Public Safety in Manchester:
A Community Assessment

ACLU
New Hampshire

Manchester Community Needs Assessment: Review of Existing Data and Resources

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Executive Summary

This report reviews and compiles existing data, literature, and resources on a range of key factors that contribute to community safety for residents in Manchester, New Hampshire. Here "community safety" refers to a holistic approach that seeks to understand and invest in the needs of communities so that all residents feel safe. Community safety is multifaceted and includes everything necessary for people to thrive—from housing to environmental hazards to mental health services.[1] This research product is designed to serve as a resource for stakeholders seeking to understand and support Manchester.

Drawing on data and reports from the U.S. Census Bureau, the U.S. Center for Disease Control and Prevention, the New Hampshire Department of Health and Human Services, and other national, state, and local resources, this report examines a variety of community needs in Manchester with a community safety lens. Note that our exploration of existing resources is not exhaustive, but rather seeks to elevate high-quality data and sources.

This report was developed by the Carsey School of Public Policy at the University of New Hampshire and generously funded by the American Civil Liberties Union of New Hampshire (ACLU-NH). The authors would like to thank Lauren McGinley, Executive Director of the New Hampshire Harm Reduction Coalition (NHHRC), for sharing some helpful information and background on harm reduction efforts in the state. The conclusions and opinions in this paper are those of the authors and not of the ACLU-NH or the NHHRC.

Key Findings

Like other places in the state and nation, one of Manchester's most pressing community safety issues is substance use disorder. The challenges of addressing the issue are exacerbated by ineffective systemic responses. Identifying where existing responses diverge from evidence-based recommendations can help shape a community action agenda.

Recent data suggest the need for an effective SUD response is pressing.

- Substance use disorder (SUD) prevalence has almost doubled in New Hampshire in recent years—from 8.6 percent during 2016-2018 to 16.2 percent in 2021.
- The number of suspected opioid overdoses in Manchester peaked in 2017 at 877 and hit a recent low in 2020 at 412. However, suspected opioid overdoses have been climbing since, with 573 in 2021 and 701 in 2022.

A punitive approach to SUD is ineffective, costly, and can create more harm.

- Many harm reduction strategies—such as syringe service programs or overdose reversal medications like Narcan—are proven to save lives and be cost-effective.
- Mobile crisis response models are promising strategies for providing SUD and mental health services. These models are most supportive with high availability and longer hours of operation (such as 24/7 service models).
- Common challenges and barriers to implementing harm reduction programs include stigma, lack of trust, limited availability of programming, racism, and a lack of input from people who use drugs.

[1] (FrameWorks Institute 2023)

Engagement with the criminal justice system, including contact with jail services, is uneven and especially concentrated among some groups.

- There is a small group of "high utilizers" of jail services that are very costly to the state and counties.
- That these high utilizers tend to be booked for nonviolent charges, have higher mental and behavioral health needs including SUD, and are more likely to have experienced homelessness suggests an intersection between incarceration and unmet social, economic, and health needs.
- There are serious racial disparities among both the general jail population and high utilizers. Black Granite Staters are 6.2 times more likely to be in jail and 2.8 times more likely to be high utilizers than white Granite Staters.

Manchester is unique, diverse, and has a set of specific needs. Work to address community safety in Manchester needs to consider the context in which that work occurs and include the community in that planning.

Manchester is younger and more racially and ethnically diverse than the state overall, which offers significant potential for the city to be a state and regional leader in inclusive community safety planning. However, the city also faces areas of lower resources and higher risks than other parts of the state.

- Over the last decade, poverty rates in Manchester have been consistently higher than in either Hillsborough County or New Hampshire.
- Further, even within Manchester, poverty rates are uneven. Poverty rates among Hispanic or Latine, Black, and multiracial Manchester residents are more than twice as high as among non-Hispanic white residents.
- Among New Hampshire communities, Manchester stands out for having higher risk of exposure to harmful air pollutants. Lead exposure is a particular concern.
- Violent crime is low overall in New Hampshire and has decreased in both Manchester and statewide over the last decade.

Access to affordable housing is a rapidly growing challenge for Manchester and New Hampshire. The risks of becoming unhoused are uneven and perpetuate inequity.

- One-in-three people experiencing homelessness in New Hampshire in 2021 were in Manchester. Across the state, Black residents were four times more likely to experience homelessness than white residents. Hispanic/Latine residents were twice as likely.
- Both local and state residential rental markets are very tight, characterized by high demand, low vacancy rates, and affordability challenges.

Demographic Overview

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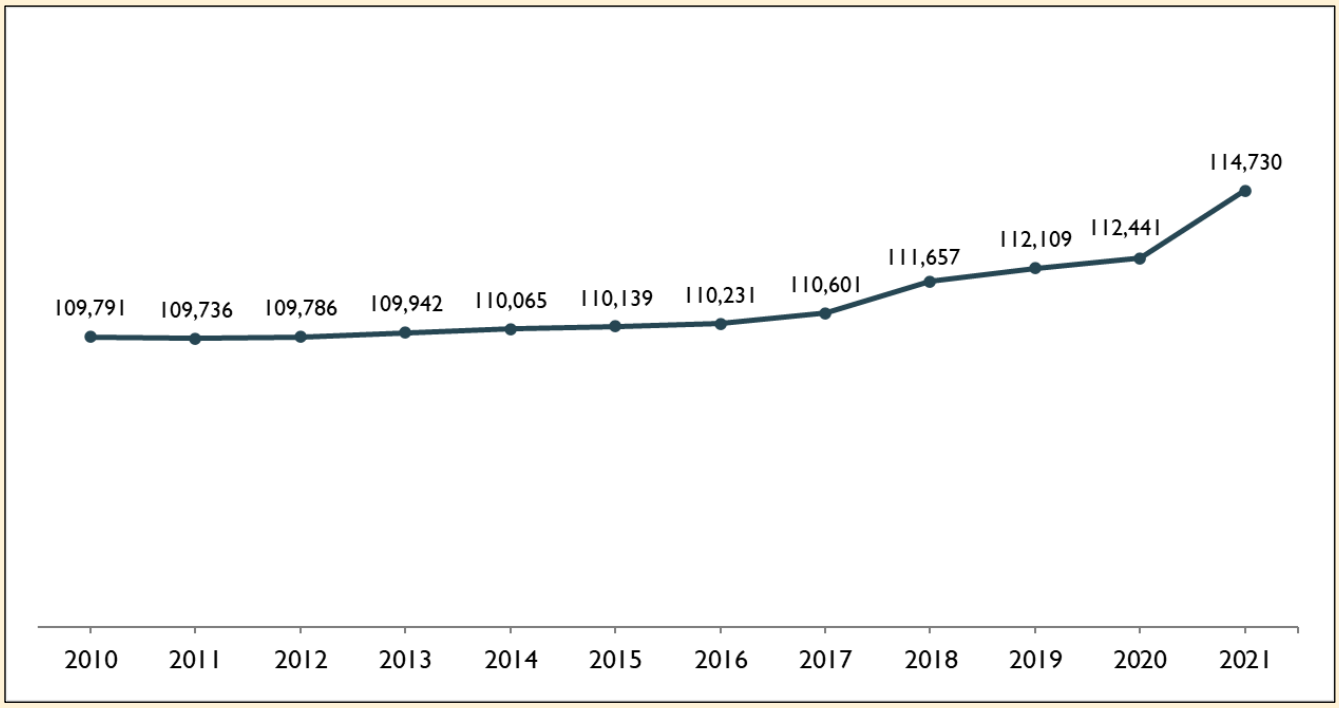
Demographic Overview

Population

Over the last decade, Manchester's population has steadily increased from an estimated 109,791 residents in 2010 to 114,730 residents in 2021 (See Figure 1).[2]

Figure 1. Total Population of Manchester, 2010-2021

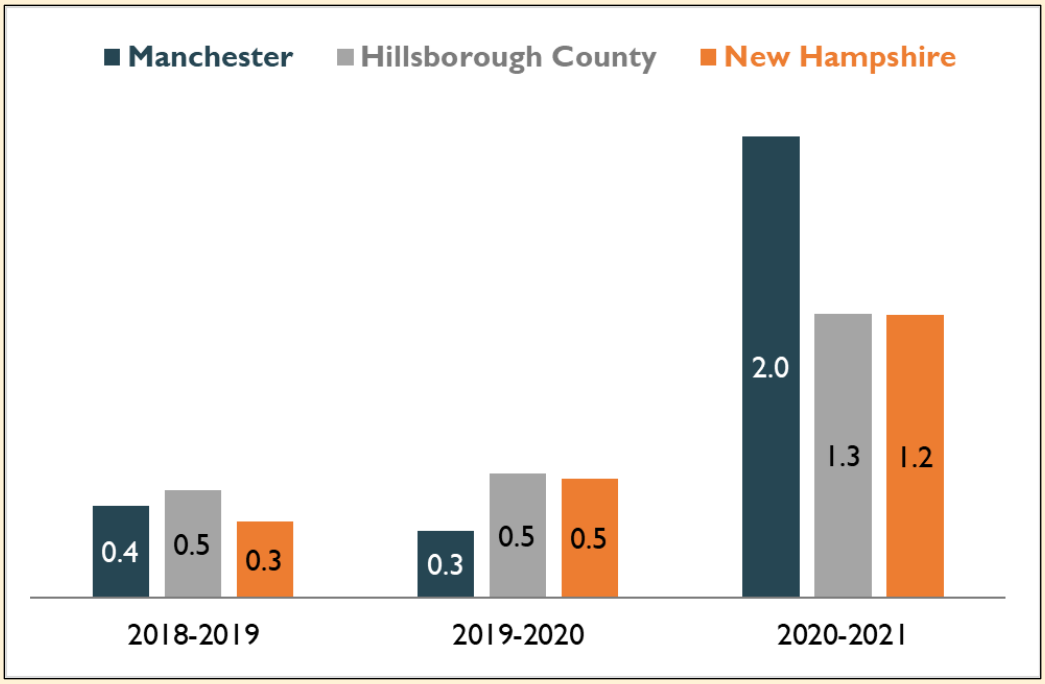


Source: U.S. Census Bureau, American Community Survey, 2010-2021 5-year estimates
Note: Estimates are drawn from overlapping five-year periods (e.g., "2021" refers to the population as calculated from data collected between 2017 and 2021).

Figure 1, above, suggests that Manchester experienced a population increase in the most recent period. While population growth is not unique to Manchester, the extent to which the population grew is somewhat distinct. Figure 2, below, shows that New Hampshire and Hillsborough County also experienced population change between 2020 and 2021 periods, although Manchester's increase was proportionately larger. Available data do not allow for description of these new residents, although in-migrants from other states, rather than high fertility or international migration, typically drive population gains for New Hampshire.[3]

[2] Note that these are American Community Survey 5-year estimates, meaning that the 2010 estimate is calculated from data collected from 2006-2010, which increases the reliability of small area estimates for cities.
[3] See, for instance, https://carsey.unh.edu/publication/migration-sustains-new-hampshire-population-gain.

Figure 2. Estimated Percent Change in Population for Manchester, Hillsborough County, and New Hampshire, 2018 – 2021



Source: U.S. Census Bureau, American Community Survey, 2018 – 2021 5-year estimates.
Note: "2018-2019" denotes the percent change in population between 2018 and 2019. Estimates are drawn from overlapping five-year periods (e.g., "2021" refers to the population as calculated from data collected between 2017 and 2021).

Age

The median age in Manchester was 36.9 years in 2021, compared to the statewide median age of 43.0.[4] In 2021, the percent of the Manchester population under 18 years old was similar to that of New Hampshire (18.9 percent and 19.0 percent, respectively). However, Manchester had a lower share of adults aged 65 and older than statewide (13.8 percent compared to 18.2 percent; see Figure 3).

[4] U.S. Census Bureau, American Community Survey, 2021 5-year estimates

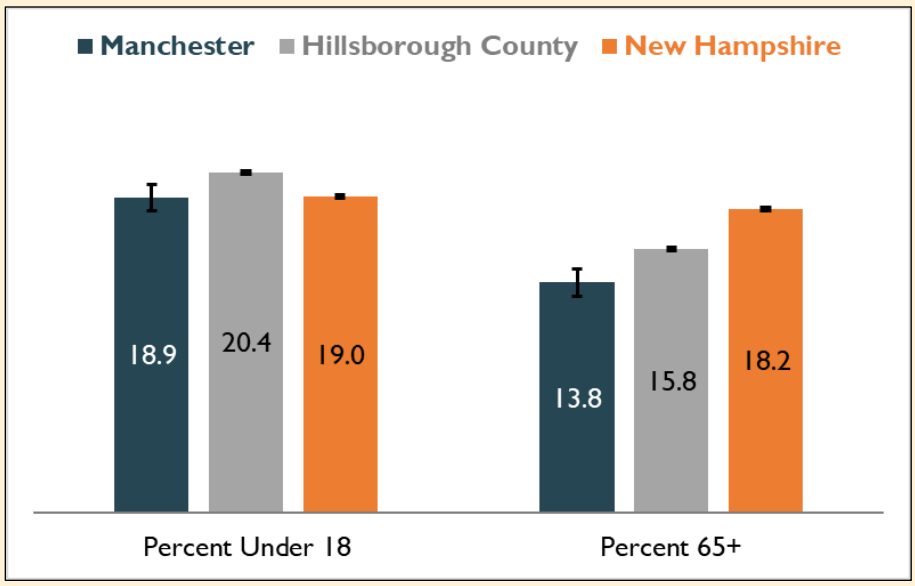
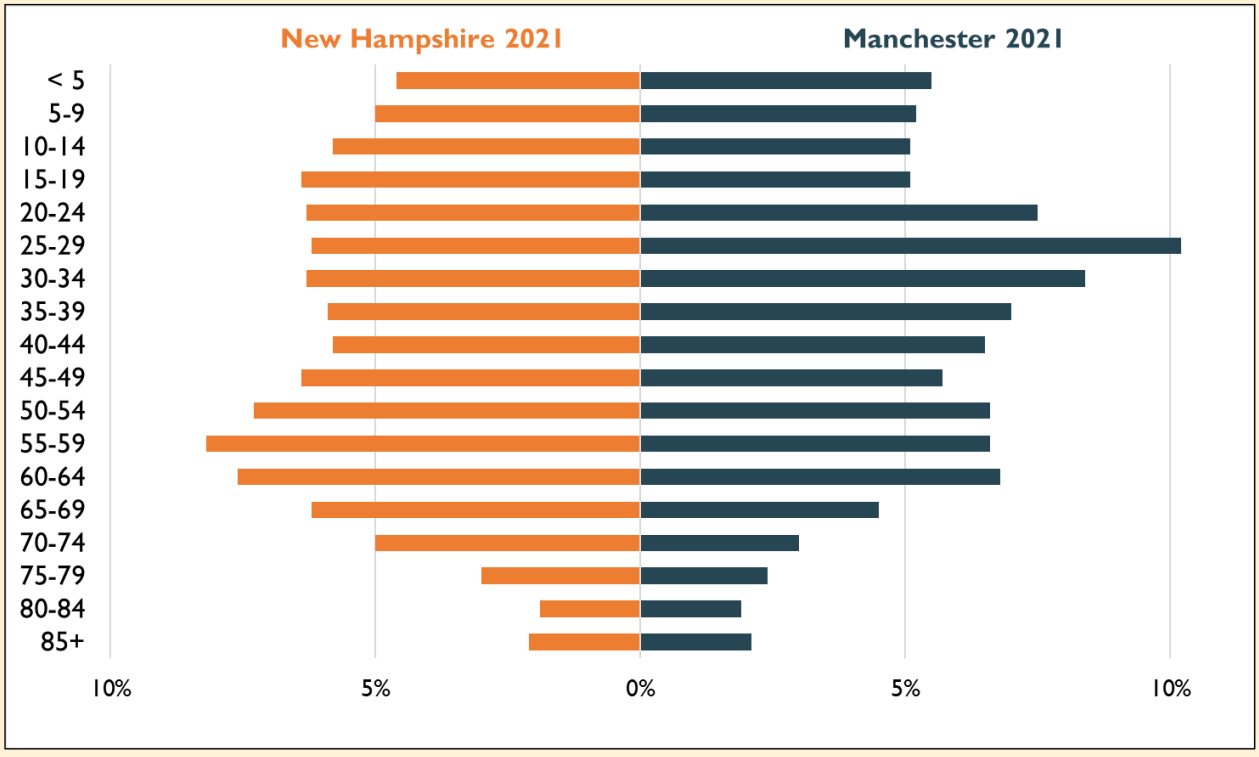


Figure 3. Percent of the Population Under Age 18 and Aged 65 or Older, Manchester, Hillsborough County, New Hampshire, 2021

Source: U.S. Census Bureau, American Community Survey, 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level.

Manchester's younger-than-statewide population is visible in its age structure (Figure 4), particularly in its larger than statewide share of the population who are age 25-29 and the smaller than statewide shares that are ages 55 and older.

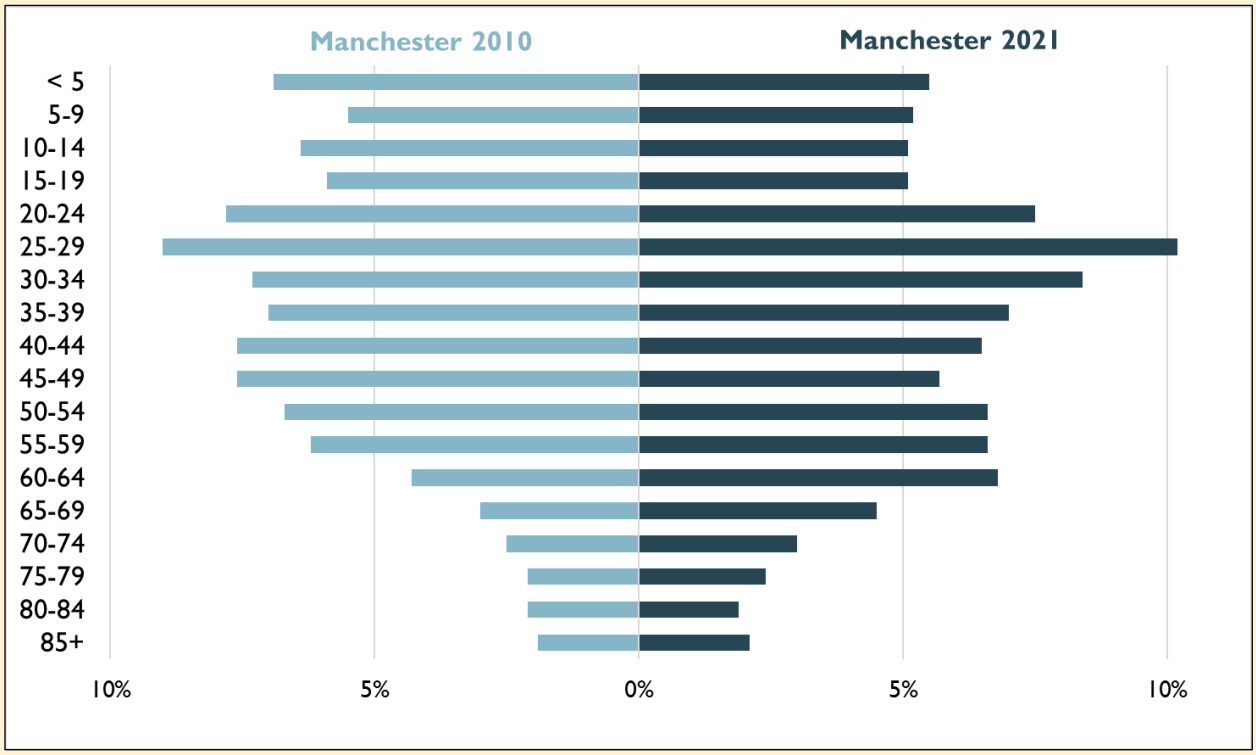
Figure 4. Distribution of Population by Age Groups, New Hampshire and Manchester, New Hampshire, 2021



Source: U.S. Census Bureau, American Community Survey, 2021 5-year estimates

In 2010, the median age in Manchester was 35.8 years, about one year younger than in 2021. Figure 5 shows how the city's age structure has shifted more broadly in the past decade, with smaller shares of very young children (under age 5), in part likely connected to the smaller shares of adults in their late 30s and early 40s who might be the parents of that age group. At the other end of the age spectrum, Manchester has seen growth in the share of the population comprised of older adults aged 60 to 69 in particular.

Figure 5. Distribution of Population by Age Groups, Manchester, New Hampshire, 2010 and 2021



Source: U.S. Census Bureau, American Community Survey, 2010 and 2021 5-year estimates

Race and Ethnicity

Manchester has long been especially racially and ethnically diverse compared to New Hampshire as a whole, and this pattern continues to be true in the most recent Decennial Census.[5] Table 1 shows that not only is Manchester becoming more racially and ethnically diverse over time, these transitions are also happening at a faster pace than statewide. By 2020, less than three-quarters of Manchester's population was non-Hispanic white, compared with 87 percent statewide. By 2020, nearly one of every three Black Granite Staters lived in Manchester.[6]

[5] U.S. Census Bureau, 2020 Decennial Census. For earlier estimates, see the City of Manchester's "Snapshots of Social and Economic Well-Being by Race" report which uses Census data back to 1990. https://www.manchesternh.gov/portals/2/Departments/health/Snapshots%20092404%20Social%20Econ.%20Well%20Being%20in%20our%20Community.pdf

[6] U.S. Census Bureau, Decennial Census, 2020. The Census Bureau tallied 18,655 non-Hispanic Black New Hampshire residents in 2020; 5,916 lived in Manchester.

Table 1. Racial-Ethnic Composition of Manchester and New Hampshire, 2010 and 2020

	Manchester		New Hampshire	
	2010	2020	2010	2020
American Indian or Alaska Native alone, not Hispanic or Latino	0.2	0.2	0.2	0.2
Asian alone, not Hispanic or Latino	3.6	4.1	2.1	2.6
Black or African American alone, not Hispanic or Latino	3.7	5.1	1.0	1.4
Hispanic or Latino, any race	8.1	11.8	2.8	4.3
Two or More Races, not Hispanic or Latino	2.0	4.2	1.4	4.0
Native Hawaiian / Pacific Islander alone, not Hispanic or Latino	0.04	0.02	0.01	0.02
Some other race alone, not Hispanic or Latino	0.2	0.5	0.1	0.4
White alone, not Hispanic or Latino	82.0	74.0	92.3	87.2

Source: U.S. Census Bureau, Decennial Census, 2010 and 2020
Notes: Totals may not sum to 100 percent due to rounding.

As is true statewide, Manchester's child population is "at the forefront of the demographic changes of the past decade."[7] Table 2 shows that less than half of children enrolled in Manchester School District (a public school district in Manchester) are non-Hispanic white, compared with 83 percent statewide.

Table 2. Percent Enrolled by Race-Ethnicity, Manchester School District and Statewide, 2022-2023 School Year

	Manchester School District	New Hampshire
American Indian or Alaska Native	0.2	0.2
Asian or Pacific Islander	3.9	3.2
Hispanic	29.7	8.1
Black Non-Hispanic	10.9	2.1
White Non-Hispanic	49.5	82.9
Multi-Race	5.7	3.6

Source: Bureau of Educational Statistics, Division of Education Analytics and Resources, New Hampshire Department of Education
Notes: Based on enrollment as of October 1, 2022. Totals may not sum to exactly 100 percent due to rounding.

[7] https://www.unh.edu/unhtoday/2021/09/nhdiversity

Disability

In 2021, an estimated 13.9 percent of Manchester residents had a disability, similar to the statewide estimate. As Figure 6 shows, there was not much change in disability prevalence from 2012 to 2021.

