience, the *2016 National Survey of Children's Health* estimated that almost one in ten New Hampshire families with children under the age of 18 are unable to demonstrate at least one of four resilience qualities during difficult times. Resilience qualities include talking together about what to do when faced with a problem, working together to solve problems, knowing their strengths, and staying hopeful in difficult times. In addition, the same survey reports that almost one in five New Hampshire children (19.7%) have experienced at least two adverse childhood experiences, which raises the potential of poor physical and mental health, and negative social consequences later in life. (Hughes, et al., 2017)

Specific to women who had a live birth in 2016, *New Hampshire Pregnancy Risk Assessment Monitoring System* (NH PRAMS) data illustrate mothers' behaviors supportive of positive health outcomes for her and her baby, as well as opportunities whereby mothers can be more supported to engage in those healthy behaviors. For example, 93% of mothers began prenatal care in the first trimester, 91% ever breastfed their baby, and 16% felt comfortable asking for help for depression after their delivery. Conversely, 20% of women could not afford dental care during their pregnancy, 12% smoked shortly after pregnancy, and 22% are bed-sharing at least some of the time (Division of Public Health Services, 2018).

Further illustrating the socioeconomic and health challenges experienced by New Hampshire families with young children, New Hampshire home visitors report their participant families as most commonly facing housing, transportation, and behavioral health care challenges, with legal needs being the least-resourced challenge **(Figure 22)**. Interestingly, these issues do not match the most commonly reported requested services in the *NH Family & Caregiver Survey*: food support, health care support, and oral health care **(Figure 6).**

A possible cause of this discrepancy may be stigma attached to issues so closely related to poverty and behavioral health, and a reluctance of respondents to report needed services. Also, a major partner in distributing the *NH Family & Caregiver Survey* was NH WIC, which may have skewed responses in terms of respondents reporting use of food support services. The results of the *NH Home Visitor Survey* were confirmed in the PhotoVoice focus groups, whereby participants openly discussed their home visitors supporting them in the areas of housing, transportation, and behavioral health care. Additionally, home visitors may choose to focus on longer-term challenges for families, who are focused on the day-to-day challenges of raising children and remaining economically stable.

Communities with Risk

This needs assessment update uncovers existing disparities at both the county and local municipality level which justifies the targeting of limited home visiting and family strengthening resources. Per HRSA guidance, communities showing increased risk in at least two domains are considered at risk. This needs assessment update additionally considers locally-available quantitative data and results from the NH Family Caregiver and Home Visitor surveys to identify additional at-risk communities. Full data tables including the z-scores for all the referenced county and local municipality z-scores are included in the data summary tables submitted to HRSA, and available by request from NH MIECHV. General findings and considerations for these communities are discussed below. Regions are discussed in order of level of need, as informed by a combination of the HRSA and local data indicator analysis, results of the *NH Family & Caregiver Survey*, and the PhotoVoice project.

BELKNAP COUNTY AND LACONIA

As illustrated by the z-score analysis, and supported by the *NH Family & Caregiver Survey*, Belknap County and specifically, the city of Laconia, demonstrate higher risk for poor outcomes that might be mitigated by additional home visiting and family strengthening supports. Belknap County had four at-risk domains, per the HRSA and additional local data indicators, including Adverse Perinatal Outcomes, Substance Use Disorders, Crime, and Child Maltreatment. In addition, the city of Laconia was shown at-risk in the Substance Use Disorder domain. The indicators for Belknap County and Laconia which indicated high-risk compared to the rest of the state (meaning, z-score greater than 1.0) include:

- Low birthweight
- Preterm birth
- Alcohol use
- Marijuana use
- Non-medical use of pain relievers

- Smoking while pregnant
- Prescription drug misuse
- Crime reports
- High school dropout (Laconia, only)
- Overdose deaths (Laconia, only)
- EMS Narcan administration (Laconia, only)

Results from the *NH Family & Caregiver Survey* also indicate a statistically significant higher need (or information seeking- behaviors) as it relates to health care and information on a healthy pregnancy. Additionally, families from Belknap County report statistically significant numerous barriers to accessing supports for a healthy pregnancy.

COOS COUNTY AND BERLIN

Similar to Belknap County, Coos County demonstrated risk in all but one domain, according to HRSA and local indicators: Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, and Child Maltreatment. The town of Berlin, also demonstrated risk in the Socioeconomic Status and Adverse Perinatal Outcomes domains. The individual indicators for Coos County and Berlin, which indicated high risk compared to the rest of the state include:

- Poverty (also, Berlin)
- Unemployment (also, Berlin)
- High school dropout
- Low birthweight (also, Berlin)
- Uninsured (under 65)
- Preterm birth
- Alcohol use
- Tobacco use
- Smoking while pregnant (Berlin, only)
- Binge drinking
- Heroin use
- Sexual assault
- Domestic violence

Interestingly, Coos County respondents to the *NH Family & Caregiver Survey* indicate needing less help in finding supports for their family, and report experiencing significantly fewer barriers to accessing child care. One explanation for this reported resilience is a general sense of independence and self-reliance exhibited by many families living in northern New Hampshire where resources are scarce, and overcoming access challenges are the "norm" rather than the exception.

STRAFFORD COUNTY AND ROCHESTER

Strafford County is the final county to qualify as "high-risk" based on the HRSA indicators, alone, showing risk in the Substance Use Disorder and Crime domains. With additional locally-available data, the city of Rochester also qualifies as high-risk in the Substance Use Disorder domain. Dover - another local municipality examined due to its population in relation to the county overall - did not have any indicators with a z-score greater than 1.0. The individual indicators for Strafford County and Rochester which indicate high-risk compared to the rest of the state include:

- Alcohol use
- Marijuana use
- Non-medical use of pain relievers
- Crime reports
- Juvenile arrests
- High school dropout
- Overdose deaths
- EMS Narcan administration (also, Rochester)

There were no statistically significant *NH Family & Caregiver Survey* results separating Strafford County from the rest of the state, except in a significantly higher need for food supports.

SULLIVAN COUNTY

Sullivan County demonstrated high-risk in one domain based on HRSA-prescribed indicators alone: Adverse Perinatal Outcomes. Additional locally-available data indicators proved Sullivan County high-risk in an additional two domains: Crime and Child Maltreatment. The single municipality examined in Sullivan County based on population - Claremont - did not demonstrate high- risk for any of the local municipality data indicators. The individual indicators for Sullivan County which indicate high-risk compared to the rest of the state include:

- High school dropout
- Low birthweight
- Preterm birth

- Tobacco use
- Juvenile arrests
- Domestic violence

While Sullivan County may have one of the fewest number of indicators qualifying the county as high-risk,

results of the *NH Family & Caregiver Survey* highlight a great need in this area of the state. Per survey results, Sullivan County families with young children have significantly higher need as compared to the rest of the state for:

- Support finding services, in general
- Information on a healthy pregnancy
- Parenting information
- Housing
- Food supports
- Cash assistance

Sullivan County families also report experiencing significantly more barriers in accessing housing, employment, food, and cash assistance.