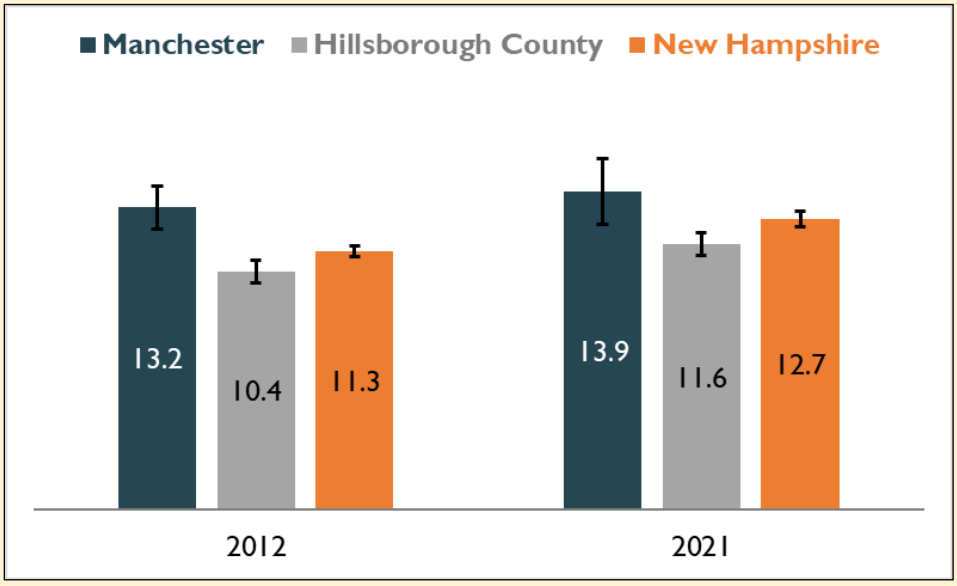
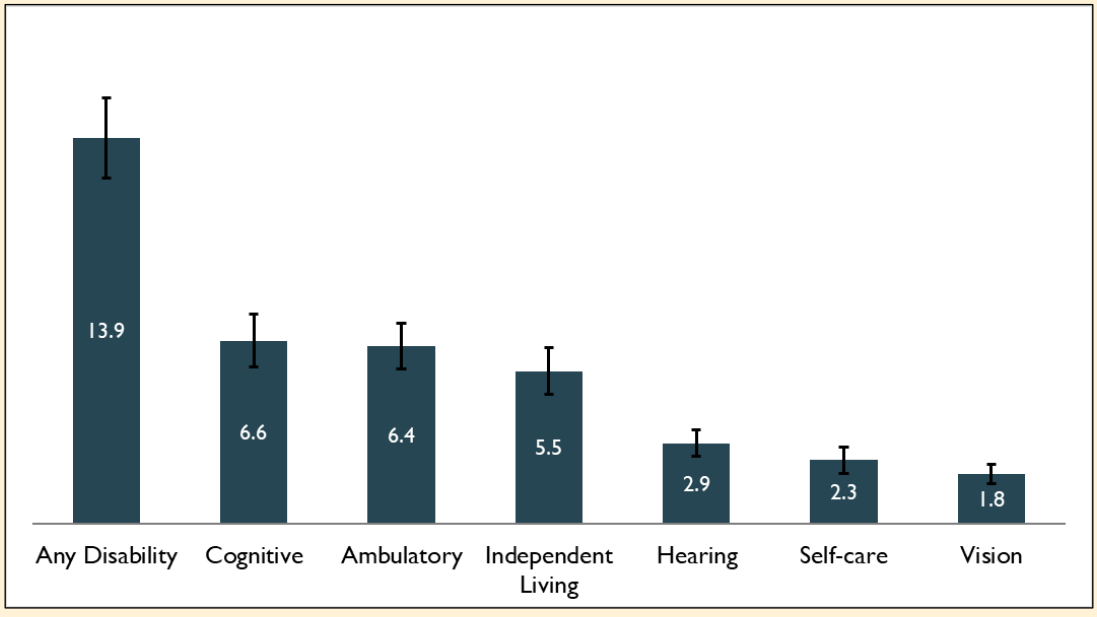


Figure 6. Percent of the Population with a Disability, Manchester, Hillsborough County, New Hampshire, 2012 and 2021

Source: U.S. Census Bureau, American Community Survey, 2012 and 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level. Note that 2008-2012 5-year estimates are used because neither the 2006-2010 nor 2007-2011 5-year estimates are available for this topic via data.census.gov tables.

The most common types of disabilities among Manchester residents were cognitive and ambulatory disabilities in 2021 (see Figure 7).

Figure 7. Percent of the Population by Disability Type, Manchester, 2021

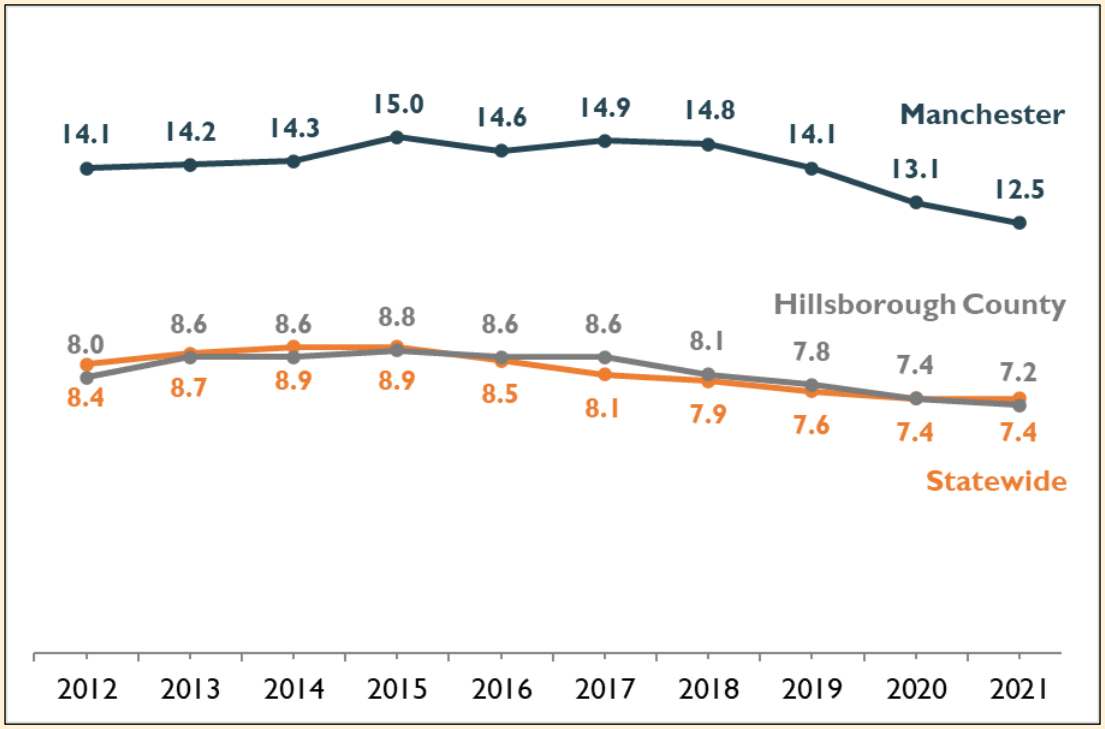


Source: U.S. Census Bureau, American Community Survey, 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level. An independent living disability is difficulty doing errands alone such as visiting a doctor's office or shopping due to a physical, mental, or emotional condition (only asked among people 15 years and older). A self-care disability is difficulty dressing or bathing. Self-care, ambulatory, and cognitive disability questions are asked of individuals ages 5 and older.

Poverty

Manchester has consistently had a higher poverty rate than in other places statewide, including Hillsborough County or New Hampshire overall. Although Manchester's poverty rates have trended down in the past several years, the most recent estimates suggest that one-in-eight Manchester residents has an income below the poverty line.

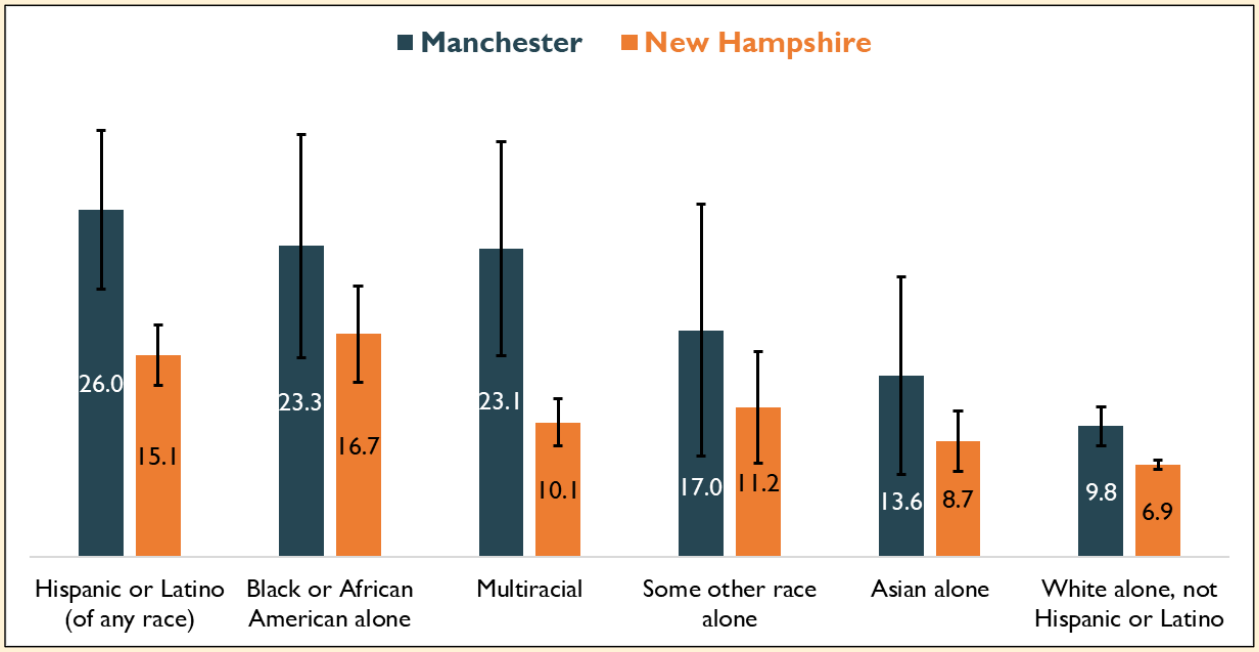
Figure 8. Percent of the Population in Poverty, Manchester, Hillsborough County and New Hampshire, 2012-2021



Source: U.S. Census Bureau, American Community Survey, 2012-2021 5-year estimates
Notes: Estimates are drawn from overlapping five-year periods (e.g., "2021" refers to the population as calculated from data collected between 2017 and 2021). Here "percent of the population in poverty" refers to the percent of people below 100% of the federal poverty threshold. Poverty is designated at the family unit level (among individuals related by blood, marriage, or adoption). A family and all its members are considered in poverty if their total money income falls below their family size- and composition-specific threshold. In 2021, the poverty threshold for a single, non-elderly adult was $14,097, per the U.S. Census Bureau.

As shown in Figure 9, poverty is disproportionately experienced by Manchester residents of color: poverty rates among Hispanic or Latino, Black, and multiracial people are more than twice as high as among Manchester's non-Hispanic white residents. While the pattern of racial-ethnic disparities aligns with patterns of poverty statewide, Manchester's estimated poverty rates are equal to or higher than statewide for all racial-ethnic groups.

Figure 9. Percent of the Population in Poverty by Race, Manchester and New Hampshire, 2021



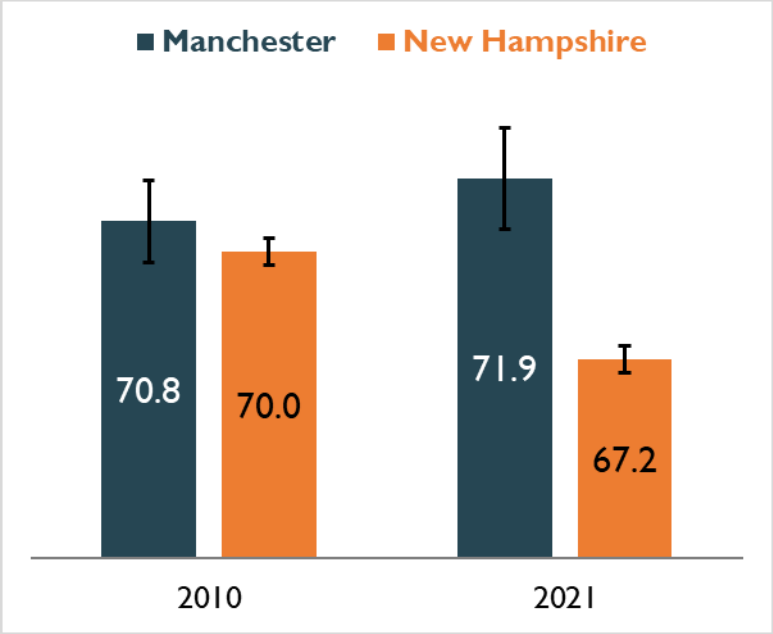
Source: U.S. Census Bureau, American Community Survey, 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level. Here "percent of the population in poverty" refers to the percent of people below 100% of the federal poverty threshold. Poverty is designated at the family unit level (among individuals related by blood, marriage, or adoption). A family and all its members are considered in poverty if their total money income falls below their family size- and composition-specific threshold. In 2021, the poverty threshold for a single, non-elderly adult was $14,097, per the U.S. Census Bureau. The racial categories of American Indian and Alaska Native (AIAN) alone & Native Hawaiian and Pacific Islander (NHPI) alone were excluded due to very large margins of error for the Manchester estimates.

Employment

Figure 10 shows that Manchester has long had a strong workforce participation rate, which is becoming more robust compared with shifts affecting the state overall. More than seven in ten Manchester adults (over age 16) participate in the labor force by working or searching for work. This rate was comparable to the statewide level about a decade ago. However, by 2021, Manchester's labor force participation remains steady, while the state's has ticked downward. This is in part due to the state's changing demographics: as the state's older adult population grows, a shrinking share is working or seeking work. Further, Manchester does not struggle with disproportionately high unemployment: just 2.3 percent of the city's labor force was unemployed in September 2023, suggesting a strong labor market persists.[8]

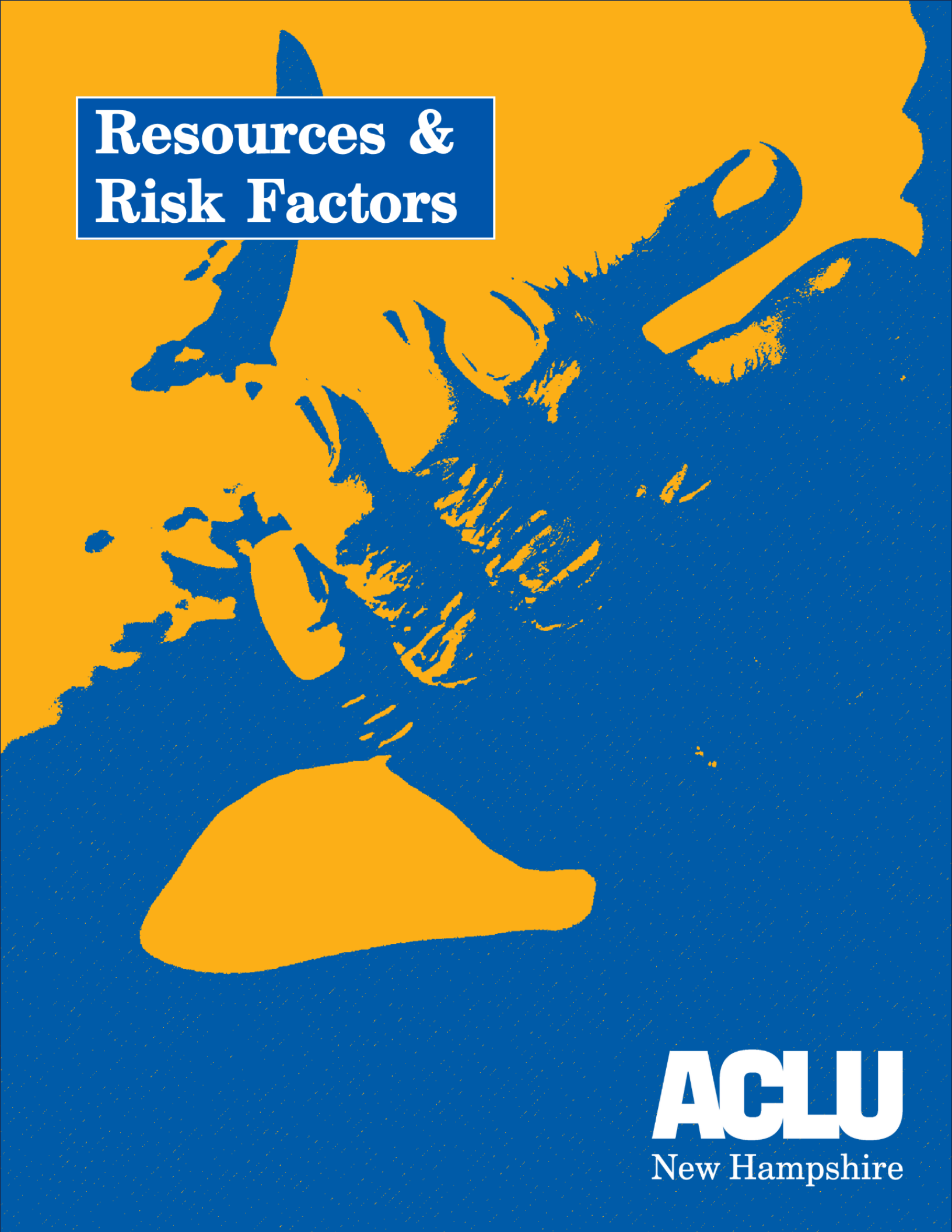
[8] https://fred.stlouisfed.org/series/MANC933URN#0

Figure 10. Labor Force Participation Rate Among Population 16 Years and Over, Manchester and New Hampshire, 2010 and 2021



Source: U.S. Census Bureau, American Community Survey, 2010 and 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level.

Resources & Risk Factors



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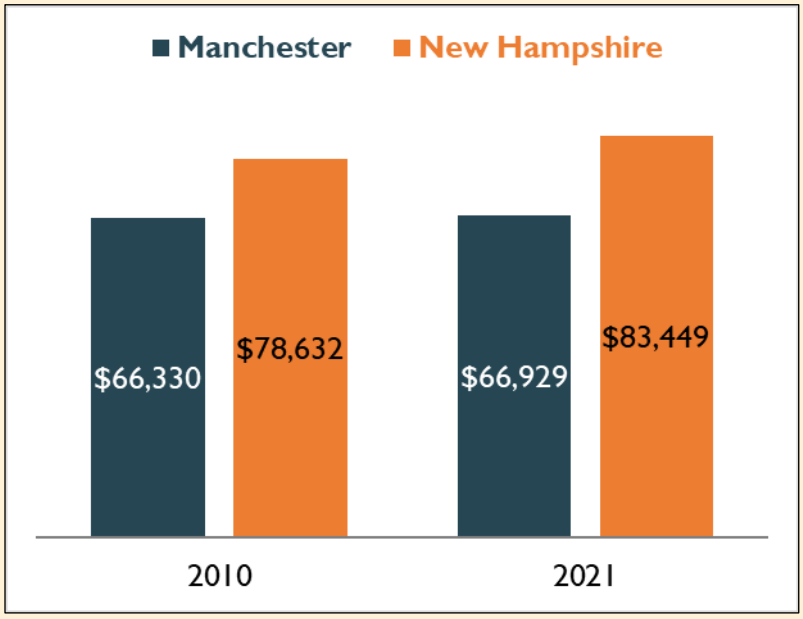
Income

Median household income is consistently lower in Manchester than statewide (see Figure 11). In 2010, the gap between Manchester households and households statewide was about $12,000. By 2021, this gap had widened to more than $16,000.

Figure 11. Median Household Income, Manchester and New Hampshire, 2010 and 2021



Source: U.S. Census Bureau, American Community Survey, 2010 and 2021 5-year estimates
Note: Income from 2010 is inflation-adjusted to 2021 dollars using the Consumer Price Index.

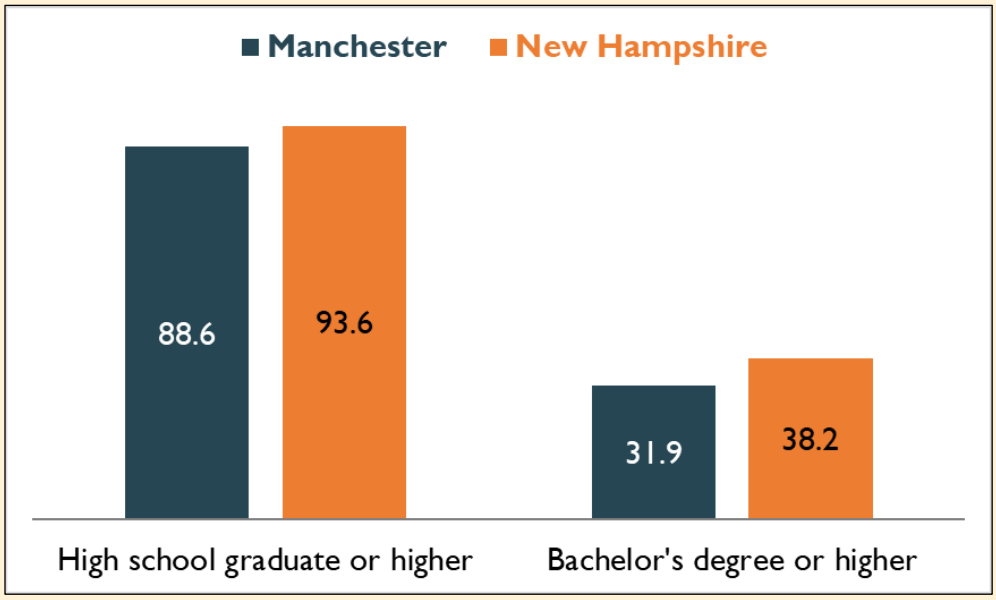
Data from the Massachusetts Institute of Technology's Living Wage Calculator suggests that a household with one adult and one child would require an annual pre-tax income of $76,311 to meet all necessary expenses in the Manchester-Nashua metropolitan area—about $10,000 more than the median household income in 2021.[9]

Education

Manchester has slightly lower educational attainment than statewide, with just under 90 percent of the city's population having at least a high school diploma, compared to almost 94 percent statewide. Similarly, the share with at least a bachelor's degree is lower in Manchester than statewide (Figure 12).

[9] "Living Wage Calculation for Manchester-Nashua, NH". https://livingwage.mit.edu/metros/31700.

Figure 12. Educational Attainment Among Adults Age 25 or Older, Manchester and New Hampshire, 2021



Source: U.S. Census Bureau, American Community Survey, 2021 5-year estimates
Note: Estimates are percentages.

Health Insurance

Figure 13 shows that the share of residents under 65 years old without health insurance decreased from 2013 to 2021 among both Manchester residents and statewide. However, in both 2013 and 2021, a higher share of Manchester residents under 65 did not have health insurance as compared to New Hampshire residents statewide.

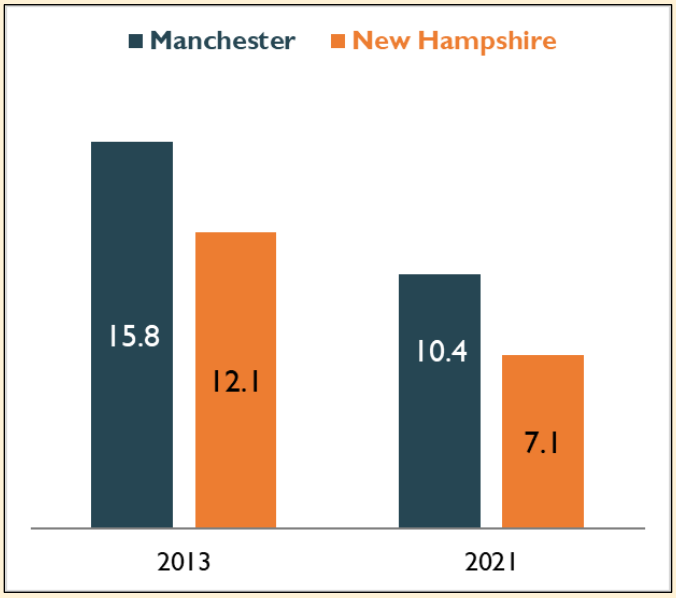


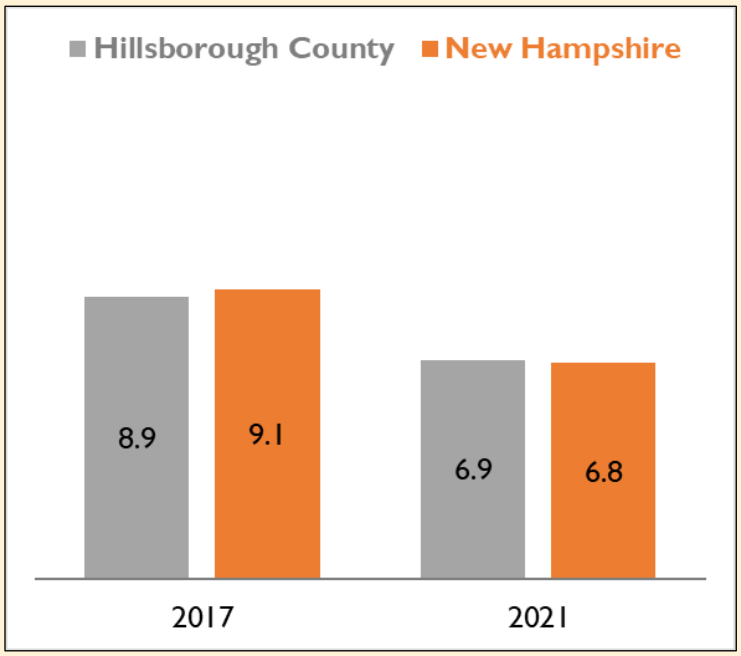
Figure 13. Percent of the Population Under 65 Without Health Insurance, Manchester and New Hampshire, 2013 and 2021

Source: U.S. Census Bureau, American Community Survey, 2013 and 2021 5-year estimates
Notes: Error bars indicate the margin of error at the 95 percent confidence level. Data are presented for 2009-2013 as this is the earliest 5-year period for which the American Community Survey was available via data.census.gov.

Food Insecurity

Food insecurity rates are very similar in Hillsborough County (6.9 percent in 2021) compared to statewide (6.8 percent; see Figure 14). Food insecurity rates were also similar across these two geographies in 2017, although both a bit higher than in 2021 at 8.9 percent in Hillsborough County and 9.1 percent in New Hampshire.

Figure 14. Food insecurity rates, Hillsborough County and New Hampshire, 2017 and 2021



Source: Feeding America's Map the Meal Gap, 2017 and 2021.
Note: These are modeled estimates. Also note that food insecurity rates are not available at the sub-county level, so there is no estimate for Manchester.

Social Safety Net Programs

In part reflecting Manchester's lower household income, rates of receipt of public assistance, including benefits from the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) are higher in the city than statewide (Figure 15). Beyond lower incomes, it is also possible that Manchester's social services infrastructure is stronger, and better at connecting eligible residents with supportive services.

Despite relatively higher rates of assistance, benefits remain meager: the Center on Budget and Policy Priorities estimates that the average SNAP benefit per person in fiscal year 2024 will be $6.20 per day.[10]

[10] https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits

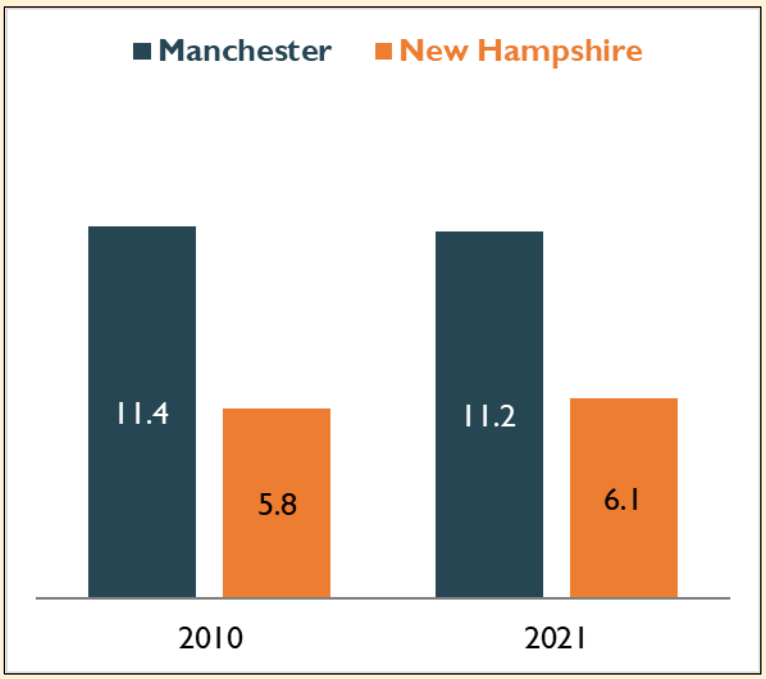


Figure 15. Percent of Households Receiving SNAP, Manchester and New Hampshire, 2010 and 2021

Source: U.S. Census Bureau, American Community Survey 2010 and 2021 5-year estimates

The National School Lunch Program aims to provide free or low-cost lunches to students each school day. Students can qualify for the program based on household income and family size[11] or through categorical eligibility wherein their participation in other Federal Assistance Programs (such as SNAP) or their status as a migrant, homeless, runaway, or foster child qualifies them.[12] Although not all eligible students actually participate, free and reduced-price lunch (FRPL) eligibility can be a useful proxy for need and nutrition risk.

During the 2022-2023 school year, about a quarter of students in New Hampshire were eligible for FRPL (23.8 percent) whereas about half of students in the Manchester School District were FRPL eligible (49.9 percent).[13] As shown in Table 3, free and reduced-price lunch eligibility rates among schools in the Manchester School District ranged from 21.8 percent at Green Acres School (an elementary school in the Green Acres neighborhood) to Beech Street School (an elementary school in the Kalivas/Union neighborhood) at 85.0 percent. Note that due to federal policy changes, it is not appropriate to compare FRPL eligibility data over time.

Table 3. Percent of Students Eligible for Free and Reduced-Price Lunch (FRPL) by Manchester School, 2022-2023 School Year

	Percent Eligible for FRPL
Bakersville School	70.2
Beech Street School	85.0
Gossler Park School	69.3
Green Acres School	21.8

[11] To be eligible for reduced-price lunch, students must live in families with incomes below 185 percent of the federal poverty guideline, or about 51,000 for a family of four during the 2022-2023 school year (via https://www.govinfo.gov/content/pkg/FR-2022-02-16/pdf/2022-03261.pdf).
[12] https://fns-prod.azureedge.us/sites/default/files/resource-files/NSLPFactSheet.pdf
[13] Source: Bureau of Educational Statistics, Division of Education Analytics and Resources, New Hampshire Department of Education

Henry J. McLaughlin Jr. Middle School	49.2
Henry Wilson Elementary School	66.4
Highland-Goffes Falls School	48.6
Hillside Middle School	50.3
Jewett School	38.6
Manchester Central High School	47.1
Manchester Memorial High School	34.5
Manchester School of Technology (High School)	41.6
Manchester West High School	51.1
McDonough School	62.1
Middle School At Parkside	60.7
Northwest Elementary School	57.7
Parker-Varney School	53.3
Smyth Road School	36.2
Southside Middle School	50.5
Webster School	43.7
Weston Elementary School	42.9

Notes: Based on data as of October 31, 2022.
Source: Bureau of Educational Statistics, Division of Education Analytics and Resources, New Hampshire Department of Education

In addition to standard social safety net benefits like SNAP, the Covid-19 pandemic was associated with several additional safety net offerings that buffered New Hampshire residents from hardship. Perhaps one of the most important for Hillsborough County residents was the New Hampshire Emergency Rental Assistance Program (ERAP). Designed to support residents with housing costs—including rent, utilities, and heating—the program has infused Hillsborough County with more than $129 million in aid since it began accepting applications in spring 2021. Hillsborough has received more ERAP assistance than any other county, with 84 percent of the expenditures there going to support rental costs for Hillsborough County residents.[14]

[14] https://www.goferr.nh.gov/transparency/nherap-dashboard

Transportation

Although Manchester has perhaps some of the most robust public transit offerings in the state, transportation remains a challenge statewide. As Figure 16 shows, seven percent of Manchester households do not have access to a vehicle, limiting the flexibility of their commuting range and distance.

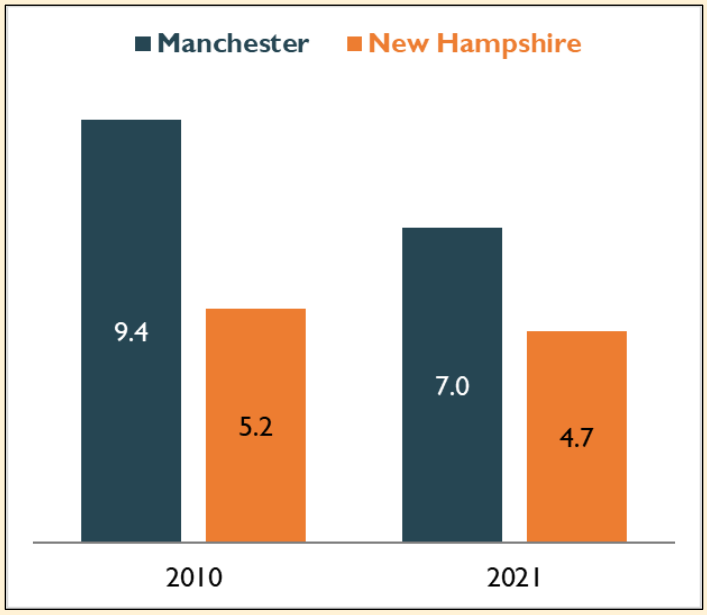


Figure 16. Percent of Households with No Vehicle, 2010 and 2021

Source: U.S. Census Bureau, American Community Survey 2010 and 2021 5-year estimates

Forty-five percent of Manchester residents' jobs are more than 10 miles from home, making a car essentially a necessity for those residents (Table 4). For those without private transportation, Manchester does have a public transit system, but bus routes have limited coverage in the city, and their frequency may not align fully with residents' needs. Addressing challenges of public transit is especially essential as an equity enhancing lever: as the New Hampshire Fiscal Policy Institute points out, public transit is disproportionately utilized by lower income people, people who speak a language other than English at home, Hispanic and Latino populations, and those working in the service sector.[15]

Table 4. Distance to Job for Employed Manchester Residents, 2021

	Count	Percent
Less than 10 miles	31,538	54.8
10 to 24 miles	15,437	26.8
25 to 50 miles	7,565	13.1
Greater than 50 miles	3,049	5.3
All Jobs	57,589	100.0

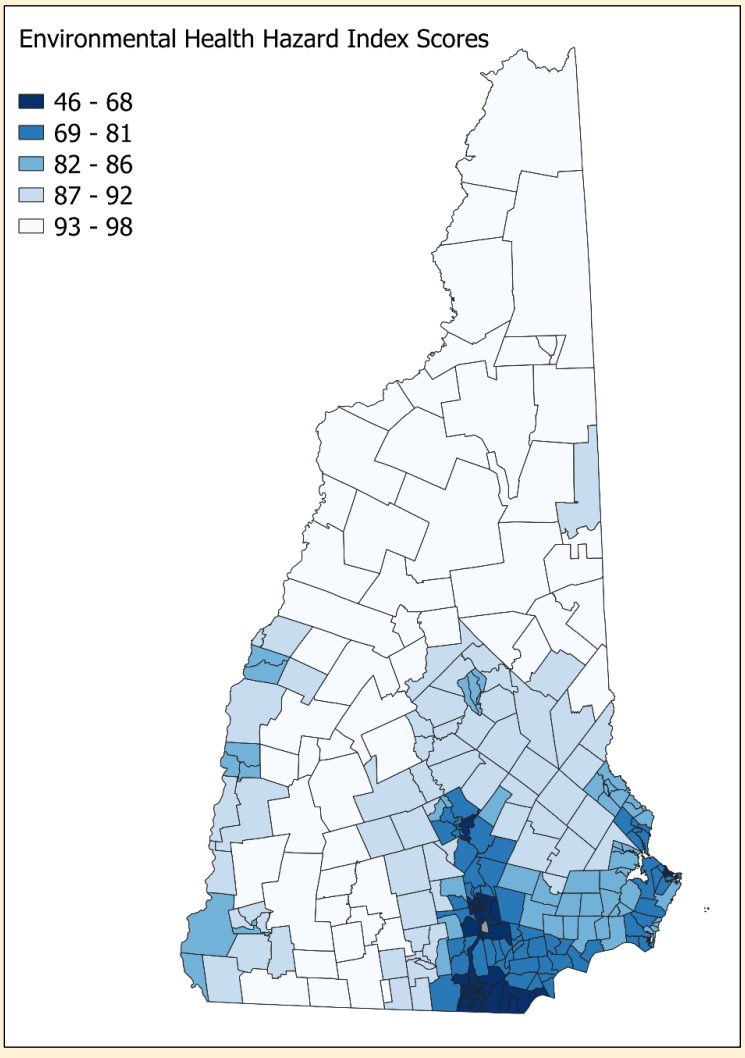
[15] https://nhfpi.org/blog/new-hampshire-policy-points-transportation/

Source: U.S. Census Bureau, OnTheMap, 2021. Note: Distance is measured as the number of miles between a worker's home Census Block and the Census Block in which they are employed. Counts are of jobs, rather than workers, such that a single worker could hold more than one job.

Environmental Hazards

Environmental hazards—commonly including water and air pollution—can affect human health in complex ways. Evidence suggests that both exposure to and impacts of that exposure are unevenly distributed across populations, with serious implications for health and well-being.[16]

Map 1 shows data from the Department of Housing and Urban Development (HUD) that summarizes "potential exposure to harmful toxins at a neighborhood level."[17] Focused on air pollutants that are seriously injurious to human health, the Environmental Health Hazard index ranges from 0 to 100 and is constructed so that higher values indicate less exposure to toxins (i.e., better air quality). Some of the lowest scores—indicating higher exposure to toxins—are found in Concord, Manchester, Nashua, and Portsmouth (see Map 1).



Map 1. Environmental Health Hazard Index Scores by Census Tract in New Hampshire, 2014

Source: Geospatial Data Storefront of the U.S. Department of Housing and Urban Development (HUD) available at https://hudgis-hud.opendata.arcgis.com/datasets/HUD::environmental-health-hazard-index/about. The

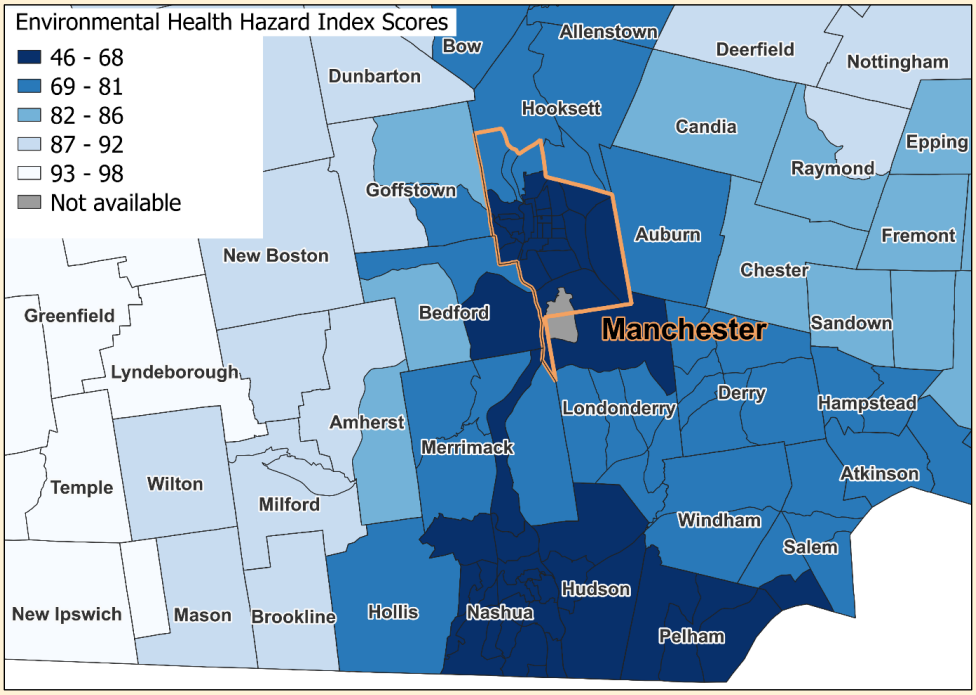
[16] https://www.cdc.gov/nceh/tracking/tracking-intro.html
[17] https://hudgis-hud.opendata.arcgis.com/datasets/HUD::environmental-health-hazard-index/about

Environmental Health Hazard Index is based on 2014 National Air Toxics Assessment (NATA) data. Data were mapped by quintiles in QGIS by authors.

Map 2 provides a closer look at air pollutants throughout Manchester, Nashua, and the surrounding area. The two census tracts with the worst score in the state—both with a score of 46—are in the center of Nashua. Most census tracts in Manchester have Environmental Health Hazard Index scores in the most dangerous range (46 – 68) except for three census tracts in the north, still with scores in the second most dangerous range.

In Manchester, lead stands out as a key pollutant. New Hampshire Public Radio reports that Manchester has "the highest rate of elevated lead levels among children"[18] and the City of Manchester established a Lead Exposure Prevention Commission in 2023 to address this serious concern.[19] Even lower levels of lead exposure can have lasting impacts on children's brain development[20] and children living in older housing—often children experiencing poverty, children of color, and immigrants and refugees—are at a higher risk of lead exposure.[21] One analysis found that six of the ten New Hampshire census tracts with the highest share of older (pre-1980) homes were in Manchester.[22]

Map 2. Environmental Health Hazard Index Scores by Census Tract in Manchester and Surrounding Area, 2014



Source: Geospatial Data Storefront of the U.S. Department of Housing and Urban Development (HUD) available at https://hudgis-hud.opendata.arcgis.com/datasets/HUD::environmental-health-hazard-index/about. The Environmental Health Hazard Index is based on 2014 National Air Toxics Assessment (NATA) data. Data were mapped by quintiles in QGIS by authors.

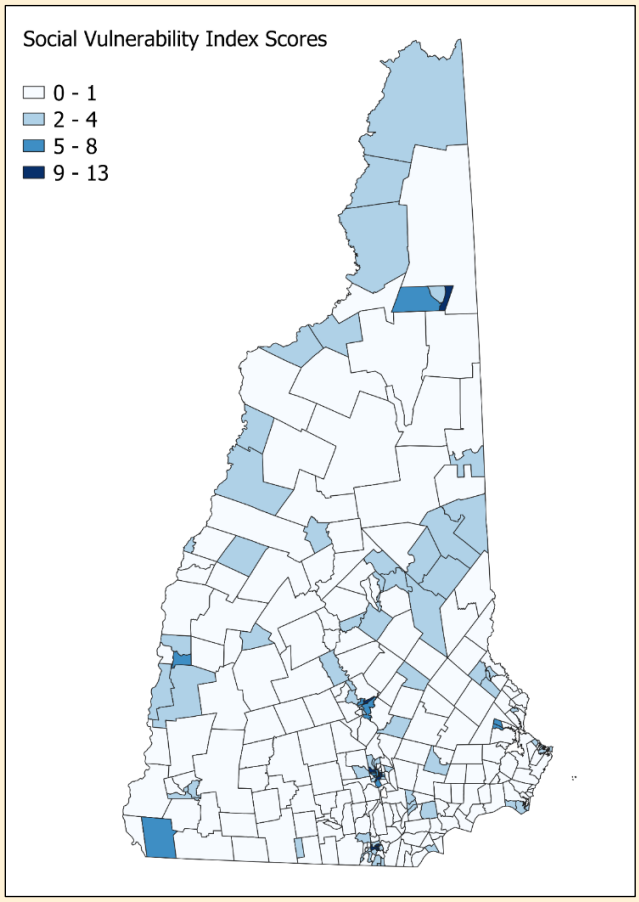
[18] (Hoplamazian 2023) referencing (Healthy Homes and Lead Poisoning Prevention Program 2023)
[19] https://civicclerk.blob.core.windows.net/stream/MANCHESTERNH/04cedbb1-a449-4e50-858b-dbae5bb06201.pdf?sv=2021-10-04&st=2023-05-19T14%3A11%3A21Z&se=2024-05-19T14%3A16%3A21Z&sr=b&sp=r&sig=sLIJ2ATjTr3fnDreT4Rs3ITGSmBvhhvF8sFeAm1yzwM%3D
[20] (Healthy Homes and Lead Poisoning Prevention Program 2023)
[21] (Ragsdale, Cuno Booth, and Bassett 2021)
[22] Ibid.

Social Vulnerability Index (SVI)

The New Hampshire Social Vulnerability Index (SVI) is an emergency response planning tool based on a Centers for Disease Control and Prevention (CDC) project that was designed to identify communities that are particularly vulnerable and would likely need extra support in the event of an emergency or disaster.[23]

The SVI uses 16 measures of social determinants of health—nonmedical factors that influence health outcomes[24]—from the U.S. Census Bureau's American Community Survey 2015-2019 5-year estimates to calculate a summary index score of social vulnerability for each New Hampshire census tract. These 16 measures span the following four categories: household composition/disability, housing/transportation, race/ethnicity and language, and socioeconomic status.[25] The SVI score for each census tract is the number of measures out of 16 total that were above the 90th percentile among all NH census tracts. The lowest possible score of 0 indicates low vulnerability, whereas any score at or above 10 indicates high vulnerability.

As shown on Map 3, census tracts in major cities like Concord, Manchester, and Nashua stand out with higher SVI scores, along with two tracts in Berlin.



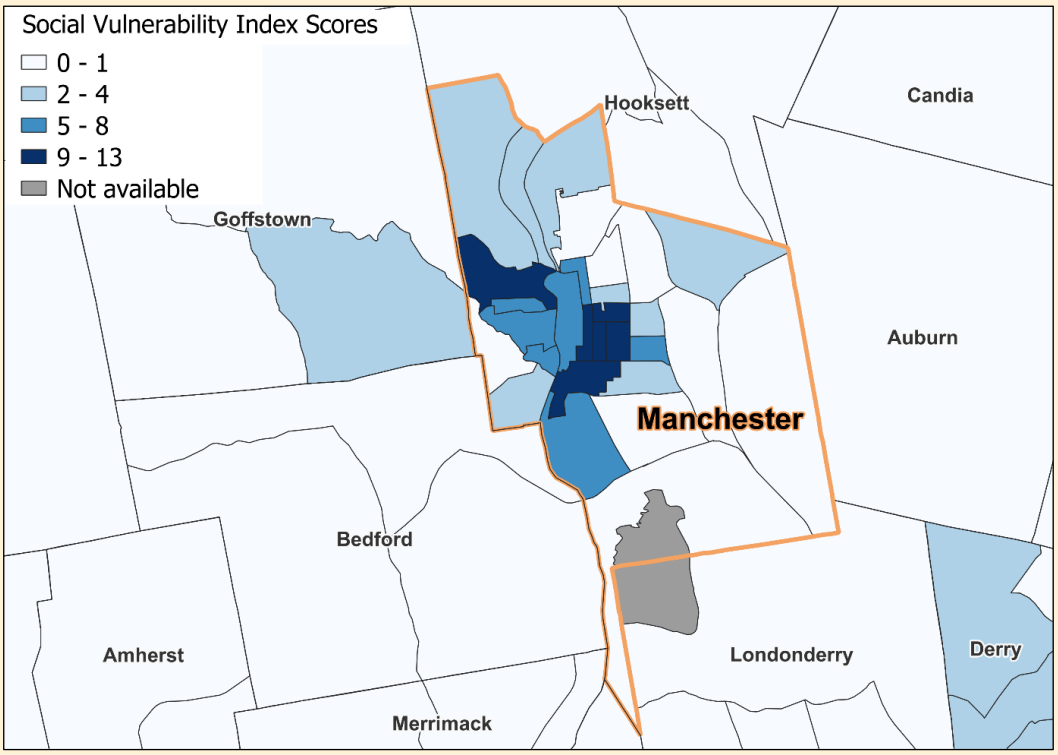
Map 3. Social Vulnerability Index Scores by Census Tract in New Hampshire, 2015-2019

Source: NH Environmental Public Health Tracking Program, Division of Public Health Services, NH Department of Health and Human Services. Accessed via NH DHHS Data Portal. Data were mapped by natural breaks (Jenks) in QGIS by the authors.

[23] https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=social-determinants-of-health&subtopic=social-determinants-of-health&indicator=social-vulnerability-index-(svi)
[24] For a full definition of social determinants of health, see https://www.cdc.gov/about/sdoh/index.html.
[25] Full list of measures available at Ibid.

The census tract with the highest SVI score in the state is in Manchester. With an SVI score of 13, parts of the Kalivas/Union and Corey Square neighborhoods have extremely low income per capita at just $17,000, about one-quarter of the population without a high school diploma, and two-thirds of households with children headed by a single parent. Five other census tracts in the center and west side of Manchester had SVI scores of nine or higher (see Map 4).

Map 4. Social Vulnerability Index Scores by Census Tract in Manchester, 2015-2019



Source: NH Environmental Public Health Tracking Program, Division of Public Health Services, NH Department of Health and Human Services. Accessed via NH DHHS Data Portal. Data were mapped by natural breaks (Jenks) in QGIS by the authors.

Housing

ACLU
New Hampshire

Housing

Constrained Inventory and Rising Costs

Housing affordability is a significant challenge nationally. Home availability is down, driven by limited supply and insufficient new construction, while at the same time home prices and the cost of rent have increased considerably.[26] New Hampshire Housing's *2023 New Hampshire Statewide Housing Needs Assessment* estimates that "between 2000 and 2020, New Hampshire's home sales prices rose 111 percent and rents increased 94 percent, while household median income increased only 73 percent."[27] The New Hampshire Association of Realtors (NHAR) reported that residential housing affordability reached the lowest it has been in over 20 years in October 2023 with an Affordability Index of 58, signifying that statewide median income is 58 percent of that which is required to qualify for a home at the median home price.[28] NHAR attributes high prices to a lack of inventory.