CHESHIRE COUNTY

Per HRSA indicators, Cheshire County demonstrates risk in one domain - Child Maltreatment - along with the Crime domain, per locally-available indicator data. Cheshire's largest municipality - Keene - did not have any data indicators with a z-score greater than 1.0. The individual indicators for which Cheshire County did show high-risk are:

- Illicit drug use
- Heroin use
- Child maltreatment
- Juvenile arrest

Further fleshing out the picture of need in Cheshire County, respondents to the *NH Family & Caregiver Survey* reported a statistically higher need for dental care and transportation supports. Unfortunately, these families also report significantly more barriers to accessing needed dental care, as well as food supports.

CARROLL COUNTY & CONWAY

While Carroll County did not qualify as high-risk in any one domain, either by HRSA or local indicator standards alone, the county and Conway did - in aggregate - have more indicators flag as high-risk than several other high-risk counties (by HRSA prescribed standards), including:

- High school dropout
- Juvenile arrests
- Uninsured (under 19)
- Uninsured (under 65)
- Heroin use
- Low birthweight (Conway, only)
- Preterm birth (Conway, only)

Additionally, Carroll County families report having a higher need for parenting information and child care support than the rest of the state, and face significantly greater challenges in accessing behavioral health care and case assistance.

HILLSBOROUGH COUNTY & MANCHESTER

Similar to Carroll County, Hillsborough County did not qualify as high-risk in any one domain, however, within its borders, the city of Manchester did have significantly higher rates of crime reports and low-birthweight deliveries than the rest of the state. Nashua did not have any indicators flag as high-risk, compared to the other municipalities included in the analysis. Hillsborough County's z-score for illicit drug use was also 1.23, higher than the state average.

While surprising results in so few indicators being high-risk, considering two of the state's urban hubs are located within Hillsborough County's borders (Manchester and Nashua), one might consider the existing resources within those communities currently in place to address higher need expressed by those cities' residents.

Only minimal additional context was provided on this region of the state in the *NH Family & Caregiver Survey*, which showed Hillsborough families having a significantly higher need for supports in finding services (perhaps related to confusion created by the volume of services available in the area), and experience greater barriers in accessing transportation and translation supports. Positively, Hillsborough families report having a significantly easier time accessing food supports within their communities.

MERRIMACK COUNTY & CONCORD

Merrimack County demonstrated high-risk in the locally-defined Crime domain, with a higher rate of juvenile arrests than the state average. Merrimack County also has a higher rate of high school dropouts

than the rest of the state. At the municipality level, Concord did not have any data indicators flag as high-risk. Furthermore, Merrimack County families responding to the *NH Family & Caregiver Survey* did not report a significantly higher need for services in any one category, nor heightened barriers to accessing services. These results do not mean need does not exist for Merrimack County families, only that the comparative need in this geographic area is similar to the "average" of other New Hampshire families.

GRAFTON COUNTY

Similar to Hillsborough County (and Rockingham County, discussed next), Grafton County did not qualify as high-risk in any one domain, either HRSA or locally-defined. Two individual indicators where Grafton County flagged as high-risk were income inequality and uninsured (under 19). The *NH Family & Caregiver Survey* results did not produce any statistically significant results for Grafton County, except positively in that families report experiencing fewer barriers to accessing transportation supports.

ROCKINGHAM COUNTY

Rockingham County is the only New Hampshire county to not have a single data indicator (HRSA or local) flag as high-risk. Similarly positive, the *NH Family & Caregiver Survey* results only showed Rockingham County as facing significantly greater barriers to child care than the rest of the state.

SPECIAL POPULATIONS

JSI/CHI conducted tests of significance between demographic groups to identify disparities between language groups, race and ethnicity, and nativity status. While results demonstrate some significant difference in need for and ease of accessing services, small sample sizes produced unreliable analysis for reporting.

Identifying Home Visiting Capacity and Quality of Services

New Hampshire has many different types of home visiting programs offered by a variety of agencies to guide and assist parents- to-be and parents of young children in the early stages of raising a family. These initiatives include Healthy Families America-NH, various home visiting programs through the Comprehensive Family Supports and Services contracts, Head Start, Early Head Start, pre-school, "home-grown" family support and strengthening programs offered by local family resource centers, and more. While each initiative offers different services, they share goals of promoting healthy pregnancies, positive birth outcomes, and creating safe and nurturing environments for children and families to thrive and reach their fullest potential.

The system of New Hampshire home visiting programs may well be described as a "patchwork" of funding streams, contracting agencies, and dedicated professionals working to improve the health and well-being of families. New Hampshire does not currently have any centralized intake or service provision structure to administer programs offering home visiting programs, support standardized professional development, or monitor quality of services between programs. However, the small size of the state and the close-knit nature of many agencies facilitates informal efficiencies that allow shared resources for serving families, supporting staff development, and the provision of quality services.

Existing Capacity

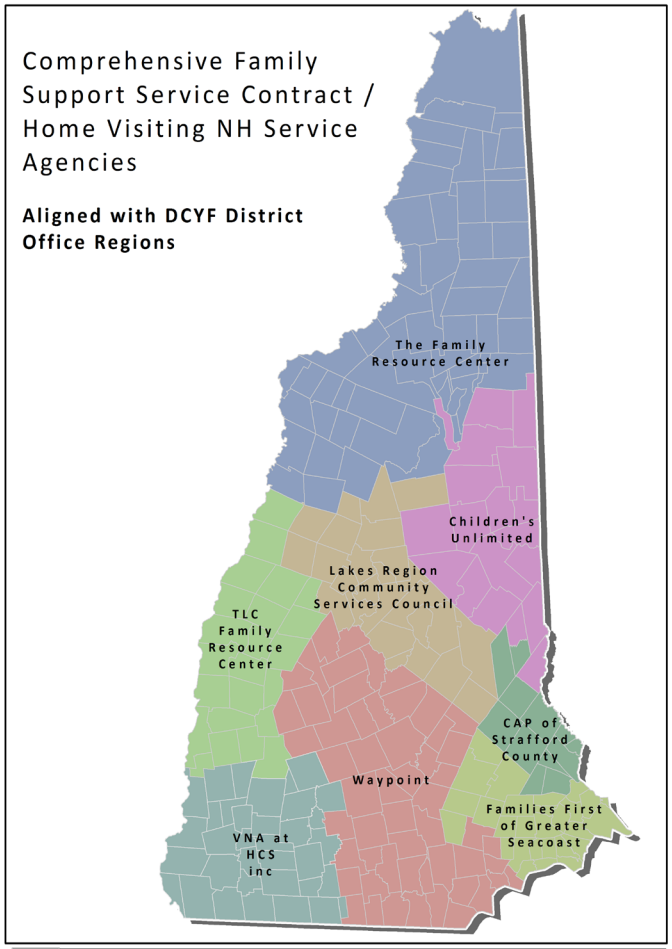
For the purposes of this needs assessment update, "early childhood home visitation services" are defined as state or federally funded programs, where voluntary home visiting is a primary intervention strategy for providing services to pregnant women and/or children birth to kindergarten entry, excluding programs with few or infrequent visits or where home visiting is supplemental to other services. In New Hampshire the home visiting programs fitting this description include the DCYF/TANF and MCH-funded Comprehensive Family Support Services / Home Visiting NH program, the MIECHV-funded Healthy Families America (HFA) program, and the Administration for Children and Families-funded Early Head Start program. These programs are currently administered by contracted community-based organizations across the state, many of which hold multiple home visiting contracts.