Figure 17 shows that in 2021, more than one-third of Manchester households were housing cost-burdened, meaning housing costs exceeded 30 percent of household income.

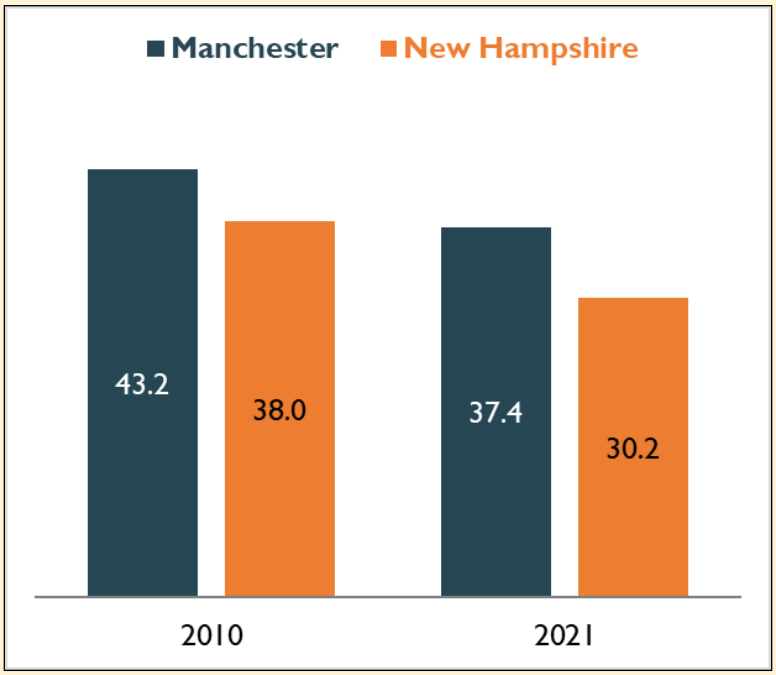


Figure 17. Percent of Households that are Housing Cost-Burdened, Manchester and New Hampshire, 2010 and 2021

Source: U.S. Census Bureau, American Community Survey, 2010 and 2021 5-year estimates
Note: "Housing cost-burdened" refers to households that spend more than 30 percent of their income on housing costs.

According to New Hampshire Housing's *New Hampshire 2023 Residential Rental Cost Survey Report*, in 2023 the statewide median monthly gross rent (including utilities) for a two-bedroom apartment was $1,764—up 11.4 percent from 2022.[29] In order to afford this, a renter would have to make over $70,600 per year, or about 137 percent of the statewide median renter income. The 2023 median two-bedroom rent in Hillsborough County was even higher, at $2,002, equivalent to 145 percent of median renter income in the county.

[26] See, for example, https://housingmatters.urban.org/research-summary/addressing-americas-affordable-housing-crisis and https://www.pewresearch.org/short-reads/2022/03/23/key-facts-about-housing-affordability-in-the-u-s/
[27] (Root Policy Research for New Hampshire Housing 2023, p.1)
[28] https://www.nhar.org/news/article/affordability-low
[29] (McCann, Moran, and Lessner 2023)

The New Hampshire residential rental market is very tight, characterized by high demand, low vacancy rates, and affordability challenges. In terms of constrained housing supply, the 2023 vacancy rate was only 0.8 percent for all types of rentals.[30] The vacancy rate was even lower in Hillsborough County, at just 0.6 percent for all units. NH Housing estimates a current shortage of more than 23,500 housing units statewide and that New Hampshire will need to add almost 90,000 housing units between 2020 and 2040.

Exposure to Homelessness is Uneven and Growing

According to the NH Coalition to End Homelessness' *2021 State of Homelessness in New Hampshire Report*, a total of 4,682 people experienced homelessness in New Hampshire throughout 2021.[31] More than one third were in Manchester (a total of 1,714). Notably, Granite Staters identifying as Black or African American were four times more likely to experience homelessness than those identifying as white. Granite Staters identifying as Hispanic were two times more likely to experience homelessness as compared to white Granite Staters.

In 2021, the 2021 New Hampshire Official Point-in-Time (PIT) Count was 1,491 people experiencing homelessness at the time of the count.[32] This estimate is lower than the overall estimated number of people experiencing homelessness throughout the year since it is a count from one day only. The 2021 PIT Count was lower than the 2010 count of 1,612 Granite Staters.[33] This may be due, in part, to the pandemic-era supports available to people experiencing housing disruptions that were still widely available into 2022.[34] Indeed, the 2022 PIT Count indicates only slight increases in the count of people experiencing homelessness (1,605).[35] However, preliminary figures from the 2023 PIT Count suggests that there were around 2,441 people experiencing homelessness—a substantial jump from recent previous years.[36] Paired with the expiration of pandemic-era supports, New Hampshire's historically weak infrastructure for supporting individuals at risk for homelessness—particularly in more rural areas—is a serious vulnerability.[37] The implications of this increase are considerable, not least because a recent study found that the rates of sudden cardiac death are seven times higher among people experiencing homelessness than among the general population.[38]

Strategies to Address the Housing Crisis

New Hampshire

There is broad agreement that the housing crisis is a top concern for the state of New Hampshire.[39] August 2023 results from the University of New Hampshire's Survey Center's Granite State Poll found that housing was the most selected number one concern among New Hampshire residents.[40] Additionally, a July 2023 survey conducted by the Saint Anselm College Survey Center found that more than three quarters of Granite State voters (78 percent) support building more affordable housing in

[30] Ibid., note that a 5 percent vacancy rate is considered ideal.
[31] (Savard et al. 2022)
[32] As described in Savard et al. 2022 (pg. 9), "The PIT Count is required by HUD annually to include a 24-hour count of individuals experiencing unsheltered and sheltered homelessness on the last Wednesday in January." This estimate is very literally a count taken at one point in time.
[33] (NH Coalition to End Homelessness 2012)
[34] (Heller 2023)
[35] (de Sousa et al. 2022)
[36] (Lynch 2023)
[37] https://www.nhceh.org/wp-content/uploads/2022/01/understanding-homelessness-one-pager-v5-1-1.pdf
[38] (Haghighat et al. 2023)
[39] For example, New Hampshire hospital leaders and community development leaders identified housing as a top social need in (Swack, Boege, and Barnett 2023).
[40] (Cotter 2023)

their communities and 60 percent support changing zoning regulations to make building more housing easier.[41]

The NH Council on Housing Stability was established in November 2020 by Governor Sununu via Executive Order 2020-22. The interdisciplinary, cross-sector team was tasked with creating and then implementing a strategic plan to improve housing stability in New Hampshire.[42] At least some expert recommendations to guide this planning already exist. For instance, New Hampshire Housing identifies the central way to address the housing crisis and accommodate projected population and employment growth is through increasing housing production.[43] The 2023 NH Statewide Housing Needs Assessment proposes two primary strategies to increase housing production: 1) to allocate more state and federal funding and financing tools to support housing development, and 2) through changing state and local regulatory policies to efficiently encourage more housing development.[44]

Enacting these kinds of regulatory shifts is often easier said than done, however, as a key feature of New Hampshire housing development is the very local nature of its zoning and planning boards. Often staffed by lay people with careers in potentially unrelated industries, these boards are often hesitant to make changes that would trigger permanent shifts in local character.[45]

Recent legislation aims to address this issue. The 2023 state budget bill HB2 established a new Housing Champion program, which includes a housing infrastructure municipal grant and loan program and a housing production municipal grant program.[46] The aim is to support new affordable housing development, particularly workforce housing, in communities that choose to participate. The program will include four elements, as outlined by attorney Chloe Golden in the NH Business Review:

- "**Preapplication grants:** Municipalities interested in earning Housing Champion designation may apply for small grants to help them meet the requirements of the program. The grants may be used for board member training and hiring consultants to develop master plans and revise land use regulations.

- **Housing Champion designation:** The designation is the centerpiece of the law. By earning the designation, municipalities that have committed to increasing housing development in their community become eligible for two additional sources of funds — infrastructure funding and per-unit production grants. To qualify for the designation, communities must adopt zoning, site plan and other land use regulations that promote workforce housing; train members of land use boards on appropriate procedures, and laws that apply to board members; implement sewer and water infrastructure improvements; and implement public transportation and walkability infrastructure like sidewalks.

- **Infrastructure funding:** A common concern facing municipalities considering workforce housing is the overburdening of existing infrastructure. Likewise, lack of infrastructure may deter developers from even considering communities. The new program seeks to mitigate this problem by providing Housing Champion designees with grants or low interest loan programs to expand infrastructure and accommodate new housing.

[41] (Feingold 2023)
[42] (Council on Housing Stability 2021)
[43] (Root Policy Research for New Hampshire Housing 2023)
[44] For additional details on specific policies that are proven to support housing development, see page 8 of (Root Policy Research for New Hampshire Housing 2023).
[45] E.g., https://carsey.unh.edu/publication/rural-housing-challenges
[46] https://legiscan.com/NH/text/HB2/2023

- **Housing production municipal grants:** The program pays for actual production, awarding grants on a per-unit basis for certificates of occupancy that a town issues for workforce housing units." [47]

The NH Department of Business and Economic Affairs is still working to iron out the details of the program and its implementation, which will be finalized by July 1, 2024, with support from an advisory committee.

Manchester

As recommended by NH Housing and other housing experts, Manchester has begun updating its zoning regulations. In 2021, the Manchester Planning Board officially adopted the 2021 Manchester Master Plan[48] which outlines the city's vision for the future. The Master Plan includes recommendations to update land use and development regulations such as the Manchester Zoning Ordinance, and to create a land use code.[49] The last time the Manchester Zoning Ordinance was updated was in 2001—over 20 years ago.[50] This updating process, which includes many opportunities for public and stakeholder engagement, began at the end of 2021 and is anticipated to be ongoing through 2024.[51]

In the meantime, various housing projects and efforts aim to tackle the housing and homelessness crisis in Manchester including but not limited to the following:

- It's reported that "The City of Manchester has allocated $16.7 million in the last three years toward increasing affordable housing and addressing homelessness and substance use disorder in the City of Manchester. This has resulted in the development of over 500 new units of affordable housing and supporting over 100 emergency, transitional, SUD treatment and rapid rehousing beds."[52]

- In November 2023, the Manchester Ink Link published a Manchester housing update listing out 28 housing projects—representing 2,288 housing units—in the works, some now completed and occupied.[53]

- In August 2023, Manchester Mayor Joyce Craig announced that the City of Manchester would be partnering with the National Alliance to End Homelessness, a national nonprofit, to help strategize and fill service gaps.[54]

- The collaborative Manchester Continuum of Care (CoC) is a U.S. Department of Housing and Urban Development (HUD) program that works to provide systems of care to prevent and end homelessness in Manchester.[55] The Manchester CoC receives more than $3 million in federal funds annually for homelessness response.[56]

    - Recently, pandemic-era relief funds aimed to support affordable housing have become available to towns and municipalities in New Hampshire via InvestNH, a program funded New Hampshire's State and Local Fiscal Recovery Funds through the American

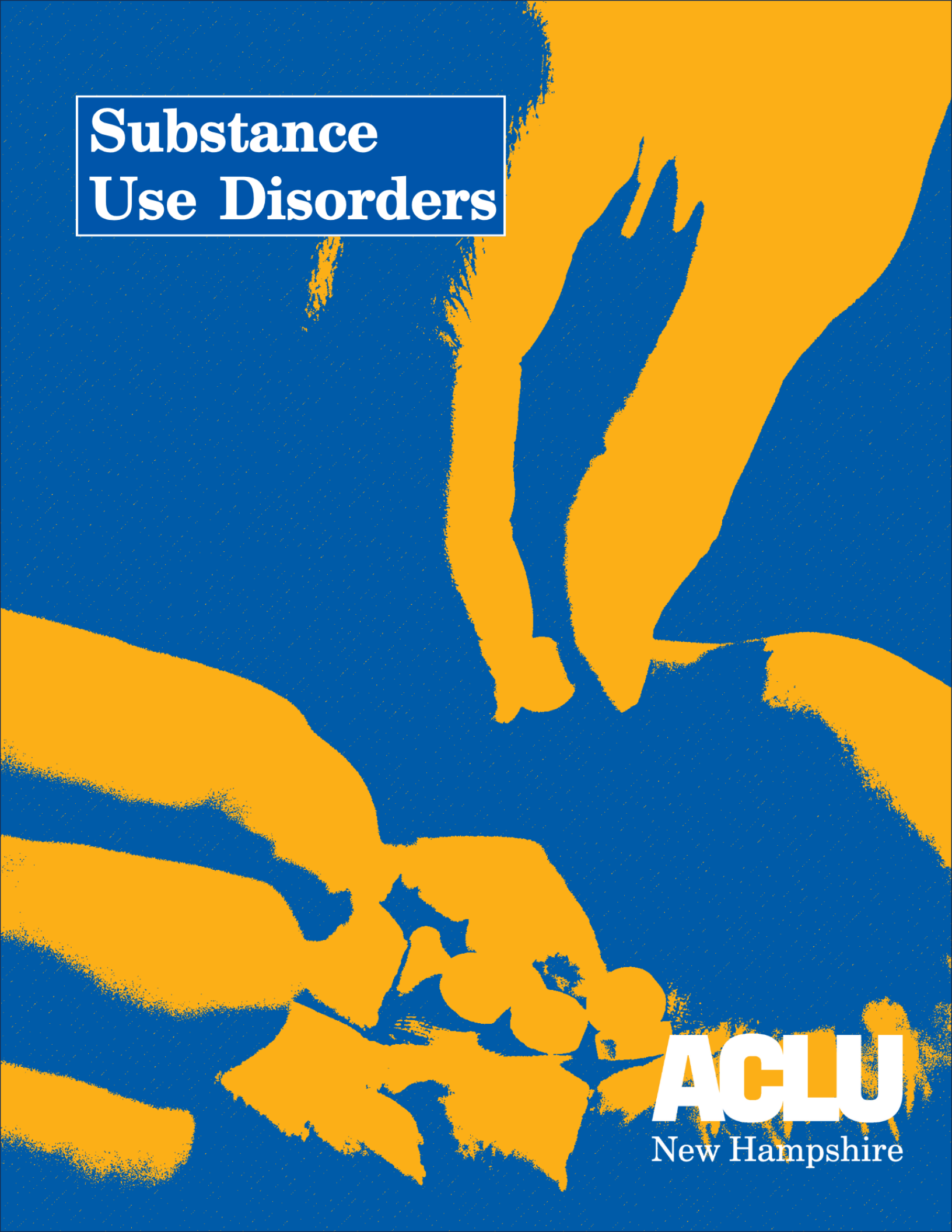
[47] (Golden 2023)
[48] (Plan Manchester 2021)
[49] https://www.manchesternh.gov/Departments/Planning-and-Comm-Dev/Land-Use-Code
[50] (Sylvia 2023b)
[51] https://www.manchesternh.gov/Departments/Planning-and-Comm-Dev/Land-Use-Code
[52] (Sylvia 2023a)
[53] (Robidoux 2023b)
[54] (Fleming 2023)
[55] https://www.manchester-coc.org/
[56] (Beloin 2023)

Rescue Plan Act (ARPA).[57] The City of Manchester received a $2 million grant from the InvestNH Municipal Per-Unit Grant Program, which will be allocated to develop 192 affordable housing units near Veteran's Memorial Park.[58]

- In an August 2023 presentation to the Manchester Board of Alderman, the Director of Homelessness Initiatives reported that in 2023 to date the initiative has served 310 people experiencing homelessness, connected 274 people experience homelessness with services, and helped transition 27 people out of homelessness.[59]
    - The Director, named Adrienne Beloin, also submitted a memorandum outlining the plan for the recently established Department of Housing Stability which will spearhead a City-wide coordinated response to reducing homelessness and increasing housing stability.[60]

[57] https://www.nheconomy.com/investnh-housing
[58] (Sylvia 2023a)
[59] (Robidoux 2023a)
[60] (Beloin 2023)

Substance Use Disorders



ACLU New Hampshire

Substance Use Disorders

Definitions & Background

What are substance use disorders (SUDs)?

A substance use disorder (SUD) is "a complex condition in which there is uncontrolled use of a substance despite harmful consequences."[61] Substance use disorders are treatable brain disorders that affect areas of the brain involved in stress, reward, and self-control.[62] This conceptualization of SUDs is based on neuroscience research and moves beyond earlier myths that SUDs were a moral failing requiring punishment, rather than medical disorders requiring treatment.[63]

Throughout this paper, the term "substance use disorder" will be used because this language is less stigmatizing than "substance abuse." For example, there is evidence that the term "substance abuse" or "substance abuser" evokes a more negative and punitive perception, even among trained mental health professionals.[64]

SUDs are mental health conditions.

The American Psychiatric Association's current *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) includes substance-related and addictive disorders.[65] A substance use disorder is identified via "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" such as physical risk or social impairment.[66]

Based on symptomology, substance use disorders can be classified as mild, moderate, or severe. Note that while the term 'drug addiction' is widely used (even in clinical settings) to describe severe substance use disorder, it's not used as a diagnostic term in the DSM-5-TR because of its negative connotations. Severe substance use disorder is characterized by three recurring stages of binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation (seeking the substance again following some period of abstinence).[67]

Substance-related disorders in the DSM-5-TR include 10 classes of drugs. Excluding caffeine, a diagnosis of SUD can be applied to any of the other 9 classes, which are: alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives/hypnotics/anxiolytics (such as barbiturates), stimulants (such as cocaine), tobacco, and other/unknown substances.[68] This paper will focus primarily on opioid use disorder.

While not the focus of this discussion, it is worth noting that in addition to substance use disorders, the DSM-5-TR also contains substance-induced disorders. Substance- or medication-induced disorders are often temporary, wherein a substance induces a mental disorder, such as a methamphetamine-induced anxiety disorder or alcohol-induced depressive disorder. Substance-induced disorders are

[61] https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder
[62] (National Institute on Drug Abuse 2020b)
[63] (National Institute on Drug Abuse 2020b; Volkow, Koob, and McLellan 2016)
[64] (Kelly and Westerhoff 2010)
[65] (American Psychiatric Association 2022b)
[66] Ibid.
[67] (Office of the Surgeon General 2016)
[68] (American Psychiatric Association 2022b)

more common among those with multiple substance use disorders, and for those who are not in treatment.[69] Substance withdrawal also falls under this category.

Co-occurrence of SUD and other mental health conditions is common.

While substance use disorders are mental health conditions, it is also common that they co-occur with other mental health conditions, such as anxiety disorders, depressive disorders, bipolar disorders, or posttraumatic stress disorder (PTSD).[70] In fact, comorbidity is very common. About 1 in 4 adults with a serious mental illness (which includes mental disorders causing serious impairment, such as major depression or schizophrenia) also have a substance use disorder.[71]

Research suggests there is a complex relationship between substance use disorder and mental health, with several potential mechanisms that could describe their co-occurrence, including that mental health conditions might trigger substance use disorder (particularly through attempts to self-medicate), that changes to the brain triggered by substance use may increase risk of developing a mental disorder, or that genetic and environmental factors can function as risk factors that increase the odds of developing a substance use disorder or a mental health condition.[72]

Despite the significant connection between SUD and other mental health conditions, research on how best to serve people with co-occurring conditions is not strongly established.[73] Some scholarship has linked heightened risks of SUD to anxiety disorders especially, and outlines the importance of social workers who address SUD collaborating with medical professionals who can develop a plan to also address anxiety, including through careful selection of pharmacological interventions that have low risk for dependency.[74]

SUD changes the brain. People with SUD can't "just say no."

It's a misconception that people with severe substance use disorder simply lack the willpower or morals to quit their drug use.[75] While environmental factors and personal choice play some role in SUD, the relative contribution of these factors is equivalent to that of other less stigmatized chronic illnesses. A literature review comparing substance use disorder with three other chronic illnesses—asthma, type 2 diabetes, and hypertension—found that environmental factors, genetics, and personal choice (e.g., adherence to medical advice, limiting exposure to aggravating factors) are involved to a similar degree in the development and course of all these disorders.[76] Further, concentrating on individual-level actions can pull focus from the significant systemic challenges a person may face in disease management, such as barriers to access to quality healthcare.

As is outlined in the DSM-5-TR, a key characteristic of substance use disorders is a change in brain circuits that can remain even after detoxification. The DSM-5-TR describes that "the behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli."[77]

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[69] (Torrens, Gilchrist, and Domingo-Salvany 2011)
[70] (American Psychiatric Association 2022a; Conway et al. 2006; Goldstein et al. 2016; Jones and McCance-Katz 2019; National Institute on Drug Abuse 2020a)
[71] (National Institute on Drug Abuse 2020a)
[72] https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health
[73] (Murthy, Mahadevan, and Chand 2019)
[74] (Brady et al. 2013)
[75] https://nida.nih.gov/publications/drugfacts/understanding-drug-use-addiction
[76] (McLellan et al. 2000)
[77] (American Psychiatric Association 2022b)

Research shows that three areas of the brain—the basal ganglia, the prefrontal cortex, and the extended amygdala—are notably involved in and impacted by substance use disorders.[78] Disruptions to these areas reduce the sensitivity of reward systems, increase the activation of stress systems, and reduce executive functions such as self-control and decision making.[79] Existing evidence suggests that changes to the brain can persist long-term, even after years of abstinence.[80] Further research is needed to better understand how long these changes last and how reversible they are.

Neuroimaging studies have shown that people with substance use disorders experience physical brain changes, including up to a 20 percent reduction in the density or thickness of prefrontal cortex grey matter.[81] These changes to the prefrontal cortex can disrupt important processes such as self-control, behavioral monitoring, emotion regulation, decision-making, memory, motivation, attention, and interoception.[82]

Disruptions to interoception, or awareness of one's own body, can result in a person's inability to understand or perceive the severity of their SUD—commonly mislabeled as "denial" about having an illness and needing treatment.[83] While the word "denial" implies intentional deception, it may instead be that dysfunctional neural circuits are impairing a person's ability to perceive the severity of their substance use disorder.[84]

Relapse is just as common for other chronic diseases as it is for SUD.

Relapse—also called reoccurrence of use—is normal and not a sign of failure.[85] Just as in other diseases, an SUD relapse is the return of symptoms after a period of remission. As the Centers for Disease Control and Prevention outlines: "More than anything, reoccurrence of use may be a sign that more treatment or a different method is needed. A routine review of one's treatment plan may be necessary to determine if another method could be more effective."[86]

While SUD relapse is stigmatized, relapse is a common element of many diseases. A literature review found that relapse rates among people treated for substance use disorders were comparable with those among people treated for other chronic illnesses, specifically hypertension and asthma. While the reviewed studies identified relapse rates ranging from 40 to 60 percent for people treated for SUDs, the range of relapse rates for hypertension and asthma were 50 to 70 percent.[87]

A 2019 study following inpatients at five SUD treatment centers in Norway found no significant difference in the level of pretreatment intrinsic motivation between patients who experienced a relapse and those who did not relapse (as of a follow-up three months after discharge).[88] The factors that were associated with a higher risk of relapse were younger age and having a co-occurring psychiatric diagnosis.

Implications of substance use disorder as "deviance."

Historically, one of the most popular approaches to understanding substance use has been through the lens of deviance.[89] This framing positions people with SUD as (deliberately) apart from mainstream

[78] (Office of the Surgeon General 2016)
[79] Ibid.
[80] (Goldstein and Volkow 2011; Wobrock et al 2009; Zhang et al. 2018)
[81] (Goldstein and Volkow 2011)
[82] Ibid.
[83] (Goldstein et al. 2009; Goldstein and Volkow 2011)
[84] (Goldstein et al. 2009; Verdejo-García and Pérez-García 2008)
[85] (National Institute on Drug Abuse 2020b)
[86] https://www.cdc.gov/stopoverdose/stigma/index.html
[87] (McLellan et al 2000; National Institute on Drug Abuse 2020b)
[88] (Andersson, Wenaas, and Nordfjærn 2019)
[89] (Akins and Mosher 2015; Klaue 1999)

society and reinforces the "otherness" of people with SUD,[90] including as weak, immoral, or personally failing.[91] Legal systems draw upon and reinforce the deviant label, and as a result, "drug use continues to be penalized, despite the fact that punishment does not ameliorate substance use disorders or related problems."[92] As will be discussed in further detail in the later section on Public Safety and Criminal Justice, punitive measures are ineffective, costly, and can create more harm.