High-level descriptions of these programs, as well as service area maps are documented in the following narrative.

COMPREHENSIVE FAMILY SUPPORT SERVICES CONTRACTS / HOME VISITING NH

In 2019, the NH Temporary Assistance for Needy Families (TANF) took over administration of the Comprehensive Family Support Services (CFSS) contract with eight community-based organizations from NH DCYF. This administrative change reflects the importance of supporting the perception of home visiting as a preventive intervention, rather than a reactive or punitive program. The contracts catchment areas align with the 11 District Offices (see map below). These contracts are funded by TANF and Maternal and Child Health through the Title V Block Grant. The CFSS contracts' Scope of Services are agency-specific. For those contracts not with a Family Resource Center, CFSS contracts require home visits and collaboration with such supports as parent education, playgroups, and those services promoting economic success, if these services are available in communities. For those contracts with Family Resource Centers, an array of home visits, parenting education, playgroups, etc. are required.

Also administered through this program is Home Visiting NH - a Medicaid-billable home visiting program available to first time mothers under the age of 21 who enroll within 2 weeks of the child's birth. In 2019, the NH Legislature considered a bill to expand the availability of this program to all Medicaid-eligible pregnant women. In July 2019, Governor Sununu signed the bill in to law.



	Contracted Agency	Aligned District Offices
	Waypoint	Concord, Manchester, Southern
	Community Action Partnership of Strafford County	Rochester
	Children's Unlimited, Inc.	Conway
	Families First of the Greater Seacoast	Seacoast
	Lakes Region Community Services Council	Laconia
	The Family Resource Center	Berlin, Littleton
	TLC Family Resource Center	Claremont
	VNA at HCS, Inc.	Keene

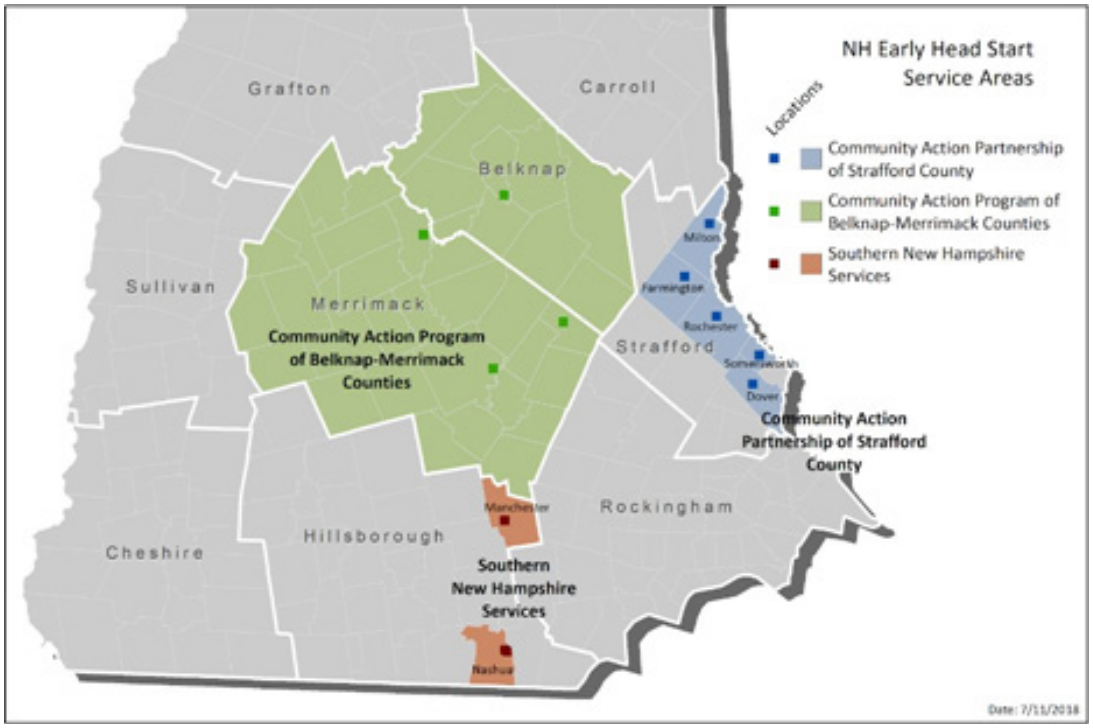
Date: 10/9/2019

Purpose / Desired Outcome	Broad-based family support contracts, requiring a home visiting component. Voluntary; provided by community-based organizations; aimed at promoting family health and wellness through the enhancement of strengthening factors, and decreasing of stressors to prevent child abuse and neglect. Prevention-oriented to help families learn and grow.
Priority Population	Families at risk for child abuse and neglect with a child under the age of 21
Services Provided	Home or community-based visits, parent education, playgroups, and connections to services supporting economic success
Number served	1,021 children completed/ended services in 2018; 393 prenatal women and children under 48 months entered services in year ending 6/30/17. CFSS has no cap on caseload and serves families as needed.
Profile of population served (of those completing services in 2018)	3.5% engaged with DCYF; 41% from single- parent home; 8% live with extended family; 56% male; 21% have some mental health issues, 18% have developmental delays; 86% from families with low income; 23% have parents with low educational attainment; 17% have family members experiencing substance use issues.
Discharge and enrollment data provided by NH DCYF, including the Comprehensive Family Support Services: Statewide Outcomes Report 2014-2018	

EARLY HEAD START - HOME VISITING COMPONENT

Currently, three agencies receive funding from the US Administration for Children and Families to offer Early Head Start and Head Start, in addition to two other grantees who receive Head Start-only funds (see map below). A free program, families with children under the age of three may enroll in Early Head Start, and with children from three to five in Head Start. For the Early Head Start component, New Hampshire families have several program options from which to choose, with home visiting being the focus of this report: daily center-based care, or weekly home visiting services. This variety of service delivery methods ensures young families have consistent access to effective supports as the needs of their children and family unit change.