Stigma

One challenge inherent in the "othering" of people who use substances or have substance use disorders is the resulting stigma. At its most basic, stigma against people with SUD "creates barriers to treatment," according to the National Institute on Drug Abuse.[93] Research suggests that those who view heightened opioid use as a result of personal choice are more likely to favor punitive responses and less likely to favor public-health oriented policies or policies that explicitly support people with SUD.[94] Research finds that, in part, "belief that a substance misuser's illness is a result of the person's own behavior can influence attitudes about the value and appropriateness of publicly funded alcohol and drug treatment and services."[95]

Beyond dampening support for policy mechanisms that would support people with SUD, stigma has individual-level impacts among those experiencing SUD that reinforce poor outcomes. For instance, among substance using individuals, experiences of use-related discrimination have been linked with worse mental and physical health,[96] and the National Institute on Drug Abuse identifies stigma as a reason that people with SUD sometimes delay or avoid seeking care.[97]

Addressing stigma

Given the deep roots of stigma and discrimination in the nation's approach to SUD, identifying mechanisms to reduce stigma is both important and challenging. The National Academies of Sciences, Engineering, and Medicine published a volume focused on ending discrimination against people with mental health conditions and SUD, although evidence of effective strategies were skewed toward those addressing stigma against mental health conditions.[98] Potential strategies include educational outreach campaigns, SUD literacy campaigns, increasing contact between those experiencing SUD and the broader population, particularly through peer services.[99]

Perhaps the most common approach to reducing stigma is educational campaigns. However, evidence on the effectiveness of such outreach campaigns has been mixed. Little evidence tests SUD campaigns specifically, but findings from the mental health literature may apply. For instance, a campaign intended to highlight the genetic drivers of schizophrenia—intended to reduce blame on people dealing with mental health conditions—instead underscored how "different" people with a mental health condition were, and as a result, undermined confidence in people's capacity for condition management and/or recovery.[100] Other research suggests that "for changing stigma at a structural level, contact-

[90] (Becker 1963)
[91] (Zwick, Appleseth, and Arndt 2020)
[92] (Volkow 2021)
[93] https://nida.nih.gov/research-topics/stigma-discrimination#stigma
[94] (Kennedy-Hendricks et al. 2017; Sylvester, Haeder, and Callaghan 2022)
[95] P. 36 in https://www.ncbi.nlm.nih.gov/books/NBK384915/; see also (Olsen et al. 2003)
[96] (Ahern, Stuber, and Galea 2007)
[97] https://nida.nih.gov/research-topics/stigma-discrimination#stigma
[98] https://www.ncbi.nlm.nih.gov/books/NBK384915/
[99] Ibid.
[100] (Schomerus et al. 2012)

based training and education programs targeting medical students and professionals (e.g. police, counsellors) are effective."[101]

In recent years, activists, scholars, and federal officials worked to support reframing of the common language related to SUD in public, legal, and medical settings.[102] For instance, shifting from language centered around choice and willpower to language that recognizes SUD as a disease is a central thread.[103]

Substance Use Statistics

SUD prevalence

How common are substance use disorders in New Hampshire? According to the 2016-2018 National Survey on Drug Use and Health (NSDUH), in Southern New Hampshire an estimated 8.3 percent of people ages 12 and older had a substance use disorder in the past year (Table 5).

In other words, one in 12 people had a substance use disorder in the past year in Southern New Hampshire. This is very similar to the statewide estimate of 8.6 percent. Nationally, 7.4 percent of people 12 or older had a substance use disorder during the 2016-2018 period.[104]

Table 5. Percent of the Population (aged 12 or older) Experiencing Each Substance Use Disorder in the Past Year, Southern New Hampshire and New Hampshire, 2016-2018

	Southern New Hampshire			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Substance Use Disorder[105]	8.3	7.1	9.8	8.6	7.5	9.7
Alcohol Use Disorder[106]	6.1	5.1	7.4	6.3	5.3	7.4
Illicit Drug Use Disorder[107]	3.0	2.4	3.8	3.2	2.6	3.8
Pain Reliever Use Disorder[108]	0.6	0.4	1.0	0.7	0.5	0.9

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016-2018
Notes: "Southern New Hampshire" estimates include Cheshire, Hillsborough, and Rockingham Counties. "Lower" and "Upper" refer to a 95 percent confidence interval.

However, SUD prevalence is estimated to be much higher in 2021. These more recent estimates are available at the national and state level, but not for the Southern New Hampshire region.[109] In 2021, nearly one in six Granite Staters aged 12 and older had a substance use disorder in the past year (16.2 percent; see Table 6).

[101] (Livingston et al. 2021)
[102] (Office of National Drug Control Policy 2017)
[103] (Zwick, Appleseth, and Arndt 2020)
[104] The 95 percent confidence interval is 7.2 percent (lower) and 7.5 percent (upper).
[105] Substance Use Disorder is defined as "meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)." Illicit drug use "includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs."
[106] Alcohol Use Disorder is "defined as meeting criteria for alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)."
[107] Illicit drug use "includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine."
[108] Includes pain relievers such as Vicodin, OxyContin, Percocet, Hydrocodone, and Percodan.
[109] The most recent local area estimates for Southern New Hampshire are those from 2016-2018 presented in Table 5.

The national estimate was about the same, at 16.5 percent of the population aged 12 or older. The estimates of SUD prevalence are a bit higher among the population aged 18 or older, at 17.0 percent in New Hampshire and 17.4 percent in the United States.

Table 6. Percent of the Population Experiencing Each Substance Use Disorder in the Past Year by Age, New Hampshire and United States, 2021

	New Hampshire			United States		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Substance Use Disorder (Among population aged 12 or older)	16.2	13.7	19.1	16.5	16.0	17.1
Substance Use Disorder (Among population aged 18 or older)	17.0	14.3	20.1	17.4	16.8	18.0
Alcohol Use Disorder (Among population aged 12 or older)	12.1	10.0	14.5	10.6	10.1	11.0
Drug Use Disorder[110] (Among population aged 12 or older)	7.7	6.1	9.6	8.6	8.2	9.0
Opioid Use Disorder[111] (Among population aged 12 or older)	1.3	0.9	2.1	2.0	1.8	2.2
Pain Reliever Use Disorder (Among population aged 12 or older)	1.2	0.8	1.9	1.8	1.6	2.0

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021
Notes: "Lower" and "Upper" refer to a 95 percent confidence interval.

Prevalence of drug and alcohol use among youth

The Youth Risk Behavioral Survey (YRBS) is a national health behaviors survey of high school students from both public and private schools that is conducted by the CDC.[112] Tables 7-13 present estimates of drug and alcohol use among high school students in the Greater Manchester area and in New Hampshire statewide according to the 2021 YRBS. Note that, of course, drug and alcohol use does not necessarily equate to a substance use disorder. As available, estimates are presented for different demographic groups. When comparing between groups, please keep the "lower" and "upper" bounds of each estimate in mind—while rates among some groups may appear especially high, sampling error may mean that rates that seem very different are not statistically distinguishable. However, it is also important to note that rates of drug and alcohol use may be especially high among students who face hardship or trauma and utilize substances as a coping mechanism, including those facing discrimination due to their race-ethnicity, sexual orientation, gender identity, and/or socioeconomic position.[113]

[110] Drug Use Disorder includes "the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year." Similar to what was called "Illicit Drug Use Disorder" in the 2016-2018 NSDUH.
[111] Opioid Use Disorder is defined as "meeting the criteria for heroin or pain reliever use disorder."
[112] https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm
[113] See, for example (Felner et al. 2020; Gameon and Skewes 2021; Pokhrel and Herzog 2014; Watson et al. 2020).

Table 7. Percent of students who currently drank alcohol (at least one drink of alcohol on at least one day) during the past 30 days, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	18.3	15.7	21.2	21.3	20.1	22.5
Sex						
Female	20.3	17.0	23.9	24.8	23.3	26.5
Male	15.8	12.3	19.8	18.1	16.7	19.5
Race / Ethnicity[114]						
Hispanic/Latino	17.0	12.0	23.1	22.3	19.2	25.6
White	21.6	18.1	25.3	21.9	20.6	23.2
Grade						
9th grade	8.4	5.3	12.5	10.2	8.9	11.6
10th grade	13.4	10.3	17.1	16.0	14.6	17.5
11th grade	21.2	14.8	28.8	23.5	21.7	25.4
12th grade	32.9	28.0	38.2	37.1	34.8	39.5
Sexual identity						
Gay, lesbian, or bisexual	21.6	15.5	28.6	26.1	23.8	28.5
Heterosexual	17.9	14.8	21.4	21.0	19.7	22.4
Other/questioning[115]	18.6	11.9	26.9	17.0	14.6	19.6

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[114] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[115] Includes "I describe my sexual identity another way" and "I am not sure about my sexual identity (questioning)."

Alcohol was the most common substance used by students, with 18.3 percent of Greater Manchester area students reporting that they drank alcohol during the past 30 days (Table 7). However, binge drinking was less common, with 9.5 percent of Greater Manchester students having binge drank in the past 30 days (Table 8).

Table 8. Percent of students who currently were binge drinking* during the past 30 days, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	9.5	7.7	11.7	11.2	10.4	12.0
Sex						
Female	9.2	7.0	11.8	12.0	10.9	13.2
Male	9.4	6.7	12.8	10.5	9.5	11.6
Race / Ethnicity[116]						
Hispanic/Latino	9.0	5.1	14.3	13.1	10.9	15.6
White	11.6	9.0	14.5	11.5	10.6	12.5
Grade						
9th grade	2.3	1.0	4.5	3.9	3.2	4.8
10th grade	4.9	3.2	7.2	6.9	6.0	8.0
11th grade	11.1	7.5	15.7	13.0	11.6	14.6
12th grade	20.5	15.7	26.0	21.7	19.9	23.5
Sexual identity[117]						
Gay, lesbian, or bisexual	9.7	6.2	14.3	11.0	9.6	12.6
Heterosexual	10.1	7.7	12.8	11.7	10.7	12.7

*Binge drinking is defined as "had 4 or more drinks of alcohol in a row for female students or 5 or more drinks of alcohol in a row for male students, on at least 1 day."
Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[116] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[117] Excludes "other/questioning" category, for which data are suppressed for Greater Manchester due to small sample sizes.

After alcohol, marijuana was the most commonly used substance among those included in the 2021 YRBS. One in six high school students in the Greater Manchester area reported currently using marijuana in the last 30 days (Table 9).[118]

Table 9. Percent of students who currently used marijuana (one or more times) during the past 30 days, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	16.7	14.1	19.4	17.8	16.8	18.8
Sex						
Female	17.2	14.0	20.7	18.6	17.3	20.0
Male	15.2	12.1	18.9	16.9	15.7	18.3
Race / Ethnicity[119]						
Hispanic/Latino	22.6	17.3	28.7	22.3	19.4	25.5
White	17.9	14.7	21.5	17.8	16.7	18.9
Grade						
9th grade	10.2	6.2	15.7	8.7	7.5	10.1
10th grade	12.3	7.7	18.2	13.4	12.0	14.8
11th grade	21.4	15.6	28.3	21.9	19.8	24.1
12th grade	23.7	19.9	27.9	28.2	26.2	30.2
Sexual identity						
Gay, lesbian, or bisexual	20.9	15.7	27.0	25.0	22.8	27.2
Heterosexual	14.7	12.0	17.8	16.2	15.1	17.3
Other/questioning[120]	22.8	14.9	32.4	17.5	15.2	20.0

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[118] Note that, using 1993-2017 YBRS data, (Anderson et al. 2019) found that the passage of state medical marijuana laws did not increase the likelihood of youth marijuana use and that state recreational marijuana laws were associated with a slight decrease in the likelihood of youth marijuana use.
[119] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[120] Includes "I describe my sexual identity another way" and "I am not sure about my sexual identity (questioning)."

In 2021, an estimated 9.1 percent of Greater Manchester area students had ever taken prescription pain medication without a prescription or differently than prescribed—similar to 9.8 percent of students statewide (Table 10).

Table 10. Percent of students who ever took prescription pain medicine without a doctor's prescription or differently than prescribed, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	9.1	7.3	11.2	9.8	9.2	10.5
Sex						
Female	10.0	7.4	13.2	11.4	10.5	12.4
Male	6.4	4.5	8.8	8.1	7.3	8.9
Race / Ethnicity[121]						
Hispanic/Latino	14.7	10.1	20.5	14.4	12.1	17.0
White	8.4	6.1	11.1	9.2	8.6	9.9
Grade						
9th grade	7.6	4.3	12.3	9.0	7.9	10.1
10th grade	9.7	6.5	13.8	9.9	8.9	11.1
11th grade	7.7	4.5	12.1	10.4	9.1	11.9
12th grade	10.1	6.3	15.1	9.7	8.3	11.2
Sexual identity						
Gay, lesbian, or bisexual	15.0	9.9	21.5	17.0	15.3	19.0
Heterosexual	6.7	5.0	8.7	7.3	6.7	8.0
Other/questioning[122]	15.7	8.9	24.9	13.4	11.3	15.7

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[121] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[122] Includes "I describe my sexual identity another way" and "I am not sure about my sexual identity (questioning)."

In contrast, only 4.8 percent of Greater Manchester students had taken a prescription drug without a prescription recently, defined as "during the past 30 days" (Table 11). Again, the statewide estimate is similar, at 4.4 percent.

Table 11. Percent of students who currently took a prescription drug* without a doctor's prescription during the past 30 days, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	4.8	3.5	6.5	4.4	4.0	4.9
Sex						
Female	4.8	3.1	7.1	4.7	4.1	5.4
Male	4.3	2.4	7.0	4.1	3.5	4.7
Race / Ethnicity[123]						
Hispanic/Latino	7.6	3.8	13.4	8.4	6.5	10.7
White	5.3	3.6	7.5	3.9	3.5	4.4
Grade[124]						
9th grade	4.9	2.7	8.0	4.0	3.3	4.7
10th grade	2.8	1.2	5.4	4.0	3.2	4.8
12th grade	5.8	2.9	10.3	5.1	4.1	6.2
Sexual identity						
Gay, lesbian, or bisexual	5.8	2.9	10.3	7.1	5.8	8.5
Heterosexual	3.8	2.4	5.6	3.4	3.0	3.9
Other/questioning[125]	10.0	5.2	17.0	5.6	4.1	7.3

*Such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times.
Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021.
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[123] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[124] Excludes 11th grade category, for which data are suppressed for Greater Manchester due to small sample sizes.
[125] Includes "I describe my sexual identity another way" and "I am not sure about my sexual identity (questioning)."

The use of methamphetamines was less common, with just 2.1 percent of Greater Manchester Students and 1.6 percent of New Hampshire students reporting that they had ever used any kind of methamphetamine (Table 12).

Table 12. Percent of students who ever used methamphetamines one or more times, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	2.1	1.2	3.4	1.6	1.3	1.9
Sex						
Female	0.9	0.2	2.4	1.2	0.9	1.6
Male	2.6	1.2	4.9	1.9	1.5	2.4
Race / Ethnicity[126]						
White	1.7	0.7	3.4	1.2	1.0	1.6
Grade[127]						
9th grade	1.0	0.2	2.9	0.9	0.6	1.3
10th grade	2.0	0.6	4.6	1.0	0.6	1.4
Sexual identity[128]						
Gay, lesbian, or bisexual	1.5	0.3	4.3	2.3	1.6	3.2
Heterosexual	1.6	0.7	3.0	1.1	0.8	1.4

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021.
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

[126] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Hispanic/Latino," 'Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[127] Excludes 11th and 12th grade categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[128] Excludes the "Other/questioning" category, for which data are suppressed for Greater Manchester due to small sample size.

Heroin use was also uncommon among high school students, with 1.6 percent of Greater Manchester area students reporting they had ever used heroin (Table 13).

Table 13. Percent of students who ever used heroin one or more times, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	1.6	0.9	2.6	1.4	1.1	1.6
Sex						
Female	0.6	0.1	1.7	0.8	0.6	1.1
Male	2.0	0.9	3.8	1.8	1.4	2.3
Race / Ethnicity[129]						
White	1.7	0.8	3.1	1.0	0.8	1.3
Grade						
9th grade	1.1	0.2	3.0	0.8	0.5	1.2
10th grade	0.7	0.1	2.5	0.7	0.5	1.1
11th grade	1.7	0.5	4.2	1.6	1.0	2.3
12th grade	1.9	0.4	5.2	1.9	1.4	2.7
Sexual identity[130]						
Gay, lesbian, or bisexual	1.5	0.3	4.4	1.4	0.9	2.1
Heterosexual	1.2	0.5	2.3	1.0	0.8	1.3

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021. https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Note: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

Opioids

The opioid[131] overdose epidemic began in the late 1990s and has only grown more serious. In 1999, there were 8,050 opioid overdose deaths nationwide; in 2021, there were 80,411 opioid overdose deaths—about a tenfold increase.[132] The CDC describes the opioid overdose epidemic as occurring in three

[129] Excludes "American Indian or Alaska Native," "Asian," "Black or African American," "Hispanic/Latino," "Multiple races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[130] Excludes the "Other/questioning" category, for which data are suppressed for Greater Manchester due to small sample size.
[131] Often the terms "opioid" and "opiate" are used interchangeably, but this paper will follow the CDC guideline that "opioid" is the umbrella term. The CDC uses the term "opioid" to refer to all "natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain" (from https://www.cdc.gov/opioids/basics/terms.html). The term "opiates" refers only to natural opioids derived from the opium poppy plant (like morphine or codeine). However, most opioids are made synthetically (like fentanyl, oxycodone, or hydrocodone).
[132] https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates; Estimates can also be found via the National Center on Health Statistics, CDC WONDER.

waves: the first was a wave of prescription opioid overdose deaths in 1999, the second was a rise in heroin overdose deaths beginning in 2010, and the third and ongoing wave began in 2013 with a rise in synthetic opioid (particularly fentanyl) overdose deaths.[133]

Designed to serve as a data source for community-level action, the 2022 Greater Manchester Community Health Needs Assessment (CHNA) lists reducing and preventing substance use as a top priority for the region.[134] The 2022 Greater Manchester CHNA notes that although "substantial gains have been made in Manchester, New Hampshire, and across the US in the reduction of opioid-related deaths through widespread harm-reduction interventions in the past 5 years," the COVID-19 pandemic has contributed to a recent increase in opioid overdose deaths.[135]

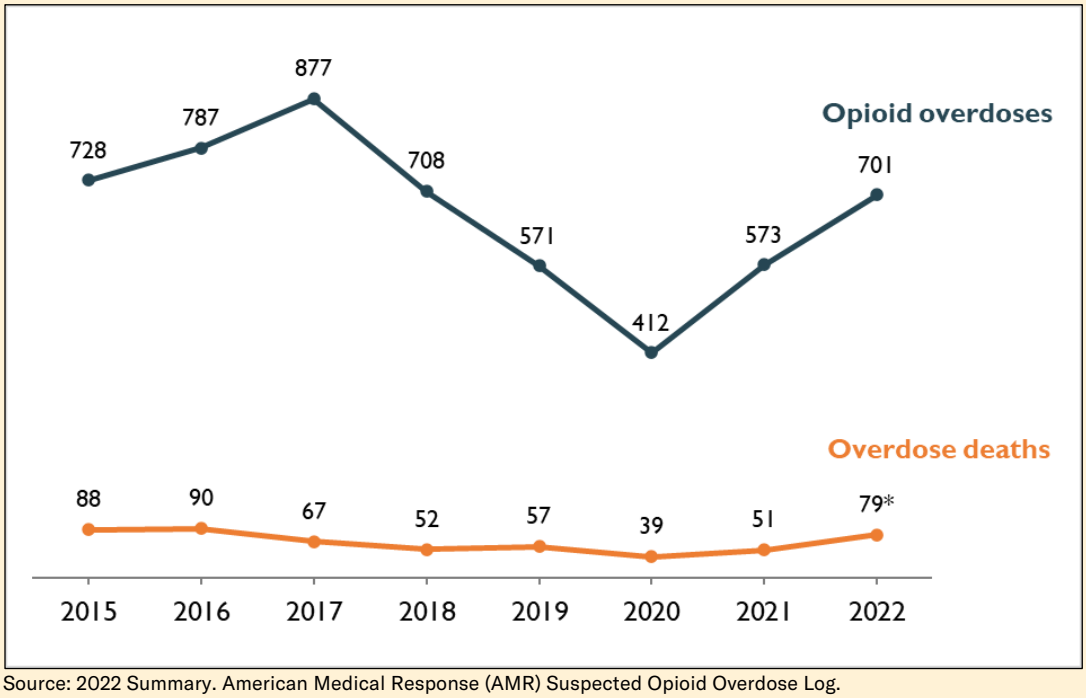
How many opioid overdoses and deaths were there in Manchester in 2022?

The New Hampshire Department of Health and Human Services (DHHS) publishes monthly Opioid Crisis Summary Reports provided by American Medical Response (AMR), a medical transportation company that tracks monthly overdose services in Manchester and Nashua.[136]

While the number of suspected opioid overdoses declined from a peak of 877 in 2017 to less than half that at 412 in 2020, overdoses have been climbing since then (see Figure 18). There were 573 suspected opioid overdoses in 2021 and a jump to 701 suspected overdoses in 2022 (a 22 percent increase from 2021 to 2022).

Following a similar pattern, suspected opioid overdose deaths over this period were highest in 2016 at 90, generally decreased for the next few years, and then increased again in 2021 and 2022.

Figure 18. Number of Suspected Opioid Overdoses and Suspected Opioid Overdose Deaths in Manchester, 2015-2022



Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf

[133] https://www.cdc.gov/opioids/basics/epidemic.html
[134] (City of Manchester Health Department 2022)
[135] Page 31 (City of Manchester Health Department 2022)
[136] Available at: https://www.dhhs.nh.gov/programs-services/health-care/substance-misuse-data-page

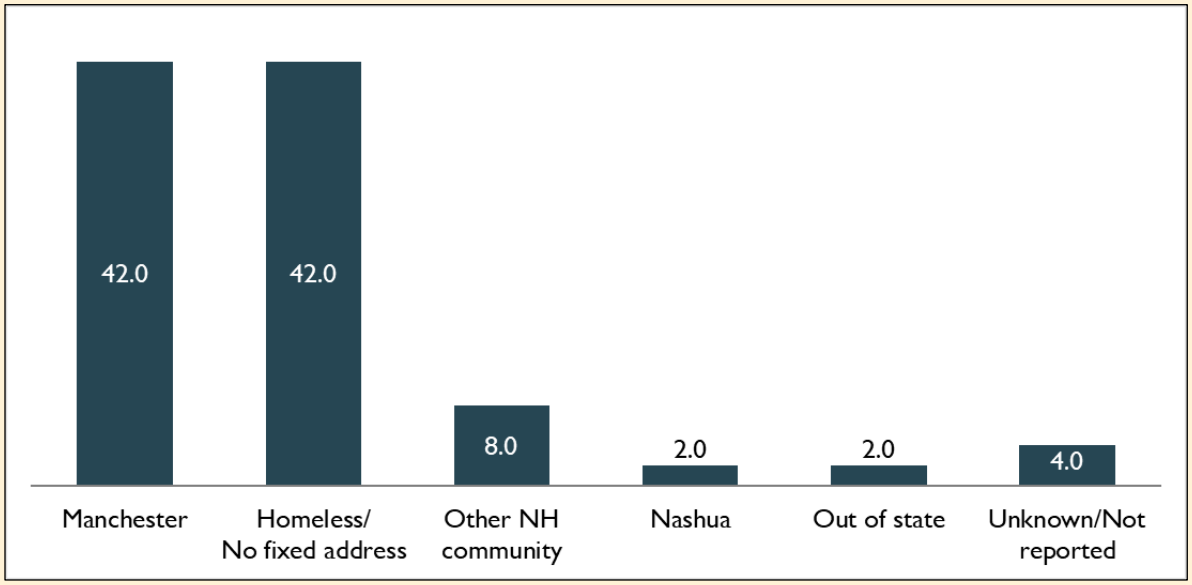
Notes: Suspected opioid overdose deaths for 2022 include 72 confirmed deaths and 7 pending toxicology confirmation by the Office of the Chief NH Medical Examiner. Suspected opioid overdoses do not necessarily represent unique individuals, as one person could have had more than one suspected opioid overdose.

What do we know about the people experiencing these overdoses?

The AMR reports include some limited demographic information about the folks who experienced a suspected opioid overdose in Manchester in 2022.[137] Most people experiencing a suspected opioid overdose were reported as male (77 percent) and only 23 percent were female.[138] The average age was 39 years old. Most were reported as white (72 percent), four percent were reported as Hispanic or Latino, four percent were reported as Black or African American, but 20 percent did not have a reported race-ethnicity.