Purpose / Desired Outcome	Comprehensive services for children promote school readiness, and include early education, health, nutrition, social and emotional health, and services for all children including Dual Language Learners and those with special needs. Services for parents promote family engagement, and include parent leadership and social service supports.
Priority Population	Children under the age of 3 and pregnant women with low income.
Services Provided	Weekly home visits; regular peer/social activities; for pregnant women: coordination of prenatal and postpartum care and other physical/behavioral health care. Education/ support topics focus on health and parenting education, housing assistance, domestic violence services, adult education and job training referrals, etc.
Number served	In 2017-2018, EHS allocated 241 funded slots to for pregnant women and children enrolled in the home visiting component of the program. An additional 144 funded slots were allocated for center-based services.
Demographics of population served (of all EHS enrolled participants)	14% experienced homelessness during the enrollment year; 30% are participants of color (including bi/multi-racial); 15% non- English primary language; 17% eligible for early intervention services.
Program description provided by NH Head Start Directors Association. Home visiting enrollment data derived from publicly available agency annual reports on number of individuals served.; demographic data provided by Office of Head Start Program Information Reports.	



HEALTHY FAMILIES AMERICA - NEW HAMPSHIRE

As previously described, the New Hampshire MCHS stakeholders selected the Healthy Families America (HFA) model following the 2010 Needs Assessment. It was first implemented by local agencies in 2012. The HFA model is based on the theory that strong, early, nurturing relationships between children and caregivers fosters healthy child development and prevents child abuse and neglect. Seven agencies contracted to provide HFA (see map below) have all achieved accreditation by Prevent Child Abuse America, HFA's "home organization" that oversees model development, implementation, fidelity, professional development, and advocacy for the HFA model.

The HFA model does not allow for waiting lists, so families must be seen by a HFA visitor or referred to another program within a prescribed amount of time.

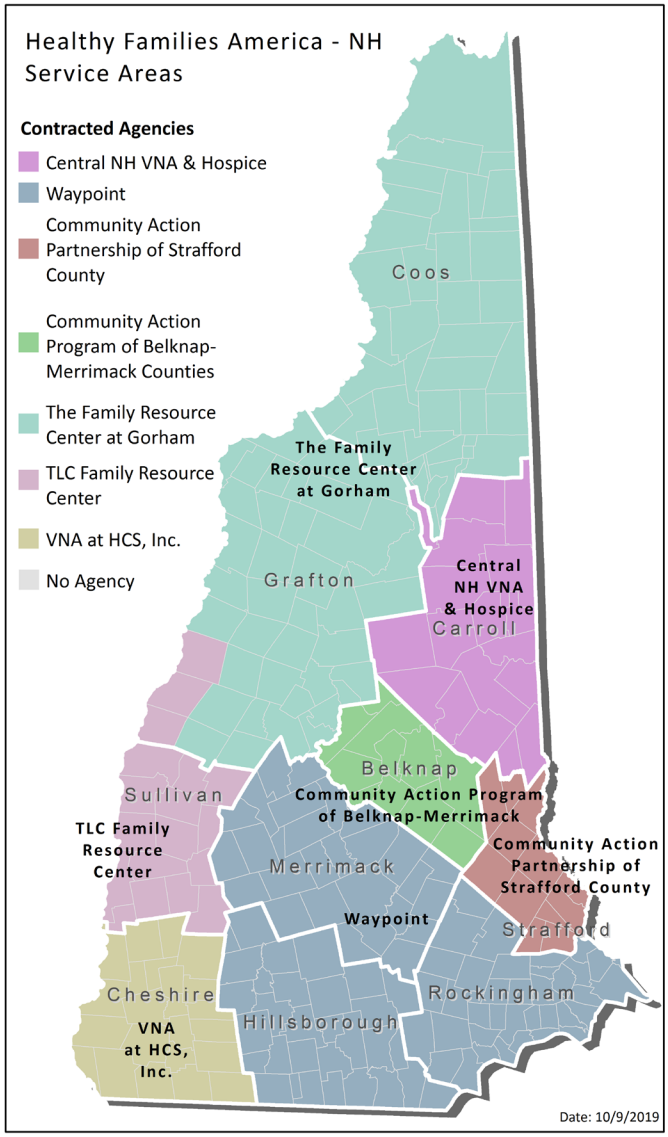


Figure 23: 2017 HRSA-estimated number of MIECHV-eligible families in need, versus # of families funded

County	# eligible families	# families served by HFA	% need
Belknap	521	15	2.9%
Merrimack	745	23	3.1%
Carroll	379	20	5.3%
Hillsborough	1340	89	6.6%
Strafford	524	35	6.7%
Cheshire	320	28	8.8%
Sullivan	181	16	8.8%
Rockingham	296	27	9.1%
Grafton	104	14	13.5%
Coos	38	21	55.3%
TOTAL	4448	288	6.5%

Purpose / Desired Outcome	(1) Reduce child maltreatment; (2) improve parent-child interactions and children's social-emotional well-being; (3) increase school readiness; (4) promote child physical health and development; (5) promote positive parenting; (6) promote family self-sufficiency; (7) increase access to primary care medical services and community services; and (8) decrease child injuries and emergency department use.
Priority Population	Pregnant teens, first time mothers under 25, women pregnant for the first time, women at risk for health complications during pregnancy, pregnant women or mothers of young children with substance use challenges.
Services Provided	Family strength assessments, as well as child development and maternal depression, and intimate partner violence screenings; home visits to promote positive parent-child interaction through parent education, child development activities and supports, and connections to other community resources as needed. NH MIECHV endorses the Parents as Teacher curriculum, also allowing agencies to implement the Growing Great Kids curriculum.
Families served	288 families in 2017.
Profile of families served	66% of households served have a history of child abuse or neglect, or have had interactions with child welfare services; 75% report a history of substance use or substance use treatment; 13% are military families; 83% have children with developmental delays or disabilities.
Program description and data derived from the NH MIECHV program, and Home Visiting Evidence of Effectiveness website.	

Other Programs and Resources with Home Visiting Components

FAMILY RESOURCE CENTERS

While not specifically reported upon in this assessment, local Family Resource Centers (FRCs) add significantly to the home visiting capacity in the state. Fourteen FRC's across New Hampshire currently provide a continuum of family support and strengthening programs, which often include the CFSS and HFA programs. Additionally, FRCs offer "home-grown" wraparound programming that incorporate home visits with the goal of increasing family resilience.