Current place of residence is also reported, and 42 percent of those who experienced a suspected opioid overdose in Manchester lived somewhere in Manchester (see Figure 19). Two percent lived in Nashua and eight percent lived in another New Hampshire community. A considerable 42 percent were recorded as "homeless/no fixed address."

Figure 19. Reported Current Place of Residence Among Suspected Opioid Overdoses in Manchester, 2022



Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf
Note: Estimates are percentages. Suspected opioid overdoses do not necessarily represent unique individuals, as one person could have had more than one suspected opioid overdose.

Among the 701 suspected opioid overdoses in Manchester in 2022, 45 percent were repeat opioid overdose encounters, where the previous encounter had happened in either Nashua or Manchester. This is expected, as continued substance use despite significant substance-related harm is a defining feature of substance use disorder.[139]

[137] Although there were a reported 701 suspected opioid overdoses, these do not represent 701 unique individuals, as one person could have had multiple overdoses. It's important to note that all demographic information is reported as percentages of the total 701 overdoses, not of the total number of people experiencing an overdose (the latter is not reported).
[138] Note that "male" and "female" are the only gender identity options reported.
[139] (American Psychiatric Association 2022b). For more information on how SUD impacts the brain, see the earlier section called: "SUD changes the brain. People with SUD can't "just say no."" of this report.

AMR also records the type of setting where each suspected opioid overdose occurred (see Table 14). In 2022, the most common locations where suspected overdoses happened were in a home or residence (36 percent), a public building or public area (27 percent), or a roadway or vehicle (20 percent). Less commonly, seven percent happened in a business or commerical building, five percent were in a hotel or motel, two percent were in a bar or restaurant, two percent were in a medical facility, and one percent were in a jail or prison. None occurred at a firehouse, likely in part due to the Manchester Safe Station program ending in 2021.

Table 14. Setting Where Suspected Opioid Overdoses Occurred in Manchester, 2022

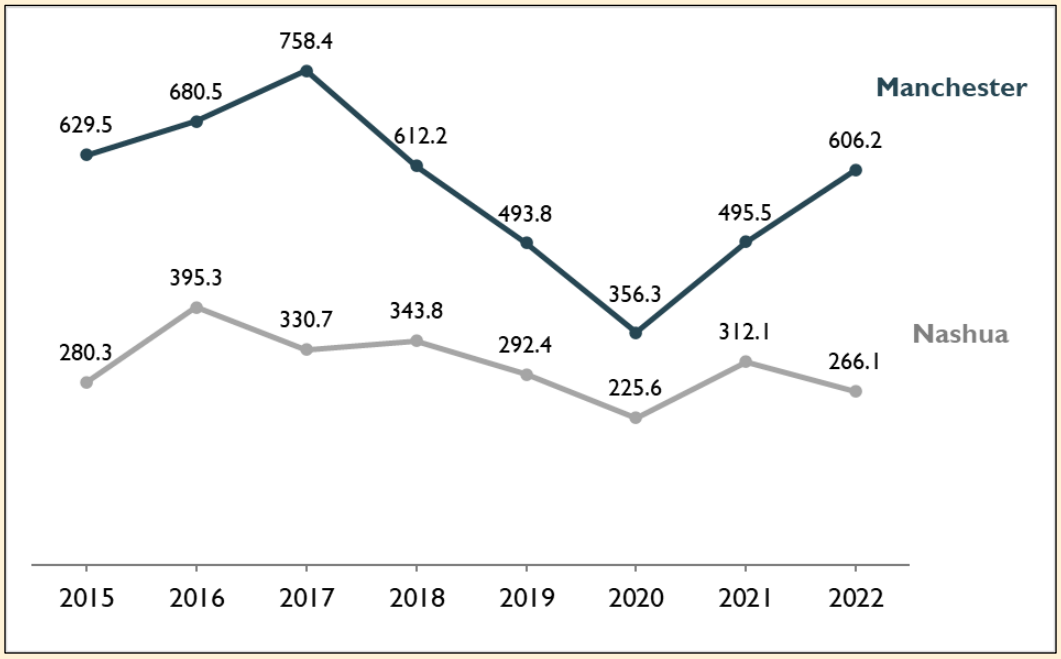
	Percent of Suspected Overdoses Occurring in Each Setting
Home or residence	36
Public building or public area	27
Roadway or vehicle	20
Business or commercial	7
Hotel or motel	5
Bar or restaurant	2
Medical facility	2
Jail or prison	1
Firehouse	0

Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf

How does this compare to Nashua and New Hampshire?

Since Manchester has a larger population than Nashua, it's not as useful to directly compare the raw number of suspected opioid overdoses in each city. A more meaningful comparison can be made by looking at the number of opioid overdoses per capita. In 2022, for every 100,000 people in Manchester there were 606.2 suspected opioid overdoses—more than twice as many per capita as in Nashua, where there were 266.1 overdoses per 100,000 people (Figure 20). In fact, Manchester has had a higher number of suspected opioid overdoses per 100,000 people than Nashua every year from 2015 to 2022 (note that 2015 is when reporting began). Note that the statewide number of suspected opioid overdoses per 100,000 population is not available.

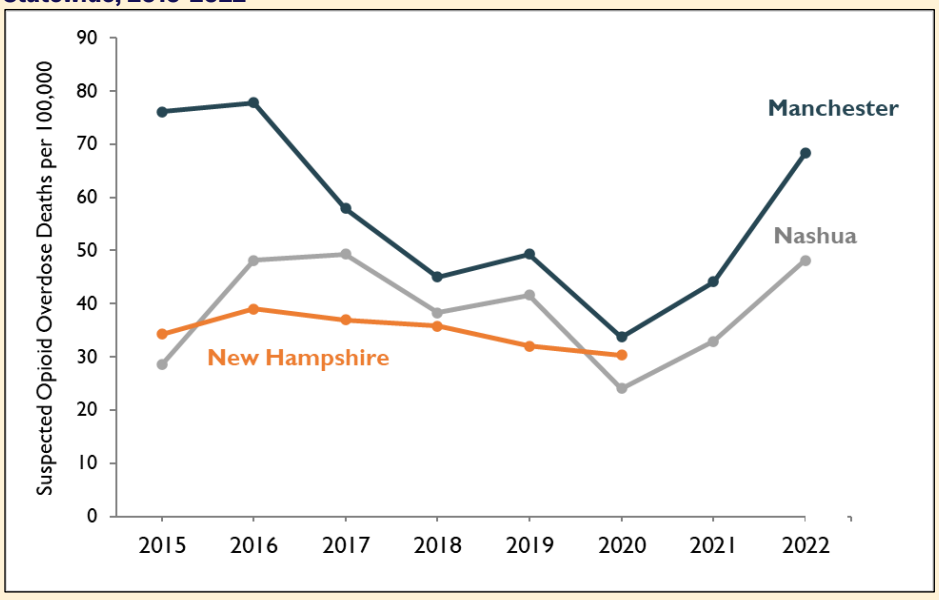
Figure 20. Number of Suspected Opioid Overdoses per 100,000 population in Manchester and Nashua, 2015-2022



Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf
Note: Suspected opioid overdoses do not necessarily represent unique individuals, as one person could have had more than one suspected opioid overdose.

The number of suspected opioid overdose deaths per capita have also been higher in Manchester than in Nashua each year from 2015 to 2022. In 2022, there were 68.3 suspected opioid overdose deaths for every 100,000 people in Manchester as compared to 48.2 deaths per 100,000 people in Nashua (Figure 21).

Figure 21. Number of Suspected Opioid Overdose Deaths per 100,000 population in Manchester, Nashua, and Statewide, 2015-2022



Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf
Notes: Suspected opioid overdose deaths for 2022 include 72 confirmed deaths and 7 pending toxicology confirmation by the Office of the Chief NH Medical Examiner for Manchester and 41 confirmed and 3 pending for Nashua. All other years include only confirmed deaths. Data are not yet available for New Hampshire for 2021 or 2022. Suspected opioid overdoses do not necessarily represent unique individuals, as one person could have had more than one suspected opioid overdose. For exact numbers, see Table 15.

Suspected opioid deaths per capita are not yet available for New Hampshire statewide for 2021 or 2022. However, in 2020, the number of suspected opioid overdose deaths per capita was only slightly higher in Manchester at 33.7 per 100,000 people as compared to 30.3 per 100,000 people statewide (see Figure 21 and Table 15).

Table 15. Number of Suspected Opioid Overdose Deaths per 100,000 population in Manchester, Nashua, and Statewide, 2015-2022

	2015	2016	2017	2018	2019	2020	2021	2022
Manchester	76.1	77.8	57.9	45.0	49.3	33.7	44.1	68.3
Nashua	28.5	48.2	49.3	38.3	41.6	24.1	32.9	48.2
New Hampshire	34.3	39.0	37.0	35.8	32.0	30.3	n/a	n/a

Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf
Notes: Suspected opioid overdose deaths for 2022 include 72 confirmed deaths and 7 pending toxicology confirmation by the Office of the Chief NH Medical Examiner for Manchester and 41 confirmed and 3 pending for Nashua. All other years include only confirmed deaths. Data are not yet available for New Hampshire for 2021 or 2022. Suspected opioid overdoses do not necessarily represent unique individuals, as one person could have had more than one suspected opioid overdose.

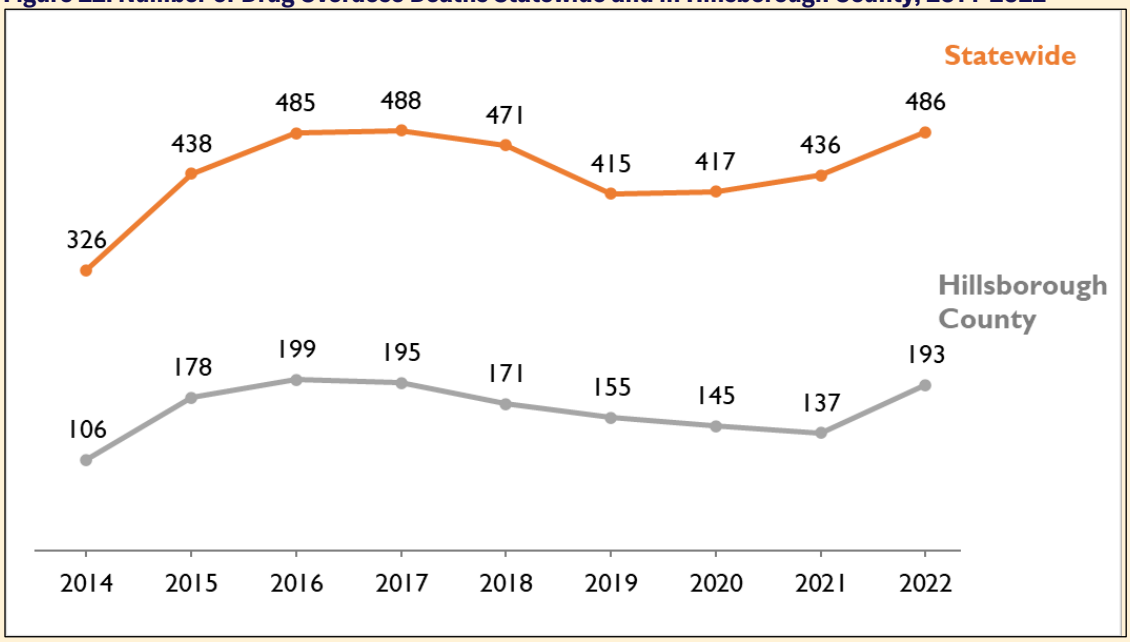
While source used above (AMR) does not have statewide data for 2021 or 2022, the New Hampshire Drug Monitoring Initiative (DMI) does have some statewide estimates for these years, although it does not include Manchester-level data (only county-level data are available). The NH DMI publishes monthly and annual overviews of substance use drawn from a variety of different sources including the NH Medical Examiner's Office, the NH Bureau of Emergency Medical Services, the NH Bureau of Drug & Alcohol Services, and the NH Division of Public Health Services.

A key difference to note is that the AMR data are specific to opioids, whereas the NH DMI primarily reports data that include all "drugs" (any drug or medication, including alcohol). However, most overdoses and overdose deaths are opioid-related—for example, 404 out of the 436 drug overdose deaths in New Hampshire in 2021 were deemed "caused by opiates/opioids" by the NH Office of Chief Medical Examiner.[140] This is also true nationally, with the CDC reporting that more than three quarters of drug overdose deaths in 2021 involved an opioid.[141] Both nationally and in New Hampshire, fentanyl—particularly illicitly made rather than pharmaceutical—was by far the most common opioid involved in overdose deaths in 2021.[142] So, while these drug overdose data include substances besides opioids, most of these cases involve opioids.

As local news outlets have reported, 2022 was the "worst year for overdose deaths in New Hampshire since 2017."[143] There were 486 drug overdose deaths in New Hampshire in 2022, with 193 of these occurring in Hillsborough County (Figure 22).

[140] (Duval and Weinberg 2021)
[141] https://www.cdc.gov/drugoverdose/deaths/index.html
[142] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/dmi-2021overview.pdf & https://www.cdc.gov/drugoverdose/deaths/opioid-overdose.html#synthetic
[143] https://www.wmur.com/article/new-hampshire-overdose-deaths-2022/42921460

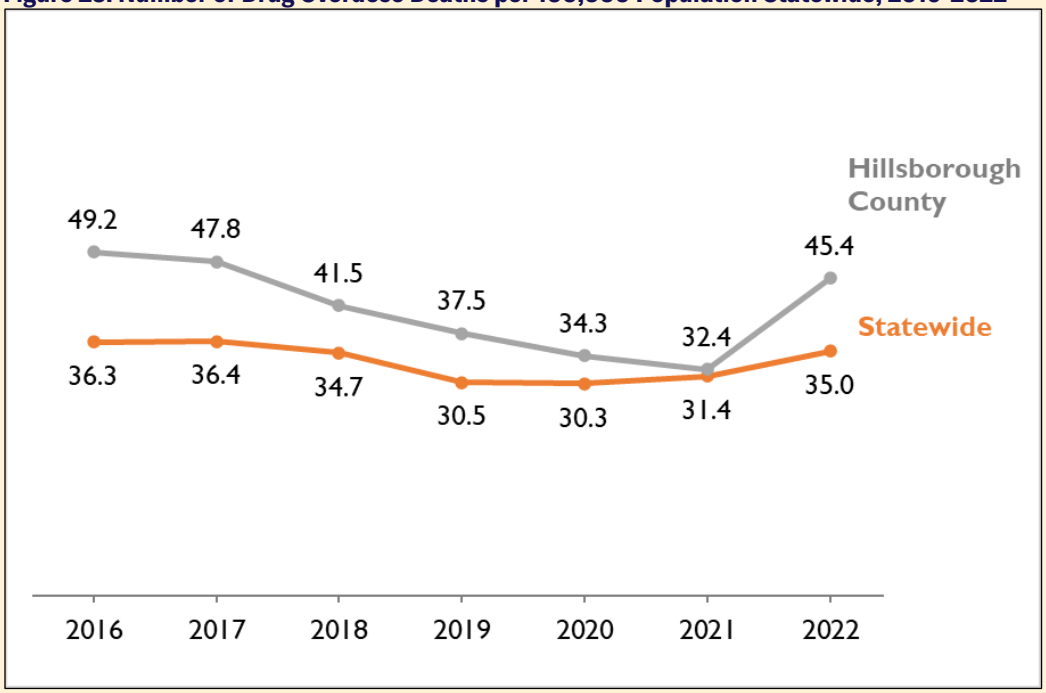
Figure 22. Number of Drug Overdose Deaths Statewide and in Hillsborough County, 2014-2022



Source: NH Information & Analysis Center, NH Drug Monitoring Initiative, 2014-2022.

Hillsborough County has had a higher rate of drug overdose deaths per 100,000 people than statewide every year since reporting begin in 2016 (Figure 23).

Figure 23. Number of Drug Overdose Deaths per 100,000 Population Statewide, 2016-2022



Source: NH Information & Analysis Center, NH Drug Monitoring Initiative, DMI Overview Reports, 2016-2022. Annual reports available here https://www.dhhs.nh.gov/programs-services/health-care/substance-misuse-data-page.
Notes: Annual DMI overview reports included Hillsborough County rates as number of deaths per 10,000 per year. Carsey authors calculated deaths per 100,000 to match the format of statewide estimates. Data only available from 2016 to 2022.

NH DMI also reports the number of opioid-related emergency department visits. However, the data collection methodology changed starting in January 2020, so any earlier years of data cannot be directly compared. Instead of creating a line graph with only a few years, these data are presented in Table 16 below.

Table 16. Number of Annual Opioid-Related Emergency Department Visits, Hillsborough County and New Hampshire, 2020-2022

	2020	2021	2022
Hillsborough County	993	1,161	1,068
New Hampshire	2,915	3,284	3,223

Source: NH Information & Analysis Center, NH Drug Monitoring Initiative.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/dmi-2022overview.pdf

Finally, the CDC's State Unintentional Drug Overdose Reporting System (SUDORS) reports on the circumstances surrounding drug overdose deaths. Among drug overdose deaths in New Hampshire in 2021, 86.6 percent had at least one potential opportunity for intervention. The CDC describes that "potential opportunities for intervention include linkage to care or life-saving actions at the time of the overdose."[144]

The most prevalent recorded potential opportunity for intervention was the presence of a potential bystander. In three quarters of drug overdose deaths in New Hampshire in 2021 there was a potential bystander present (Table 17). One of the critical ways that a present bystander could have intervened—if they had the resources available—is by administering naloxone. Administration of naloxone is a key harm reduction strategy that will be discussed in more detail in the following Harm Reduction section.

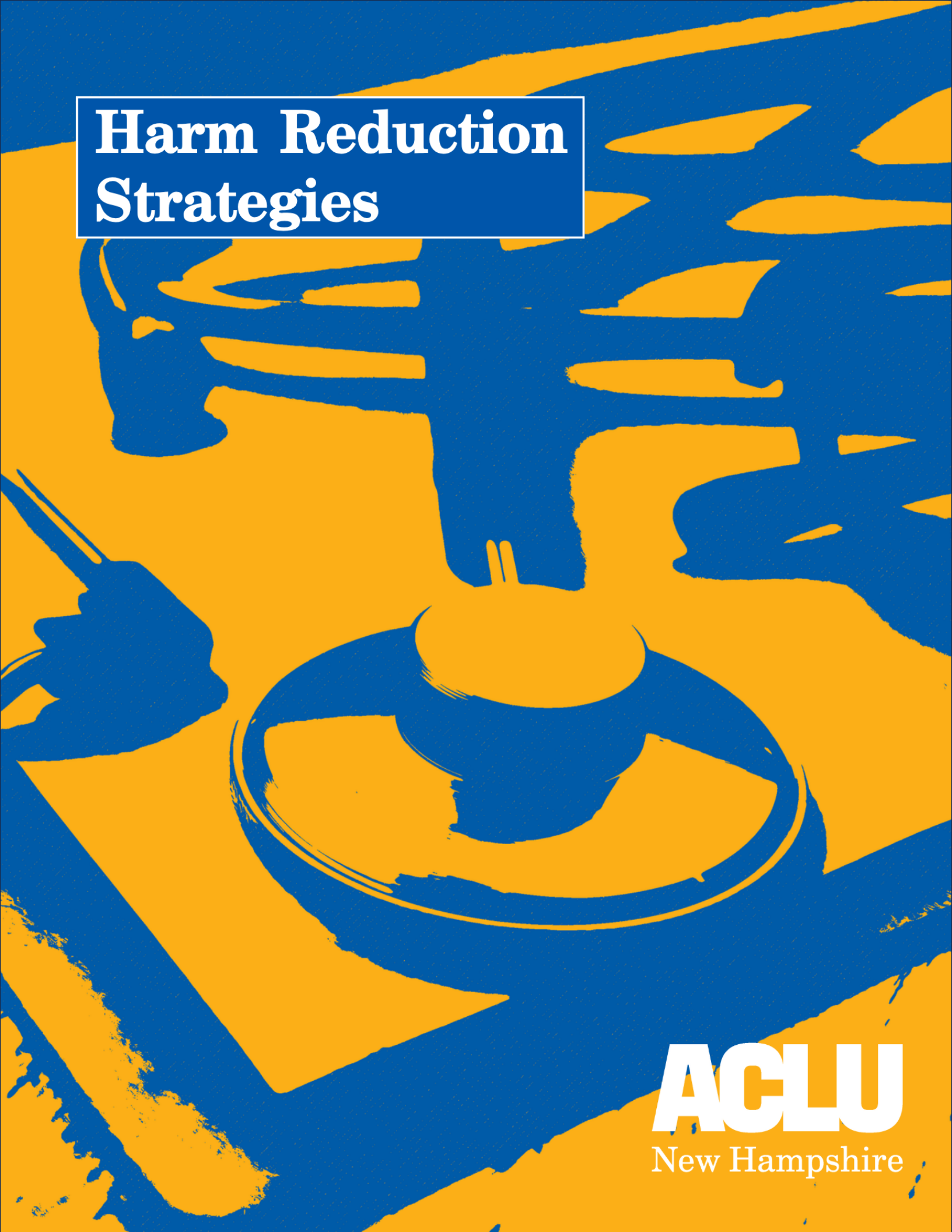
Table 17. Percent of Drug Overdose Deaths with Each Potential Opportunity for Intervention, New Hampshire and Overall, 2021

	New Hampshire	Overall*
Potential bystander present[145]	75.1	46.1
Mental health diagnosis	35.0	25.4
Current treatment for SUD[146]	17.5	6.3
Prior overdose	16.5	11.6
Recent release from institutional setting (less than one month ago)[147]	15.2	8.7
Fatal drug use witnessed	8.4	8.4

*Overall refers to 32 jurisdictions, which includes 31 states and the District of Columbia.
Source: The Centers for Disease Control and Prevention, State Unintentional Drug Overdose Reporting System (SUDORS).
https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

[144] https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html
[145] A potential bystander is a person 11 years or older who was "physically nearby either during or shortly preceding a drug overdose and potentially had an opportunity to intervene or respond to the overdose" for example, with naloxone administration.
[146] Current treatment for SUD included "medications for opioid use disorder (MOUD), living in an inpatient rehabilitation facility, or participation in mental health or SUD outpatient treatment."
[147] Includes institutional settings such as residential treatment facilities, prisons/jails, and psychiatric hospitals.

Harm Reduction Strategies



ACLU New Hampshire

Harm Reduction Strategies

Definition

What is harm reduction?

Broadly speaking, harm reduction refers to any policies, practices, or programs that are intended to reduce the risk or impact of a specific behavior. Some non-drug examples include sunscreen, seat belts, and speed limits. In the context of substance use, harm reduction refers to the policies, practices, and programs designed to reduce the negative consequences associated with drug use on people who use drugs (PWUD) and communities at large. Harm Reduction International—a non-profit NGO which advocates for the implementation of harm reduction strategies in public policy—defines harm reduction as "policies, programs and practices that aim to minimize the negative health, social and legal impacts associated with drug use, drug policies, and drug laws."[148]

The National Harm Reduction Coalition explains that "because harm reduction demands that interventions and policies designed to serve people who use drugs reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction."[149] They've also developed the following set of fundamental harm reduction principles, including that harm reduction practice:

- "Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

[148] (Harm Reduction International 2022)
[149] (National Harm Reduction Coalition 2020b)

- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use."[150]

Regardless of context, selecting evidence-based strategies is considered best practice. With regards to the opioid epidemic, evidence-based strategies are best implemented together in a comprehensive, well-integrated package. When implemented this way, these strategies have the potential to reduce the rate of fatal overdoses among PWUDs, increase the rate of enrollment in treatment programs among PWUDs, and increase the rate of abstinence from consuming opioids among PWUDs, all in a cost-effective manner.[151]

Harm Reduction Strategies & Implementation

Introduction

This section elevates some prominent and promising harm reduction strategies for supporting the needs of Manchester residents, providing examples of how, and if, each strategy has been implemented in New Hampshire and Manchester. Although matching specific levels of need, investments, and costs of delivery is beyond the scope of this paper, the aim is to identify areas that may warrant future discussion. The selected harm reduction strategies and examples of implementation are intended to be an overview but are not exhaustive. Please also note that the provided examples of resources and programs in Manchester and statewide may become out of date as programs open, close, or change.