In 2015, state legislation was passed to establish a designation process for Family Resource Centers of Quality (FRC-Q), overseen by the Wellness and Primary Prevention Committee. The process includes self-assessment based on the *National Standards of Quality for Family Support and Strengthening and New Hampshire Operational Standards for Family Resource Centers of Quality.* Community-based FRC-Q must provide core services that promote and strengthen family protective factors. These services are: 1) parenting support and education; 2) opportunities that promote social interaction for children and youth, parents, and other caregivers; 3) supports for children birth to age five; 4) information and referral; and 5) promotion of family economic success, including facilitating access to concrete supports. FRC-Q are distinguishable because of the scope and depth of the services they provide, their commitment to the Principles of Family Support and the Strengthening Families Framework, and are not defined by any one funding source.

While home visiting is not an explicitly required service delivery model for FRC-Qs, it is used in virtually all New Hampshire FRC locations. The holistic, intergenerational, referring nature of home visiting supports several core components of a FRC: family centered, and family strengthening; embedded in the community, culturally sensitive, and collaborating across systems; and impact driven and evidence-informed. (Judi Sherman & Associates, 2017) Because of the unique characteristics of each FRC (e.g., mix of programs, populations served,

Figure 24: Agencies Providing Family Strengthening and Support Programming

Agency Name	Comprehensive Family Support Services	Healthy Families America	Early Head Start	Family Resource Center Designation
Central VNA and Hospice		X		
Waypoint	X	X		
Community Action Partnership of Strafford County	X	X	X	X
Community Action Program of Belknap-Merrimack Counties		X	X	X
Easter Seals Family Resource and Child Development Center				X
Family Connections – Children Unlimited	X	X		X
Family Connections Center - Department of Corrections				X
Family Resource Center - Berlin/Gorham	X	X		X
Family Resource Center of Central NH	X			X
Families First	X	X		X
Grapevine Family and Community Resource Center				X
Greater Tilton Area Family Resource Center				X
Home Healthcare, Hospice & Community Services	X	X		
River Center – A Family and Community Resource Center				X
Salem Family Resources – Success by 6				X
Southern New Hampshire Services			X	X
TLC Family Resource Center	X	X		X
Upper Room				X
Whole Village				X

funding sources), there is no common definition of home visiting within the FRC system, nor definition of a priority population, making common data reporting for unique families or individuals served by the FRC home visiting programs between programs nearly impossible.

Types of agencies currently considered FRC - and also a member of the coalition network Family Support NH - include social service organizations, community action partnership agencies, standalone community-based family support programs, federally-qualified health centers, and visiting nurse agencies. To show the breadth of overlap and illustrate the opportunity for home visiting programs to work together under same agencies, **Figure 23** lists all the agencies currently holding a CFSS, HFA, or Early Head Start grant, and which are also currently designated a FRC.

FAMILY-CENTERED EARLY SUPPORTS AND SERVICES AND SPECIAL MEDICAL SERVICES / PARTNERS IN HEALTH

Family-centered Early Supports and Services (FCESS) is a federal, state, and insurance-reimbursement-funded program aimed to support children between the age of 8 weeks and 36 months with confirmed developmental delays, a medical condition, or those who meet certain risk criteria for delay. Federal funding is provided by The Individuals with Disabilities Education Improvement Act Part C program. Services are provided in the child's home, and parents are engaged in planning intervention strategies with trained early childhood professionals. In a report released in July 2017, the FCESS program reports having served 3,736 children with an individualized family support plan at least one time during calendar year 2015. Males accounted for 63% of the service population. Of those children screened as eligible for the program during state fiscal year 2016, 97% had a confirmed developmental delay or medical condition.

Another targeted service program which includes home visiting as a service delivery method is the Title V Special Medical Services (SMS) program, Partners in Health. This statewide program provides support to families with children ages 0 through 21 at risk for or with a diagnosed chronic health condition. Similar to FCESS, services are provided in the community or participants' homes, where Family Support Coordinators engage the family in planning for inter-disciplinary services and resources to best support the health and optimal well-being of participants. Partners in Health is administered in 13 regions, statewide, by many of the same agencies as FCESS.

Figure 25: FC-ESS and PIH Area Agencies

Agency | Headquarters	Family-Centered Early Supports and Services	Partners in Health
Central NH VNA | Wolfeboro		X
Waypoint | Manchester		X
Community Bridges | Concord	X	
Community Crossroads | Atkinson	X	X
Community Partners | Dover/Rochester	X	X
Families First | Portsmouth		X
Gateways Community Services | Nashua	X	X
Monadnock Developmental Services | Keene	X	X
Northern Human Services | Conway	X	
One Sky Community Services | Portsmouth	X	
PathWays of the River Valley | Claremont	X	
The Moore Center | Manchester	X	
VNA of Manchester and Southern New Hampshire | Manchester		X
White Mountain Community Health Center | Conway		X

Sources: N.H. Department of Health and Human Services, 2018

Quality of Home Visiting Services

As clearly reported in the *NH Family & Caregiver Survey* and the PhotoVoice project, home visiting program participants are pleased with the supports they receive enrolled in home visiting programs (**Figure 25**).

They are actively being referred to and seeking services at a significantly higher rate than families not connected to a home visiting program, and not surprisingly, are engaged with a greater number of supportive services.

Figure 26: Summary infographic showing perceptions of home visiting services

83.8

...of those who received home-visiting services **Strongly agree** that their home-visiting services were **helpful**.

(*n* = 229; *Agree*, 14.0%; *Disagree*, 0.9%; *Strongly Disagree*, 1.3%)

85.8%

...of those who received home-visiting services **Strongly agree** that their family was **comfortable** talking to their home visitor about things their family needed.

(*n* = 226; *Agree*, 12.4%; *Disagree*, 1.3%; *Strongly Disagree*, 0.4%)

79.8%

...of those who received home-visiting services **Strongly agree** that the frequency of their home visits was **sufficient**.

(*n* = 226; *Agree*, 14.5%; *Disagree*, 4.4%; *Strongly Disagree*, 1.3%)

82.9

...of those who received home-visiting services **Strongly agree** that they were **satisfied** with the home-visiting services.

(*n* = 228; *Agree*, 16.2%; *Disagree*, 0.0%; *Strongly Disagree*, 0.9%)

Specific to quality, programs each measure themselves differently according to their funding requirements and data systems. With no central home visiting or family supports and strengthening "hub" in the state to support standardization of data collection of this kind, quality and outcomes are measured at the program level. For instance, the HFA home visitors achieved a 100% developmental screening rate across all enrolled families, as well as a 100% postpartum medical visit rate for its enrolled new mothers (New Hampshire MIECHV Program FY2017). Head Start and Early Head Start programs supported 219 parents in advancing their education level, and 30 families received job training - in addition, supporting 327 children with disabilities (National Head Start Association, 2018). And for families who completed a home visiting program through the Comprehensive Family Support Services contracts, only 6% had any further engagement with DCYF (N.H. Department of Health and Human Services, 2018).

HOME VISITING WORKFORCE AND PROFESSIONAL DEVELOPMENT

None of these accomplishments could be achieved without a skilled workforce to implement the family support and strengthening programming - including home visiting - to support New Hampshire families. Home visitors in New Hampshire represent a broad range of experience and training. On average, home visitors in New Hampshire report working in the field for at least nine years, with the postpartum visiting nurses averaging the longest tenure at 20 years. The overwhelming majority (73%) have a college degree (Associate or Bachelor) and 15% have a Master's degree. The most common specialized certifications reported by home visitors include teaching/education (29%), behavioral health (11%), and social work (9%).

However, there is no universal certification training or curriculum currently offered in New Hampshire, or required for home visitors or other family support workers. Not only is this detrimental to standardized provision of quality services, but also a potential economic disincentive for staff who perform very specialized inter-relational work without the benefit of a special certification.

Similar to the larger home visiting and family supports system, there is a patchwork system of advisory groups and subcommittees looking at workforce development for the larger early childhood field, into which home visiting and family supports has been folded. To further maximize the use of training dollars and support cross-training of staff, many social service agencies employing home visitors and other family support workers will share training opportunities when resources allow.

DATA AND INFRASTRUCTURE

Challenges exist for efforts to increase funding and expand services for home visiting in that - as mentioned previously - there is no central data collection system to measure the universal impact of family support and strengthening programs, including home visiting. Without a central source of information, a set of universal definitions or data measures, and funding to support data collection infrastructure, program managers, advocates, and other stakeholders will struggle to define the true reach of these programs across New Hampshire. A centralized system for navigating the spectrum of family supports and strengthening resources would create a "no wrong door" system whereby families have streamlined access to positive supports, programs could more effectively reach their service capacity, and advocates and policy makers would have better data proving need for resources to support expanded capacity.

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

The substance use challenges facing New Hampshire at this time are at crisis level, and have been a focus of countless initiatives at the federal, state, and local levels to increase capacity and competency to support families. One area of particular focus is the impact parental substance misuse has on children. The enormity of the problem has strained the system of care as a whole and the families called to care for affected children. These children may not end up on the "radar" of DCYF, but they are at increased risk of abuse and neglect. According to a recent study by the Carsey School of Public Policy the number of children or youth removed from parental care increased from 358 in 2012 to 547 in 2016, and the percent of cases that included a substance- related allegation doubled from 30 percent to 60 percent (Smith, 2018). Further, the percent of children in state custody placed in out-of-home care

with a relative increased from 23 percent to 33 percent from 2012 to 2016. Many of those grandparents or other relatives caring for relative children are between 45 and 64 years old; living at twice the poverty level or lower. Particularly striking are the number of infants diagnosed with neonatal abstinence syndrome (NAS). New Hampshire saw a fivefold increase of these cases between 2005 and 2015, from 52 to 269 (Smith, 2018). The option for family support and strengthening services offered by home visiting is an effective strategy to respond to the needs of these families to teach skills, link to financial resources and emotional support, and ultimately prevent child maltreatment.

While a range of substance use treatment and counseling services exist in New Hampshire, offering various levels of care that meet an individual's readiness to change, the burgeoning epidemic has taxed these resources. Public and private funds support an array of services including: outpatient therapies, medication-assisted treatment, intensive outpatient therapy, outpatient withdrawal management, partial hospitalization, specialized services for pregnant and parenting women, and other specialty programs.

At the time of this update, several promising initiatives are unfolding that will positively impact the provision of services such as the statewide 10-year mental health plan for adults and children and the provision of $20 million in federal money to bolster treatment and recovery programs.

Identifying Points of Care

As a first point of contact, the Bureau of Drug and Alcohol Services funds two no-cost services that serve on the front line for individuals and family members investigating the provision of services. The NH Treatment locator (nhtreatment.org) is a comprehensive electronic database of statewide treatment agencies and individual practitioners offering substance use disorder services, including evaluation, withdrawal management (detoxification), outpatient counseling, residential treatment, recovery supports and other types of services. Users are able to search the database by location, type of service, and type of insurance accepted.

The other service is the Addiction Crisis Line. This service is available 24/7 to callers searching for advice, information and resources regarding any type of substance misuse concern. Individuals can also call 211-NH (a statewide information and referral line) to receive information about the crisis hotline. If additional services are warranted, then a caller can be referred to Regional Access Point Services (RAPS) which offers more hands-on assistance for screening, case management, and active referral to treatment and recovery support services while addressing any barriers (housing, insurance, food, etc.) someone may face while recovering from a substance use disorder. RAPS is an initiative that provides assistance in getting the identified services to begin treatment by providing screenings and access to evaluations.

Behavioral Health and Substance Use Disorder Treatment Services

The ten Community Mental Health Centers (CMHCs) located throughout New Hampshire also offer behavioral health and treatment services. They are private not-for-profit agencies that have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health, to provide publicly funded mental health services to individuals and families who meet certain criteria for services. Services provided by CMHCs include: 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Case Management, Community Based Rehabilitation Services, Psychiatric Services, and Community Disaster Mental Health Support. All CMHCs have specialized programs for older adults, children, and families. The Community Mental Health Centers also provide services and referrals for short-term counseling and support. Several have mobile crisis teams.

In addition, the New Hampshire Bureau of Drug and Alcohol Services funds thirteen non-profit organizations to provide substance use disorder services across the continuum of care in New Hampshire. **Figure 27** shows the funded agencies that provide which type of service and their location. The total number of beds and number of staff where not available for each location.

Figure 27: Bureau of Drug and Alcohol Services-funded SUD Agencies, 2019

		Dismas Home of NH | Manchester	Families in Transition | Manchester	Grafton County Department of Corrections | Haverhill	Greater Nashua Council on Alcoholism, Inc. (GNCA) | Nashua	Hope on Haven Hill | Rochester	Headrest, Inc. | Lebanon	Farnum Center | Manchester	Phoenix House | Dublin, Keene	Southeastern New Hampshire Alcohol and Drug Abuse Services (SENHS) | Dover	North Country Health Consortium (NCHC) | Littleton	West Central Services (WCS) | Lebanon	Greater Nashua Mental Health Center | Nashua
Outpatient	Individual		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Group		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	IOP		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
	PHP				✓			✓	✓				
	Withdrawal Management				✓								
Residential	Transitional Living	✓	✓		✓	✓				✓			
	Low Intensity	✓			✓		✓		✓	✓	✓		
	High Intensity				✓	✓		✓	✓	✓	✓		
	High Intensity-PPW				✓	✓							
	Withdrawal Management				✓			✓	✓				
Support	Case Management		✓	✓	✓	✓		✓		✓	✓		
	Transportation		✓		✓	✓				✓			
	Childcare		✓		✓	✓				✓			
	Integrated MAT				✓				✓	✓	✓		

In terms of quantifying the number of licensed professionals in NH, **Figure 28** shows the number of licensed professionals by region according to the *Substance Use Disorder Treatment and Other Services Capacity in NH: findings from a 2014 assessment of NH substance use disorder service system* (New Hampshire Center for Excellence, 2014).