It should also be noted that harm reduction is one element of a larger set of strategies to support people with SUD and their families. The Action Plan from the NH Governor's Commission on Alcohol and Other Drugs includes strategies around prevention, care coordination and behavioral health integration, treatment, recovery, family supports and services, data monitoring and dissemination, SUD and mental and behavioral health workforce capacity, and professional development[152] alongside harm reduction strategies.[153]

In their report about harm reduction efforts in Manchester, Makin' It Happen, a community-based public health nonprofit working with the City of Manchester,[154] outlines harm reduction best practices and includes recommendations for Manchester. They identify that there are over 40 organizations and agencies in the Greater Manchester Region that operate across prevention, treatment, and recovery. The largest anchor organizations within this system are the City of Manchester, Granite United Way, Easterseals, Catholic Medical Center, Dartmouth-Hitchcock, and Elliot Health System. The report asserts that comprehensive harm reduction in Manchester can be achieved through improving collaboration, care coordination, and leveraging existing service contracts.[155]

Syringe service programs (SSPs)

Overview

The primary functions of syringe service programs (SSPs)—also often called needle and syringe programs (NSPs) or needle exchange programs (NEPs)—serve as both a clean needle dispensary service

[150] Page 1 in (National Harm Reduction Coalition 2020b)
[151] (Centers for Disease Control and Prevention 2018)
[152] Professional development includes training and technical assistance across sectors on many topics such as trauma-informed practices, harm reduction strategies, evidence-based care coordination, screening and active referral strategies, among others. See (NH Governor's Commission on Alcohol and Other Drugs 2022) for more.
[153] (NH Governor's Commission on Alcohol and Other Drugs 2022)
[154] Makin' It Happen is subcontracted by the City of Manchester Health Department per https://www.manchesternh.gov/Portals/2/Departments/health/2023%20Org%20Chart%20by%20Services.pdf?ver=2023-09-12-102715-433
[155] (Makin' It Happen 2021)

and a used needle disposal service for people who inject drugs (PWIDs). These community-based programs often provide a range of other services, including naloxone (Narcan) training and distribution, vaccines and testing for prevalent diseases (such as HIV, HPV, and COVID-19), fentanyl and xylazine ("tranq") testing, wound care, and education for safer drug use.[156]

SSPs also often serve as the initial point of contact between PWIDs and medical providers. This makes SSPs a vital gateway for medical providers to build rapport with PWIDs and for PWIDs to engage with and enter treatment programs and other services. A qualitative study of participants at four needle exchange sites in Canada found that clients consistently described sites as a "safe haven in an often unsafe world" where they were free from judgement and stigma.[157] The accepting and respectful environment made it easier for participants to build trust with staff and connect to other programs and resources. Other research has also shown that new SSP clients are five times more likely to enter treatment for substance use disorder and three times more likely to stop injecting than those who had never used an SSP.[158]

Syringe service programs have been elevated in academic research as a particularly compelling harm reduction strategy since they are proven to be safe and cost-effective. Programs that also provide naloxone are proven to save lives by lowering the likelihood of overdose death.[159] Further, research has shown that syringe service programs are not associated with an increase in crime rates.[160] SSPs also promote overall community health. For example, a 2011 study comparing San Francisco, California (a city with syringe service programs) and Miami, Florida (a city without SSPs at the time) found that San Francisco had 86 percent fewer improperly discarded syringes in public areas like sidewalks and parks.[161] There is also evidence that, by increasing safe disposal of syringes, SSPs reduce needlestick injuries suffered by first responders.[162]

SSPs are relatively low cost to run and contribute to reducing the transmission of infections like HIV and hepatitis C.[163] A 2015 review of literature on the cost-effectiveness of harm reduction efforts found that SSPs cost between $23-71 per person per year and have a return on investment of $1.30-5.50 per $1 invested.[164] The return on investment largely comes from the reduction in prevalence of bloodborne diseases typically contracted by PWIDs using used syringes, such as HIV and hepatitis C, and the costs saved on lifetime treatments of those diseases.[165] For example, a 2014 systematic review and meta-analysis found that a 50 percent decline in the risk of HIV transmission was associated with SSPs (although they note that other harm reduction efforts likely also contributed).[166]

The history of syringe service programs in the United States is particularly fraught with stigma and related punitive legal barriers. A study reflecting on harm reduction policy in New York City from 1984-2010 describes how in the midst of the AIDS pandemic: "Despite evidence of widespread infection and increasing deaths, a national policy of "zero tolerance" for drug use coupled with a long history of stigmatization and marginalization of drug users significantly constrained public health approaches and responses to the crisis."[167] The authors explain that while many other Western countries adopted syringe exchange programs during the early AIDS pandemic, the United States instead refused to implement such programs. In fact, the Health Omnibus Program Extension (HOPE) Act of 1988—aimed

[156] (Barndollar 2023a; Centers for Disease Control and Prevention 2018).
[157] Page 29 in (MacNeil and Pauly 2011)
[158] (Hagan et al. 2000)
[159] https://www.cdc.gov/ssp/docs/Syringe-Services-Program-Infographic_508.pdf
[160] (Marx et al. 2000)
[161] (Tookes et al. 2012)
[162] (Lorentz, Hill, and Samimi 2000) see also (Vearrier 2019)
[163] (Aspinall et al. 2014; Bernard et al. 2017)
[164] (Wilson et al. 2015)
[165] (Wilson et al. 2015) see also (Gold, Nelligan, and Millson 1997; Bernard et al. 2017)
[166] (Aspinall et al. 2014)
[167] Page 140 in (Heller and Paone 2011)

at addressing the AIDS crisis—explicitly stated that none of its funds could be used for needle exchange programs. This ban on federal funding for syringe exchange programs wasn't removed until 2009.

Examples of resources, programs, and policies in New Hampshire

It wasn't until 2017 that NH Senate Bill 234 legalized the operation of syringe service programs in the state.[168] Since 2010 it had been legal for pharmacies to sell needles without a prescription,[169] although local media reported that few did in practice, for fear that people may use drugs near or on their premises.[170] Peer-reviewed research involving interviews with PWID in New Hampshire in 2016 highlighted the immense challenge of acquiring clean needles during that time period.[171] For example, participants knew of few local pharmacies that would sell them syringes and out-of-state pharmacies were often hard to get to and came with risks of criminal justice involvement. The lack of syringe access left participants with few options but to re-use and share syringes, despite their strong preference to use clean syringes.

The first needle exchange program in New Hampshire opened at the Claremont Soup Kitchen in June of 2017 (right after legalization) and was operated by Dartmouth Medical students.[172] The program was short-lived, and forced to close in November 2017 because "the Claremont city council said it was operating too close to a school, which is against city and state law."[173]

Currently, the NH Harm Reduction Coalition reports that there are ten registered syringe service programs in the state, serving areas including Conway, Lebanon, Concord, Keene, Nashua, Manchester, and the Seacoast.[174]

Examples of resources and programs in Manchester

Queen City Exchange is a syringe services program operated by the New Hampshire Harm Reduction Coalition in Manchester, New Hampshire.[175] In addition to providing sterile syringes and safe disposal, the program offers naloxone (Narcan), overdose prevention and response education, STD prevention education and supplies, basic wound care supplies, and also provides "referrals for physical health, mental health, substance use disorder, sexual & domestic violence, housing insecurity, and food insecurity."[176]

The NH Harm Reduction Coalition reports a second syringe services program operating in Manchester called Another Day Harm Reduction. Another Day Harm Reduction (ADHR) offers nonjudgmental peer support to connect clients to "harm reduction tools, education, food/water, and other life-saving resources."[177] The ADHR website says that the organization hopes to raise funds in 2023 for a mobile unit that would support the distribution of syringes and also provide transportation for clients to get to healthcare visits or access state-funded programs.[178]

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[168] New Hampshire Senate Bill 234, see https://legiscan.com/NH/text/SB234/id/1491074
[169] N.H. Rev. Stat. Ann. §318:52-c (originally limited to 10 sold per person, now unlimited as of 2017 change).
[170] https://www.concordmonitor.com/senate-hears-testimony-on-creating-needle-exchange-7937810
[171] (Pollini et al. 2021)
[172] https://home.dartmouth.edu/news/2017/08/geisel-students-tackle-granite-states-opioid-epidemic
[173] https://www.nhpr.org/nh-news/2017-11-09/n-h-s-first-needle-exchange-program-forced-to-close
[174] https://www.nhhrc.org/syringe-services-programs
[175] https://www.nhhrc.org/queen-city-exchange-manchester
[176] Ibid.
[177] https://www.anotherdayhr.org/story
[178] https://www.anotherdayhr.org/mission

Overdose reversal medication (naloxone)

Overview

A harm reduction strategy specific to the opioid overdose epidemic is naloxone distribution. Naloxone is an FDA-approved[179] medication that safely and quickly reverses the symptoms of an opioid overdose, such as slowed breathing, low blood pressure, and unconsciousness.[180] Naloxone is an 'opioid antagonist,' which means that it binds to opioid receptors thereby blocking and reversing the effects of other opioids (like oxycodone, heroin, or morphine).[181]

Naloxone is non-addictive and produces no effects when opioids are not present in the body.[182] Naloxone is frequently administered nasally (via a nasal spray) but can also be administered intramuscularly, under the skin (subcutaneously), or via intravenous injection.[183] Because of its ability to safely and effectively reverse overdoses with negligible risk for misuse, naloxone distribution is considered a lifesaving harm reduction strategy. The most common brand name of naloxone is Narcan® (hereafter referred to as simply "Narcan").

Examples of resources and programs in New Hampshire

In response to the opioid overdose epidemic in the state, the New Hampshire Department of Health and Human Services (DHHS) initiated a Naloxone Distribution Campaign after the 2015 passage of NH House Bill 271,[184] which "expanded the allowed possession and administration of an opioid antagonist for opioid-related overdoses."[185] This multimillion-dollar campaign distributed 5,300 naloxone kits by September 2016 and continued distributing thousands more.[186] This initiative and newly expanded legalization paved the way for naloxone access.

A study in New Hampshire that conducted interviews with 36 emergency responders[187] and 76 opioid users in 2016 and 2017 found that while most perceived an increase in the availability of naloxone during that time, there were still some barriers. Opioid users reported barriers to accessing naloxone including the cost, concerns about legality, and a lack of information about where to obtain naloxone and how to use it. On the emergency responders' side, barriers to acceptance included the inaccurate belief that, while effective, naloxone enables or encourages opioid use.[188] While stigma certainly persists, more recent research—including a 2023 study in New York state[189] and a 2022 study in rural Montana[190]—found more acceptance among emergency responders.

In recent years, public access to naloxone has improved dramatically (for example, data show substantial increases in public Narcan use from 2016 to 2022 in Manchester; see Figure 8 below). A massive recent advancement in March 2023 was the FDA's approval of the first over-the-counter, nonprescription use of naloxone nasal spray—the Narcan 4mg naloxone hydrochloride nasal spray.[191] This is huge because, as SAMHSA describes, "once the transition to nonprescription status is complete, this life-saving medication used to reverse opioid overdose will be available directly to

[179] FDA refers to the U.S. Food and Drug Administration
[180] (Russell 2023)
[181] (Substance Abuse and Mental Health Services Administration 2015)
[182] (Centers for Disease Control and Prevention 2018)
[183] (Substance Abuse and Mental Health Services Administration 2015)
[184] (Bessen et al. 2019)
[185] New Hampshire House Bill 271, Chapter 65. See https://legiscan.com/NH/text/HB271/id/1245750.
[186] (Bessen et al. 2019)
[187] Including police, fire, emergency medical services, and emergency department professionals; see (Bessen et al. 2019).
[188] Ibid.
[189] (Lloyd et al. 2023)
[190] (Filteau et al. 2022)
[191] (U.S. Food and Drug Administration 2023)

consumers in places like drug stores, convenience stores, grocery stores, and gas stations, as well as online."[192]

Currently, Naloxone (Narcan) is available through some pharmacies without a prescription[193] or can also be obtained for free at any of the nine Doorway locations in New Hampshire.[194] The Doorway program consists of nine regional centers that are meant to serve as an entry point for people seeking SUD services and supports.

Doctors can also write prescriptions for naloxone, although this will no longer be necessary in the future as Narcan nasal spray transitions to nonprescription status. Complications from naloxone are very rare, and New Hampshire law does provide protection from naloxone associated liability.[195]

In April 2023, NH DHHS announced a new initiative to place 700 free overdose reversal kits called NaloxBoxes across the state.[196] A NaloxBox is a hard acrylic box containing naloxone that can be mounted to an exterior wall to provide 24/7 access to this medication.[197] NH DHHS will work with the New Hampshire Harm Reduction Coalition, the Recovery Friendly Workplace, and the state's 13 regional public health networks to distribute the NaloxBoxes.[198] NaloxBoxes are free and can be installed in businesses, hotel and motel lobbies, bathrooms, and municipal buildings, and it appears that there is substantial interest from businesses.[199]

NaloxBoxes are similar to a wider strategy of deploying "harm reduction vending machines" that dispense harm reduction tools like sterile syringes, drug testing supplies, naloxone, and safer sex supplies.[200] These are an accessible, low-barrier way to obtain supplies without use requirements.[201] Rhode Island is setting up six harm reduction vending machines across the state[202] and Vermont had set up its first naloxone vending machine in May 2023.[203] Other states have set up Narcan-specific vending machines including New York, Pennsylvania, Detroit, Las Vegas, and San Diego.[204]

Examples of resources and programs in Manchester

In Manchester, naloxone is publicly available for free at the Doorway of Greater Manchester, at both syringe service programs (Queen City Exchange and Another Day Harm Reduction), by calling 211, and at a number of pharmacies (over 25 as of September 2023, according to The Doorway's Find a Pharmacy list).[205] While still a newer program, NaloxBoxes have already started being installed throughout Manchester more broadly, with noted support from business owners who want to participate.

As it has become more widely available, public use of Narcan has continuously increased each year in Manchester since 2016 (Figure 24). The American Medical Response (AMR) reports that in 2022, an estimated 1,851 milligrams of Narcan were administered by the public in Manchester prior to the arrival of first responders, compared to just 46 milligrams back in 2016. Narcan was administered by the

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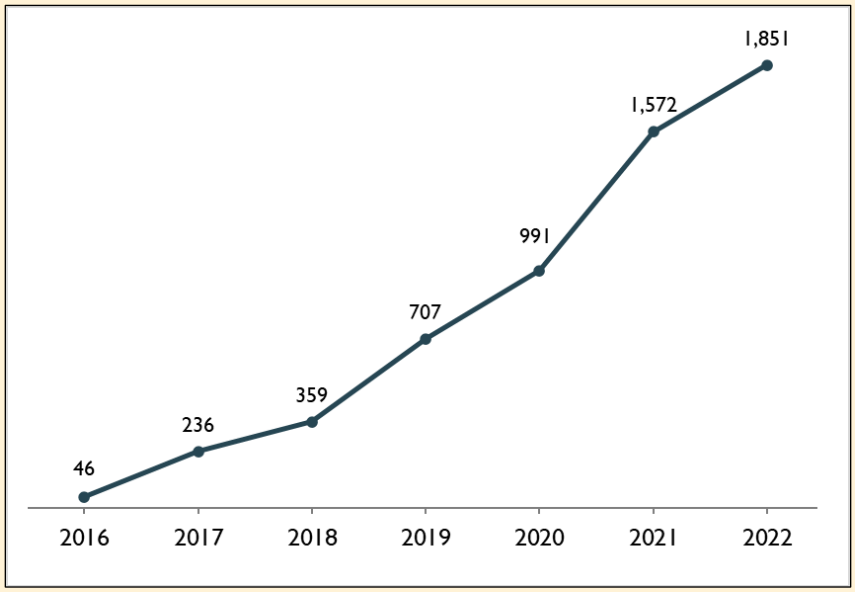
[192] (Substance Abuse and Mental Health Services Administration 2023b)
[193] (New Hampshire Division of Public Health Services 2021)
[194] (The Doorway 2023)
[195] Per NH Rev Stat § 318-B:15 (2022), "...no person who, acting in good faith and with reasonable care, stores, dispenses, or distributes an opioid antagonist or administers an opioid antagonist to another person who the person believes is suffering an opioid-related drug overdose shall be subject to any criminal or civil liability, or any professional disciplinary action..."
[196] (New Hampshire Department of Health and Human Services 2023b)
[197] See https://naloxbox.org/.
[198] (Barndollar 2023b)
[199] https://www.wmur.com/article/boxes-overdose-naloxone-new-hampshire-41123/43569325
[200] (Duncan and Wu 2023)
[201] https://harmreductionhelp.cdc.gov/s/article/Harm-Reduction-Vending-Machines
[202] https://cfar.med.brown.edu/encore-new-initiative-harm-reduction-vending-machines
[203] (Tan 2023)
[204] https://usamdt.com/drug-news/u-s-cities-installing-narcan-vending-machines/
[205] https://www.thedoorway.nh.gov/find-pharmacy

public in more than a third (34 percent) of suspected opioid overdoses in Manchester in 2022. In Nashua, public use of Narcan was recorded in only 20 percent of suspected opioid overdoses in 2022.

Figure 24. Number of Milligrams of Narcan Administered by the Public in Manchester, 2016-2022



Source: 2022 Summary. American Medical Response (AMR) Suspected Opioid Overdose Log. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/amr-dec2022.pdf
Notes: For reference, each Narcan® Nasal Spray contains a dose of 4 milligrams (https://narcan.com). Additionally, more than one dose of Narcan may be administered during the same suspected overdose (see, for example, https://www.mayoclinic.org/drugs-supplements/naloxone-nasal-route/proper-use/drg-20165181).

Drug testing equipment

Overview

As more dangerous drugs such as fentanyl and xylazine have made their way into New Hampshire's drug supply, PWUDs have had to take additional measures to counteract the increased risk of lethal overdose they now face.[206] The U.S. Drug Enforcement Administration (DEA) reports that fentanyl is one of the largest threats to PWUDs in Manchester.[207] The U.S. DEA also warns that the increasing presence of fentanyl (and other drugs) mixed with xylazine—a sedative that is also known as "Tranq"—is incredibly dangerous and increases the risk of fatal drug overdose.[208]

A person cannot see, taste, or smell if xylazine or fentanyl are present in other drugs. The best way to know if an unanticipated drug, like fentanyl or xylazine, is present in other drugs is to use drug test strips. For example, fentanyl test strips are used to test for the presence of fentanyl in other drugs. Drug testing strips are an effective and low-cost way to provide PWUDs crucial information to reduce their risk of overdose.[209]

Fentanyl test strips (FTS) are paper strips that detect the presence of the chemical or its analogs in a batch of user-ready drugs. As the CDC describes, a small amount of drug (at least 10mg) is mixed with ½ teaspoon of water (or a full teaspoon if testing methamphetamines). Then 2 to 5 minutes after

[206] (Mars, Ondocsin, and Ciccarone 2018)
[207] https://www.dea.gov/engage/operation-engage-manchester
[208] https://www.dea.gov/alert/dea-reports-widespread-threat-fentanyl-mixed-xylazine
[209] (Centers for Disease Control and Prevention 2022)

dipping the end of the strip into the sample, it will display either one pink stripe (fentanyl detected) or two pink stripes (fentanyl not detected).[210] Xylazine test strips operate similarly. A limitation of both fentanyl and xylazine test strips is that they can only determine the presence of an adulterant, but not the concentration.

Fentanyl test strips are a low cost, low barrier form of drug testing equipment.[211] Test strips can be distributed alongside other materials at a syringe service program location or elsewhere, such as part of an overdose prevention kit or overdose education campaign. A qualitative study of young adults who use drugs in Rhode Island concluded that most participants found fentanyl test strips easy to use, helpful, and altered their drug use behaviors based on the test results.[212] Research surveying PWIDs in North Carolina found that people who used fentanyl test strips and had a positive test result were five times more likely to report changing their drug use behavior to be safer.[213]

Examples of resources and programs in New Hampshire and Manchester

As with many harm reduction strategies, drug testing equipment has been legalized on a state-by-state basis. According to the Network for Public Health Law, as of August 2023, a total of 44 states had legalized some form drug testing equipment—up from 18 states in 2020.[214] In 27 of these 44 states, all drug checking equipment is legal, whereas most of the rest only specifically legalized fentanyl drug checking equipment.

In New Hampshire, drug testing equipment was considered "drug paraphernalia" in the state's Controlled Drug Act until HB 287 passed in August 2023 and removed both fentanyl and xylazine testing equipment from the definition of drug paraphernalia.[215] Since New Hampshire choose to specify which types of drug testing equipment is legal rather than legalize all testing equipment, if in the future there is a new dangerous adulterant—like how xylazine recently emerged—testing equipment for that substance will be illegal unless legalized by future legislation.

Drug testing equipment can be obtained from syringe service programs across New Hampshire and in Manchester. Fentanyl testing strips are more widely available, although xylazine test strips are also available at syringe service programs in Manchester.[216] Since HB 287 made fentanyl and xylazine test strips legal effective October 10, 2023, it is still early and access to these important harm reduction tools will continue to increase.

Medications for opioid use disorder (MOUD)

Overview

Medications for opioid use disorder (MOUD) are used to treat opioid use disorders by suppressing or reducing opioid cravings, reducing withdrawal symptoms, and/or blocking the euphoric effects of opioids.[217] MOUDs can help patients reduce or stop opioid use and are proven to be safe and effective.[218] MOUDs are most effective when treatment is elected by the patient rather than coerced or

[210] (Centers for Disease Control and Prevention 2022)
[211] (Wu et al. 2023)
[212] (Goldman et al. 2019)
[213] (Peiper et al. 2019)
[214] (Davis 2023)
[215] https://legiscan.com/NH/bill/HB287/2023
[216] Per NH Harm Reduction Coalition Facebook post: https://www.facebook.com/harmreductionNH/posts/pfbid0b1ru3RTJubZ8H9y4zYr3p5paLEoDaZ6hKxY4y1pvX1TzEjievMCW7gfsD86M71f8l
[217] (Substance Abuse and Mental Health Services Administration 2023a)
[218] (Substance Abuse and Mental Health Services Administration 2021)

mandated.[219] The term Medication-Assisted Treatment (MAT) was used previously, but in 2020 SAMHSA made MOUD their standard. It is also sometimes called opioid agonist treatment.

MOUD is considered one of the most effective pharmacological treatments for opioid dependence.[220] Numerous studies have shown MOUD's contribution to significant reductions in opioid use, opioid dependence, overdose, criminal activity, and other risky behaviors. Methadone and buprenorphine are the two major medications used in MOUD. Methadone and buprenorphine are used as analogs for one another; some patients fare significantly better on one than the other, however, both accomplish the same goal as opioid agonists. Methadone and buprenorphine bind to the opioid receptors in the patient's brain, quelling cravings and preventing withdrawal symptoms without causing euphoria, or a "high."[221]

A third medication that has been tested for use is naltrexone. Naltrexone is an opioid antagonist that blocks the brain's opioid receptors to prevent them from activating.[222] However, there is ongoing debate over the efficacy of naltrexone, and it is not universally accepted as a safe and effective MOUD like methadone and buprenorphine are.[223]

In 2023, the federal MAT Act made it easier for providers to prescribe MOUDs like buprenorphine by removing a waiver requirement.[224] This policy change will increase the number of providers authorized to prescribe buprenorphine from an estimated 130,000 to over 1.8 million across the country.[225]

Similar to MOUDs, there are also several medications for alcohol use disorder (MAUD), which treat alcohol use disorder, including acamprosate, disulfiram, and naltrexone.[226]

Examples of resources and programs in Manchester

- According to SAMSHA's opioid treatment program directory, there are three MOUD programs in Manchester—Manchester Metro Treatment, Habit Opco - Manchester, and New Season Treatment Center.[227]

- Better Life Partners also provides MOUD and alcohol use disorder treatment in Manchester and many other locations across the state.[228]

- The Farnum Center offers MOUD services and has two locations in Manchester. The Farnum Center also hosts the Extended Doorway of Greater Manchester, which operates from 5pm to 8am Monday-Friday and over the weekend (5pm Friday through 8am Monday).[229]

- The Mental Health Center of Greater Manchester (MHCGM) provides a Medication Assisted Recovery (MAR) outpatient program.[230] Importantly, the MHCGM also provides a variety of mental and behavioral health services.

[219] (National Harm Reduction Coalition 2020a)
[220] (Centers for Disease Control and Prevention 2018)
[221] Ibid.
[222] (National Institute on Drug Abuse 2021)
[223] (National Harm Reduction Coalition 2020a; Oesterle et al. 2019)
[224] https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act
[225] (Sisk 2023)
[226] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions
[227] https://dpt2.samhsa.gov/treatment/directory.aspx
[228] https://betterlifepartners.com/new-hampshire/
[229] https://farnumcenter.org/
[230] https://www.mhcgm.org/lifesaving-options-are-available-for-treating-substance-addictions/

- Groups Recover Together also provides MOUD at their Manchester location.[231]

- Some of the Doorway locations across the state have MOUD treatment programs (like the Doorway at Littleton Regional Healthcare[232] and the Doorway at Cheshire Medical Center[233]), but the Doorway of Greater Manchester does not, at the time of this writing.[234]

Overdose prevention centers

Overview

Overdose prevention centers (OPC)—sometimes called drug consumption rooms, safe injection sites, supervised injection facilities, or supervised consumption sites—allow patients to consume pre-obtained substances under supervision and with sterile equipment (such as syringes).[235] These sites provide a safe, controlled, and nonjudgmental environment for people to use drugs that were obtained elsewhere.[236] Overdose prevention centers can be in permanent locations (such as a medical clinic or dedicated brick-and-mortar space) or in a mobile location, such as a harm reduction van. Trained staff are onsite to respond quickly to drug overdoses, administer naloxone, and even supply oxygen if an overdose does occur.