Figure 28: Number of licensed professionals by region, 2014

	LADC	MLADC	CRSW	LCMHC	LICSW	Psychologist
Capital Area	14	27	3	85	152	66
Carroll County	1	7	0	36	28	7
Central NH	0	2	0	24	13	7
Greater Derry	5	15	0	60	76	20
Greater Manchester	17	52	4	110	124	49
Greater Monadnock	10	21	3	63	65	55
Greater Nashua	11	26	6	93	92	84
Greater Sullivan	6	6	0	20	19	9
North Country	14	14	6	25	34	14
Seacoast	8	23	0	86	152	74
Strafford County	12	14	3	43	95	45
Upper Valley	4	8	0	24	45	73
Winnipesaukee	13	11	1	33	36	10
Total	115	226	26	702	931	513

Source: Substance Use Disorder Treatment and Other Service Capacity in New Hampshire (2014)

Another significant effort towards addressing substance use disorders includes the implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment), incorporating primary prevention into the health care setting. SBIRT is an evidence- based, public health approach to systematic universal screening for problematic alcohol and drug use and the routine steps taken to address the screening results. Through SBIRT, healthcare providers are trained to recognize and reinforce healthy choices and behaviors, identify problematic alcohol and drug use, provide early intervention, and coordinate effective care. The adoption of the SBIRT invention across various settings has been supported and funded by multiple entities. The New Hampshire Charitable Foundation through a grant with the Hilton Foundation supported a multi-year initiative to support and train pediatricians. Concurrently MCHS through their funded contracts for primary care with all the Community Health Centers, required the adoption of SBIRT with all pregnant patients.

Most recently, the Medicaid payment reform transformation known as the 1115 Waiver, is requiring the broad adoption the SBIRT framework. In this case, all providers who receive Medicaid funds must establish protocols and procedures to screen all patients with an evidence-based assessment, provide an appropriate level of in-office intervention or brief intervention and make referrals as needed for a further assessment to determine the level of care required.

Furthermore, the primary goal of this transformation is for seven identified regions in the state to launch strategies to expand the capacity of the behavioral health workforce through recruitment, retention, and education and training strategies. Each region has set targets to hire the following professionals: licensed alcohol and drug counselors, master level social workers and mental health counselors, behavioral health coordinators, psychiatrists, psychiatric APRNs, clinical psychologists, and peer recovery coaches. At the time of this assessment update, JSI/CHI was not able obtain the specific number of new staff hired.

In addition to these statewide initiatives, home visiting programs across the state are implementing or connected to programs specific to supporting women and mothers currently using substances, in treatment, and in recovery. To name just a few, a sample of these programs include the Parent Partner Program (DCYF), Strength to Succeed program (DCYF), and Moms in Recovery (Dartmouth-Hitchcock, Cheshire/Sullivan Counties).

Capacity to Serve Pregnant Women

There are several productive and promising initiatives occurring in New Hampshire to strengthen the system of care designed to support the needs of pregnant women and families with young children. Acting as a catalyst for these efforts, the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment implemented a statewide multi-stakeholder strategy, *Collective Action – Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery, 2013-2017* (New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, 2013). The strategic plan incorporated a multi-sector approach, calling on the health and medical sector to support a culture change relative to how alcohol and drug use is viewed and effectively addressed. One of the clear goals of the Commission is action to improve prevention and treatment services relative to women of childbearing age, pregnant women, unborn babies, and newborns. As a response, the Commission created a new task force to address fetal exposure to opioids, alcohol, and other drugs. The task force has worked towards increasing the capacity and competency of providers to conduct brief interventions and provide treatment for substance use in their practice.

In 2018, a private foundation sought consultation services to develop a social marketing prevention campaign to reduce the use of alcohol and marijuana during pregnancy or while trying to get pregnant. This multi-media campaign is expected to launch in January 2019 and will include messaging to women of reproductive years and the healthcare providers who serve them as the primary intended audiences.

The state also funds several programs specifically designed to work with pregnant women. These programs ensure treatment providers give pregnant women priority for admission to substance use treatment services within 48 hours, or be referred to other available services. A current list of agencies

offering services through this funding can be found on the Bureau of Drug and Alcohol Services website: dhhs.nh.gov/dcbcs/bdas/pregnant-suds.htm.

Medication Assisted Treatment

The provision of Medication-Assisted Treatment (MAT) in the form of methadone, buprenorphine, and extended release of injectable naltrexone (Vivitrol) has greatly expanded in New Hampshire. Methadone was the first medication approved by the FDA for the treatment of opioid use disorder in 1974. This medication may only be dispensed at a certified Opioid Treatment Programs (OTPs) or methadone clinics. As of September 2018, there are three organizations for a total of eight sites that dispense methadone including sites in Concord, Hudson, Manchester (2), Newington, Somersworth, Swanzey, and West Lebanon.

Since 2002, providers with MD or DO credentials have been able to apply for a waiver to prescribe buprenorphine. Waivers are granted to treat panels of 30, 100, or 275 patients, and as of 2018, 406 providers were granted waivers. Two key features of the 2016 Comprehensive Addiction and Recovery Act (CARA) allowed MD and DOs to treat a larger number of patients and more types of providers to treat up to 30 patients. Specialty nurse practitioners (NPs) and physician assistants (PAs) are authorized to apply for a waiver to prescribe buprenorphine at the 30-patient limit. NPs and PAs are required to obtain 24 hours of training to include the eight-hour waiver training to apply for a waiver compared to eight-hours of training that is required of MDs/DOs. CARA 2.0, legislation to reauthorize and expand the 2016 CARA, proposes to expand MAT training/buprenorphine prescribing to both nurse anesthetists and nurse midwives.

Finally, extended release of injectable naltrexone is the most recent drug, approved in October of 2010, for the treatment of opioid use disorder. This medication may be prescribed by any healthcare provider (e.g., nurse practitioners, physician assistants) who is licensed to prescribe medications. There is no limit on the number of patients for whom this medication may be prescribed. According to Alkermes, Inc. a provider locator tool, New Hampshire has 14 providers listed as prescribing injectable naltrexone. Alkermes, Inc. provider locator tool is voluntary and may not reflect all New Hampshire providers offering this medication.

In addition to medication assisted treatments being provided to treat opiate addiction, the NH Tobacco Prevention and Cessation Program (TPCP) funds a free, statewide tobacco treatment service 1-800- QUITNow. This service is available to any New Hampshire resident or healthcare provider seeking assistance, coaching, or free nicotine replacement therapy. Pregnant women receive a more intensive intervention. They are assigned a female coach with special training on smoking and pregnancy, receive five coaching sessions during their pregnancy and an additional four sessions after delivery and receive special pregnancy-related material.

Treatment and Recovery Support for Judicially-Involved Women

Currently there are ten specialty court programs for offenders with substance abuse or mental health diagnoses through various Superior and Circuit Court District Division locations in New Hampshire. These treatment courts combine community-based treatment programs with strict court supervision and progressive incentives and sanctions. By linking offenders to treatment services, the program aims to address offenders' substance abuse and mental health diagnoses that led to criminal behavior, thereby reducing recidivism and protecting public safety. These treatment court programs are designed to promote compliance with treatment programs as an alternative to jail time. Felony drug court programs for adult offenders are available in Cheshire, Grafton, Rockingham, Hillsborough South, Belknap, and Strafford Counties.

OPPORTUNITIES FOR HOME VISITING

In September 2018, the NH Home Visiting Task Force engaged in a strategic planning session to inform its work in the coming years. Recognizing the strengths and opportunities across New Hampshire (both of families, and of the services supporting those families), the priorities identified during the strategic planning session are well aligned with the opportunities and challenges identified in this needs assessment update: 1) access and delivery of services, 2) data, 3) advocacy, and 4) infrastructure.

Access and Delivery of Services

According to the National Home Visiting Resource Center's (NHVRC) 2017 Yearbook, New Hampshire had 65,000 families that featured a pregnant woman, and/or children under 6 years old not yet in kindergarten. NHVRC calculated this number based on the risk categories that generally drive various home visiting program recruitment - children under 1 year-old, single mother, parent with no high school diploma, teen mother, low income. Forty-seven percent (47%) of the 65,000 possible families (30,550) would have met at least one of these criteria, with 15% (9,750) meeting at least two of the criteria. More narrowly defined than the yearbook count, HRSA has estimated, based on MIECHV program requirements, close to 4,500 families as being eligible for receiving services.

Because of the non-conformity in data definitions and reporting methods, this report uses several estimation methods and proxy counts to estimate the number of families served by CFSS and EHS in order to align better with the MIECHV family counts. Based on reported family size data at the state level, CFSS served approximately 750 families in 2017 (including families carried over from 2016, and families newly enrolled in 2017). EHS programs reported 415 families receiving at least one family service in either a center- or home-based setting in 2017-2018.

Figure 29: Estimate of families served by EHS, CFSS, and HFA in NH compared to HRSA and National Home Visiting Resource Center estimates of need, 2017

2017 Estimated Family Enrollment		# HRSA estimated MIECHV-eligible families	% of estimated eligible families served by MIECHV	# NHVRC estimated families in need	% of NHVRC estimated eligible families served
EHS*	415				
CFSS	745				
HFA	288				
TOTAL	*1,448*	4,448	32.6%	30,500	4.7%

**date for EHS reflects 2017-2018 reporting year*

Potential issues with these proxy calculations arise in an inability to unduplicate counts across programs should a family transition across programs during a year, and variability in fiscal years. Additionally, a significant number of families served exclusively by family resource centers and other support programs are likely excluded from this count of state and federally-supported program home visiting enrollment. Despite these caveats, New Hampshire programs are clearly not currently resourced and staffed to meet the needs of all families who would benefit from such a program. At best, based on the MIECHV criteria, programs are only able to meet 33% of the need; and when considering the broader (and arguably more realistic) NHVRC estimates, programs are funded to serve less than 5% of families in need.

On the opposite side of building capacity to increase access is family recruitment. The findings of this needs assessment align with other national research that highlight a discrepancy between the lack of perceived value of home visiting programs by the general public despite strong evidence of positive outcomes, and the positive experiences of families who participate in a home visiting program. Efforts to coordinate messaging and language for families that promotes the availability of programming, and the general benefits of home visiting may help reduce that gap between those who need services and those who access services. By building demand, family support programs also offer policy-makers and advocates important justification for the allocation of additional resources.

Data

A lack of coordinated data collection or reporting across the spectrum of state- and federally-funded family support programs creates an impossibility to identify the total number of unique families receiving services. The disconnect between data collection efforts across the programs is a direct result of variable reporting requirements by funders (e.g., definitions, timelines), agencies' systematic capacity to collect and report data, and personnel resources to coordinate such efforts.

This lack of consistent and standardized data resulted in imprecise estimates of the current home visiting and family support needs and capacities reported in this assessment. Although it does not offer a precise count of total families served or statewide capacity to provide services, it offers segmented snapshots of program data with estimated needs by individual funding sources.

The home visiting and family support community would be better positioned to demonstrate and communicate impact – as a whole community – with some shared definitions of enrolled participants, generic program characteristics, and outcome measures. The challenge in developing these shared measures is the lack of a centralized system in which the individual program-specific data collected can be efficiently translated into common measures. With a better coordinated mechanism for identifying families who receive supports, aligned with some common definitions for services and eligible enrollees, programs, advocates, and policy makers will have better information to make data-driven decisions related to the development and implementation of family support programs.

Advocacy and Infrastructure

Many groups, task forces, and initiatives within New Hampshire are currently focusing efforts on strengthening the family supports infrastructure through program planning and advocacy. A sample of these organizations and initiatives include the NH Home Visiting Task Force, Spark NH and its committees, New Futures, NH Children's Trust, Family Support NH, the Child Welfare System Transformation efforts, the NH Children's Behavioral Health Collaborative, the NH Association for Infant Mental Health, plus many, many more. The mission of each of these groups is unique, and offers a different perspective, energy, and resources towards the shared goal of keeping NH families strong.

Many professionals in the field – including NH Home Visiting Task Force members - participate in multiple groups, creating the opportunity for cross-group information sharing, coordination, and ideally, collaboration. As demonstrated by the discussions held during the NH Home Visiting Task Force meetings, many members have voiced their perceived benefit in having some sort of coordinating entity, similar to the Task Force, to enhance communication and information sharing between family support programs. This coordinating entity could serve as a hub for these programs to share information about the services they provide, develop strategies for coordinating services, develop shared language and communication efforts to promote home visiting and family support programs, and promote shared professional development for staff. Recognizing the larger early childhood and family supports system in which home visiting exists, this coordinating entity could serve to promote the information exchange between the Task Force members and the other tables, coalitions, and planning initiatives in which the Task Force members are involved.

Conclusion

With these changes to the system of home visiting and family supports on the horizon, opportunity abounds for home visiting programs to insert themselves into the decision-making process with scientifically-proven outcomes and a positive return on investment. Expanding the availability of these supports to all New Hampshire families with young children will promote healthy, stable attachments and avoid preventable adverse experiences.

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