Similar to syringe service programs, overdose prevention centers serve as a gateway to foster positive interaction between medical providers and PWUDs and to connect people to other supportive services. In Europe, overdose prevention centers are highly targeted to serve marginalized PWUD and tend to be embedded in facilities that also offer a spectrum of other health and social services.[237]

A 2017 systematic review of existing research concluded that OPCs were not associated with any increase in drug-related crime.[238] A 2021 review found that overdoes prevention centers increased access to SUD treatment and were associated with lower rates of overdose morbidity and mortality.[239] Further, there is evidence that OPCs are not associated with increased drug use, but they are associated with lower levels of public drug use and fewer improperly discarded syringes.[240]

Examples of resources and programs outside of New Hampshire

There are many overdose prevention centers internationally—nearly 200 centers across 14 different countries—and there has never been a death recorded at any of these facilities.[241] Overdose prevention centers have been in operation internationally for decades. The first facility was opened in Switzerland in 1986 and, as of 2022, Canada was the country with the most OPCs (38 total as of 2022).[242]

The first legal overdose prevention center in Canada, and North America more broadly, opened in 2003 in Vancouver, British Columbia.[243] In its twenty years of operation, this OPC (called PHS Community Services Society) has recorded 4.9 million visits, 15,050 overdose interventions, and not a single overdose death.[244] PHS Community Services Society has been on the cutting edge of OPCs and has

[231] https://locations.joingroups.com/nh/manchester/groups-recover-together-manchester-nh-grt004.html
[232] https://littletonhealthcare.org/clinics-and-affiliates/the-doorway-program/
[233] https://www.cheshiremed.org/community-programs/doorway
[234] https://www.thedoorway.nh.gov/doorway-greater-manchester
[235] www.drugconsumptionroom-international.org/index.php/what-are-they-aims-and-goals/
[236] https://nida.nih.gov/research-topics/overdose-prevention-centers
[237] (European Monitoring Centre for Drugs and Drug Addiction 2018)
[238] (Kennedy, Karamouzian, and Kerr 2017) See also: https://nida.nih.gov/sites/default/files/NIH-RTC-Overdose-Prevention-Centers.pdf
[239] (Levengood et al. 2021)
[240] (Potier et al. 2014)
[241] Transform Drug Policy Center, 2019; (Singer 2023)
[242] (Singer 2023)
[243] (Dooling and Rachlis 2010)
[244] (PHS Community Services Society 2023)

expanded their services to include a mobile overdose prevention unit, an affordable dental clinic, a credit union branch, and as of 2023 they operate over 1,600 units of low-barrier supportive housing.

In the United States, OPCs are federally illegal under a federal law prohibiting the consumption of controlled substances.[245] However, at least one unsanctioned OPC in the U.S. started operating in 2014 in an undisclosed city.[246] This effort was likened to early syringe service programs in the 1980s, which were unsanctioned at the time. An evaluation of this site published in 2020 described that from 2014-2019 the center had supervised 10,514 injections and reversed 33 overdoses, which were all reversed by naloxone (none resulted in death).[247]

In 2019, plans for an OPC in Philadelphia were blocked by legal action from the Trump Administration (the ongoing United States v. Safehouse).[248] However, other states have continued to pursue legislation to allow OPCs. The first legally sanctioned overdose prevention center in the United States was established in New York City in November 2021 and called OnPoint NYC (with two center locations, currently).[249] However, although Mayor de Blasio had authorized OPCs through executive action in 2021,[250] in August 2023 the U.S. Attorney for the Southern District of New York warned that he views OnPoint NYC as "operating in violation of federal, state and local law" because controlled substances are consumed there.[251] It is unclear what actions, if any, the U.S. attorney's office may take.

An August 2023 piece in the New York Times reported that OnPoint NYC has been used around 84,000 times by 3,700 participants and has reversed 1,000 overdoses—with not a single overdose death.[252] Both center locations were established at existing, longstanding syringe service programs that had operated in those communities for two decades.[253] These deep community roots and continued community engagement has been critical.

Another legally sanctioned OPC is set to open in Rhode Island in 2024. Rhode Island authorized an OPC pilot program through legislative action in 2021—the first in the nation to do so.[254]

There has been discussion in other New England states around OPCs as well. In Massachusetts, a proposed bill (H. 1981/S. 1242[255]) would create a 10-year pilot program for OPCs and is supported by a statewide coalition of over 30 organizations, including major hospitals, called the Massachusetts for Overdose Prevention Centers (MA4OPC).[256] In Connecticut, the 2023 Senate Bill 9[257] originally included a proposal to establish OPCs although was omitted, according to a State Capitol intern, for fear that its inclusion may jeopardize federal funding according.[258]

Examples of resources and programs in New Hampshire and Manchester

None so far. However, in New Hampshire there was a Committee to Study Harm Reduction and Overdose Prevention Programs in 2022, chaired by State Senator David H. Watters.[259] While Committee discussions opened up the conversation around OPCs in New Hampshire, the Committee did not

[245] 21 U.S.C. §856(a) of the Controlled Substances Act
[246] (Kral and Davidson 2017)
[247] (Kral et al. 2020)
[248] (Otterman 2023); See also https://www.safehousephilly.org/us-v-safehouse
[249] (Samuels, Bailer, and Yolken 2022)
[250] https://www.nyc.gov/office-of-the-mayor/news/793-21/mayor-de-blasio-nation-s-first-overdose-prevention-center-services-open-new-york
[251] (Otterman 2023)
[252] Ibid.
[253] (Giglio et al. 2023)
[254] (Otterman 2023)
[255] See https://malegislature.gov/Bills/193/H1981 and https://malegislature.gov/Bills/193/S1242
[256] https://ma4opc.org/
[257] https://www.cga.ct.gov/asp/CGABillStatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB9
[258] https://ctmirror.org/2023/05/08/a-new-step-for-overdose-prevention-in-connecticut/
[259] SB 279, Chapter Law 90:2, Laws of 2022

recommend introducing OPCs at this time and instead recommended waiting to see more data from programs in New York and Rhode Island.

Good Samaritan Laws

Overview

The term "911 Good Samaritan Law" refers to local or state legislation that may provide overdose victims and/or overdose bystanders with limited immunity from drug-related criminal charges and other criminal or judicial consequences that may otherwise result from calling first responders to the scene.[260] Frequently, bystanders who witness an overdose also use opioids themselves and so may refrain from calling emergency responders out of fear of being arrested by police, who often accompany medical responders to overdose calls.

Policies in New Hampshire

NH's Good Samaritan Law provides limited legal immunity for possession of a controlled substance when a 911 call is made in good faith and the evidence was gathered as a direct result of that 911 call. Immunity protects both the caller and the person experiencing an overdose.[261] However, it's worth noting that many are not aware of this law, its details, and/or do not trust that it will provide the protections promised. In a 2020 qualitative study of 67 New Hampshire residents who use opioids, interviewees expressed much skepticism around the NH Good Samaritan Law and also generally perceived New Hampshire laws to be harsh on opioid users.[262]

Common harm reduction implementation challenges and barriers

Stigma

As has been mentioned throughout this section, stigma against people who use drugs can be a major barrier to successfully implementing harm reduction strategies. Stigma is a major reason why people do not seek support or care for their SUD.[263] There is evidence that some health providers have bias against people with SUD, which may impact the care they provide. A 2019 survey of primary care physicians across the U.S. found high levels of stigma, with less than 30 percent reporting that they would accepting of a person taking medication for opioid use disorder marrying into their family or as a neighbor.[264]

Lack of Trust

In part because of the pervasiveness of stigma, previous negative experiences can cultivate a lack of trust and uneasiness about seeking services or support. For example, a study in Australia found that the stigma and discrimination people who inject drugs (PWIDs) faced from health care providers made them very reluctant to seek treatment. However, when treated like 'any other person' at a syringe service program (SSP), trust between the SSP staff and clients was greatly increased, improving participation and engagement with the SSP.[265] Indeed, cultivating trust through an environment free of judgement and stigma has been important to the success of harm reduction efforts.[266] Ensuring that

[260] (Carroll, Green, and Noonan 2018)
[261] (Lieberman and Davis 2023) and https://nastad.org/resources/drug-user-health-policy-map
[262] (Meier et al. 2020)
[263] https://nida.nih.gov/research-topics/stigma-discrimination
[264] (Stone et al. 2021)
[265] (Treloar et al. 2016)
[266] (MacNeil and Pauly 2011)

there is racial diversity among harm reduction service providers is an important step in building trust with communities of color.[267]

Limited availability of programming

Many programs do not have the funding, staff, or other resources to operate 24/7. Even programs with extended hours may not have the capacity to provide service to all who are interested at a given time. A 2020 study in New Hampshire identified lengthy waitlists as a barrier to OUD treatment in the state. One interviewed PWUD described "When you know someone who's willing and able and ready and physically standing there in the halls of the [treatment program] in front of you, and you say 'Come back in 8 weeks,' that's crazy. You could be dead tonight."[268] Participants in this study also reported low rates of treatment referral after experiencing an overdose in New Hampshire.[269] Not knowing where to go can also be a significant barrier to receiving care.

Racism

The system of structural racism in the United States is seen clearly in drug policy, perhaps most notoriously through the "War on Drugs," which has led to the disproportionate incarceration of Black and Hispanic/Latine communities and continues to shape present-day drug policy.[270]

A qualitative exploration of racism in harm reduction services in Toronto, Canada asked service providers and clients about their experiences and barriers to accessing services. They found that the whiteness of harm reduction spaces made both service providers of color and clients of color feel unwelcome. Physical and virtual BIPOC[271]-specific spaces are important to better serve and uphold the safety of these clients.[272]

In a health care setting, racial biases among health care providers are an added barrier for people of color with an SUD seeking care. For example, research has found that Black people experienced delays in entering treatment of up to five years compared to white people[273] and that Black youth were 49 percent less likely to receive medications for opioid use disorder than white youth.[274]

Lack of input from people who use drugs

Despite their expertise from lived experience, PWUDs are rarely involved in the research and implementation of drug-related policy. PWUDs can offer unmatched insight into the constantly changing world of illicit drugs. From understanding novel synthetic substances to following the dynamics at play in the illegal drug market, PWUDs are invaluable experts.

The North Carolina Survivor's Union (NCSU) serves as an example of successful research cooperation with PWUDs. The NCSU maintains several professional relationships in the research community, having subcontracted with organizations such as the NIH and FDA on previous projects. A key feature of research collaboratives with the NSCU is constant cooperation. Rather than tokenizing the NSCU and preventing them from playing an active role in the process, research is always done in

[267] (Godkhindi, Nussey, and O'Shea 2022)
[268] Page 8 in (Meier et al. 2020)
[269] (Meier et al. 2020)
[270] (Pamplin et al. 2023; Rosino and Hughey 2018)
[271] Black, Indigenous, and people of color
[272] (Godkhindi, Nussey, and O'Shea 2022)
[273] (Lewis et al. 2018)
[274] (Hadland et al. 2018)

collaboration. As a result, the NSCU has been involved in cutting-edge research led by PWUDs such as hepatitis testing and fentanyl strip distribution.[275]

[275] (Salazar et al. 2021)

Mental Health

ACLU
New Hampshire

Mental Health

What is a mental health condition?

A mental health condition[276] is defined as "a condition that affects a person's thinking, feeling, behavior or mood."[277] The present definition illustrates a broader transition in the clinical field toward defining mental health in a more holistic way that considers fuller contextual information and a focus on health over disease.[278]

Mental Health Statistics

Prevalence of (diagnosable) mental health conditions is high

The experience of a mental health condition is common. Data from the 2021 National Survey on Drug Use and Health show that nationwide, more than one-in-five adults (22.7 percent) experienced mental illness in the past year.[279] Mental illness captures an array of conditions, varying in severity,[280] but more than one-in-twenty have past-year experience with a mental illness that resulted in a serious functional impairment.[281]

In the United States, the most common mental health conditions are anxiety disorders, experienced by 19.1 percent of adults annually. Major depressive episodes are the next-most common, affecting 8.3 percent of adults, followed by posttraumatic stress disorder (3.6 percent). Experiencing a mental health condition is more common among some groups, with lesbian, gay, and bisexual adults especially likely to experience a mental health condition (50.2 percent in the past year), as are multiracial adults and American Indian/Alaska Native adults.

For local geographies, most available data are slightly older, but indicate that New Hampshire and Southern New Hampshire residents are not exempt from national patterns. Table 18 shows that 19.3 percent of adults in Southern New Hampshire—Cheshire, Hillsborough, and Rockingham Counties—experienced past-year mental illness between 2016 and 2018, and that rates of severe mental illness followed national patterns of one-in-twenty too.

Table 18. Percent of Adults (18 or older) Experiencing Each Mental Health Scenario in the Past Year, Southern New Hampshire and New Hampshire, 2016-2018

	Southern New Hampshire			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Any Mental Illness[282]	19.3	17.2	21.6	19.9	18.1	21.8
Serious Mental Illness[283]	5.1	4.1	6.2	5.2	4.4	6.2
Major Depressive Episode	7.7	6.5	9.1	8.0	7.0	9.2
Serious Thoughts of Suicide	4.8	3.9	5.9	4.9	4.1	5.9

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016-2018
Note: "Southern New Hampshire" estimates include Cheshire, Hillsborough, and Rockingham Counties. "Lower" and "Upper" refer to a 95 percent confidence interval.

[282] Any mental illness is defined as "having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder". See 2021 NSDUH.

The last time that the National Survey on Drug Use and Health had estimates available at a sub-county local geography was for a period between 2005 and 2010. At that time, 7.7 percent of Manchester-Nashua residents over age 12 had experienced a major depressive episode in the past year, similar to the 8.3 percent statewide.[284]

Measures of mental distress outside diagnoses for useful context

Because not every person experiencing mental health challenges will have received a diagnosis, measures that center on people's experiences (rather than their diagnoses) can help identify otherwise uncounted populations. The City Health Dashboard uses data from the Behavioral Risk Factor Surveillance Study (BRFSS) to estimate a measure of frequent mental health distress for all American cities with populations over 50,000, including Manchester. That source finds that an estimated 15.9 percent of Manchester adults reported frequent mental distress[285] in 2020, compared to 15 percent across all included cities.[286] The County Health Rankings project uses BRFSS data to estimate the number of days (of the past 30) that Hillsborough County adults reported that their mental health was not good. Those estimates suggest that the average number of "mentally unhealthy" days was 4.6 of 30, similar to both the 4.8 days statewide and 4.4 days nationally.[287]

The Youth Risk Behavioral Survey (YRBS) collects data on mental health experiences among youth, including or those in the Greater Manchester area.[288] In 2021, YRBS data show that more than two-fifths (43.6 percent) of Manchester area high schoolers felt sad or hopeless almost every day for two weeks in a row (see Table 19). This rate is similar to levels found statewide, but represent a significant uptick from 2019, when rates were lower than one third (31.9 percent).[289]

[277] https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions
[278] (Manderscheid et al. 2009)
[279] National Survey on Drug Use and Health, 2021, Table 29.
[280] https://www.nimh.nih.gov/health/statistics/mental-illness
[281] National Survey on Drug Use and Health, 2021, Table 30.
[282] Any mental illness is defined as "having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder". See 2021 NSDUH.
[283] Serious mental illness is defined as "having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder…with diagnoses resulting in serious functional impairment." See 2021 NSDUH.
[284] https://www.samhsa.gov/data/sites/default/files/NSDUHMetroBriefReports/NSDUHMetroBriefReports/NSDUH-Metro-Manchester.pdf
[285] Defined as the percent of adults who report experiencing poor mental health in 14 or more of the last 30 days.
[286] https://www.cityhealthdashboard.com/NH/Manchester
[287] https://www.countyhealthrankings.org/explore-health-rankings/new-hampshire/hillsborough?year=2023
[288] https://www.dhhs.nh.gov/programs-services/population-health/health-statistics-informatics/youth-risk-behavior-survey
[289] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/greater-manchester-yrbs-results-2019.pdf

Table 19. Percent of High School Students Who Felt Sad or Hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activity) in Past 12 Months, Greater Manchester and New Hampshire, 2021

	Greater Manchester			New Hampshire		
	Estimate	Lower	Upper	Estimate	Lower	Upper
Total	43.6	40.2	47.1	44.2	43.0	45.3
Sex						
Female	55.5	50.8	60.2	57.5	56.0	59.0
Male	30.1	26.1	34.4	30.7	29.3	32.0
Race / Ethnicity[290]						
Asian	48.4	37.0	60.0	40.9	35.6	46.4
Black	25.3	15.8	36.8	34.8	28.6	41.4
Hispanic/Latino	49.9	41.3	58.4	52.4	48.8	56.0
White	44.0	40.0	48.0	43.7	42.4	44.9
Sexual identity						
Gay, lesbian, or bisexual	72.5	64.7	79.5	71.7	69.6	73.8
Heterosexual	33.7	30.3	37.2	34.7	33.5	36.0
Other/questioning[291]	68.1	59.0	76.4	66.5	63.5	69.5

Source: The Centers for Disease Control and Prevention (CDC), Youth Risk Behavioral Survey, 2021
https://wisdom.dhhs.nh.gov/wisdom/assets/content/resources/yrbs-2021/Report-Greater%20Manchester.pdf
Notes: "Greater Manchester" estimates include students from Bedford High School, Goffstown High School, Manchester Central, Manchester Memorial, Manchester West, and Manchester School of Technology (high school). "Lower" and "Upper" refer to a 95 percent confidence interval.

Use of mental health treatment or services

Not all those who experience mental illness are able to access supportive services, although local access may be slightly higher than nationally. Using data from 2016 through 2018, 14.7 percent of U.S. adults received mental health services in the past year, about four percentage points lower than the share who experienced mental illness in that period.[292] By comparison, both in New Hampshire broadly and Southern New Hampshire specifically, there was only about a one-percentage point gap between the share of adults reporting receiving mental health services (18.5 percent in Southern NH and 19.0 percent in NH) and the share experiencing a mental health condition (19.3 percent in Southern NH and 19.9 percent in NH).

[290] Excludes "American Indian or Alaska Native," "Multiple Races," and "Native Hawaiian or Other Pacific Islander" categories, for which data are suppressed for Greater Manchester due to small sample sizes.
[291] Includes "I describe my sexual identity another way" and "I am not sure about my sexual identity (questioning)".
[292] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016-2018.

Solutions and interventions

Mobile Crisis Response

In 2020, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released guidelines defining the core components that community-based behavioral health crisis systems should include: a crisis call center, a mobile crisis response team, and a crisis stabilization facility,[293] summarized by NAMI as "someone to call," "someone to respond," and "somewhere to go."[294] Mobile crisis response teams (MCRTs) fulfill the response component, providing in-person support services for people experiencing a mental health or substance use disorder emergency.[295] When dispatched, teams meet a person on-the-scene to administer medication, make referrals, and provide follow-up connections to care. As teams are typically comprised of health care professionals, rather than law enforcement officers, MCRTs work to divert people in crisis from criminal justice responses and unnecessary hospitalizations.[296] There is some evidence that this works: for instance, 55 percent of cases handled by the MCRT were resolved without hospitalization, compared with 28 percent handled by law enforcement as usual.[297] Some models are especially well supported, including the STAR model in Denver and the CAHOOTS program in Eugene, Oregon.[298]

Given the differences in how services are dispatched, there is also some evidence that MCRTs are less expensive than other kinds of intervention. For instance, an evaluation conducted by the State University of New York at Albany found that their local child and adolescent mobile response team was a "cost-effective way to prevent hospitalizations, compared to other responders, such as the police or ambulance services."[299] A separate study quantified this cost savings at 23 percent less for those served by mobile crisis units.[300]

One study explored the effects of a mobile crisis team by randomly assigning people who had experienced a suicidal episode to receive follow up in the community through a MCRT or through a local health clinic. Although the services and referrals offered were identical across sites, participants were more than twice as likely receive a follow up visit when assigned to the MCRT than to the clinic (69.6 versus 29.6 percent). However, clinical outcomes and measures of dysfunction didn't differ between the groups afterward, suggesting this model is good at reaching people but is insufficient to address mental health on its own.[301]

Beginning in January 2022, the state of New Hampshire implemented New Hampshire Rapid Response Access Point, a hotline to support callers experiencing a mental health or substance use crisis. This phone, text, or chat hotline is initiated by the state Department of Health and Human Services (NH DHHS) and the Bureau of Behavioral Health, in partnership with the state's community mental health centers.[302] Beyond on-the-spot support, the hotline staff also provide real-time referrals and can dispatch a MCRT from any of the state's 10 community mental health centers, including the team from the Mental Health Center of Greater Manchester.[303] Data are not yet available on MCRT efficacy, but

[293] (Substance Abuse and Mental Health Services Administration 2020)
[294] (Wesolowski 2022)
[295] (Saunders, Guth, and Panchal 2023)
[296] (The Council of State Governments Justice Center 2021)
[297] (Scott 2000)
[298] https://communityresourcehub.org/resources/support-team-assisted-response-star-program-evaluation/; https://www.vera.org/behavioral-health-crisis-alternatives/cahoots
[299] https://www.albany.edu/chsr/AdolescentMobileCrisisTeamEvaluation.shtml
[300] (Scott 2000)
[301] (Currier, Fisher, and Caine 2010)
[302] https://www.mhcgm.org/news-post/mobile-crisis-team-now-part-of-the-nh-rapid-response-system
[303] (Timmins 2022)

NH DHHS staff estimated that up to 80 percent of calls to the hotline would be resolved without needing to dispatch a MCRT.[304]

Finally, research finds that integrated treatment of mental health and SUD leads to better outcomes.[305] However, outpatient mental health services are often not well equipped to support people with co-occurring conditions, and people with dual diagnoses are more likely to be hospitalized[306] or to reuse community mental health centers[307] after crisis response than are people with only a mental health diagnosis.

Expanding statewide mental health service capacity with holistic efforts

In 2019, the state released its 10-year mental health plan, which prioritized intensifying preventive, community-based supports and addressed a plan to reduce the practice of psychiatric "boarding" in emergency rooms.[308] In 2023, the state announced its plan to eliminate such boarding by 2025.[309]

To enact this plan, the state needs to grapple both with preventive care and expanded capacity. As of September 21, 2023, 39 adults and 11 children were waiting to be admitted to a designated psychiatric facility, including 22 adults who were waiting in emergency rooms.[310] Achieving part of the necessary expanded capacity will be related to the development of a new 144-bed mental health hospital in southeast New Hampshire by 2025.[311] However, upstream investments in preventive care and community-based programming is crucial.

Part of the state's preventive capacity is likely to come from its community mental health centers. For instance, the Lakes Region Mental Health Center in Laconia recently received a $2.5 million federal grant from Substance Abuse and Mental Health Services to expand supports for people experiencing homelessness. The project will include a "full-time, on-the-ground outreach worker, harm reduction supplies and education, housing, childcare and transportation vouchers and increased services to support people in recovery."[312] In recognizing that residents experiencing mental health conditions often also face homelessness and substance use disorder, the project will attempt to strengthen outreach, improve treatment outcomes, and reduce service barriers.

Recognition of youth mental health needs

In addition to expanding community mental capacity, New Hampshire is beginning to consider more upstream approaches through prevention—particularly during childhood—as part of its long-term solutions planning. Perhaps the most significant stride in this area is through its implementation of a Children's System of Care (CSoC) in 2016.[313] The CSoC gives structure to the state's "coordinated array of services" for children, including prevention, early intervention, residential care, crisis stabilization, and recovery supports.[314]

In Manchester specifically, preventive efforts include the LAUNCH Manchester program, "an early childhood initiative that promotes the overall health and well-being of children birth through 8 years and their families, utilizing a cross-sector team focused on improving access to high-quality early

[304] (Timmins 2022)
[305] https://www.samhsa.gov/co-occurring-disorders
[306] (Min, Biegel, and Johnsen 2005)
[307] (Kim and Kim 2017)
[308] (New Hampshire Department of Health and Human Services 2019)
[309] (Cuno-Booth 2023a; New Hampshire Department of Health and Human Services 2023a)
[310] https://www.dhhs.nh.gov/about-dhhs/locations-facilities/state-run-and-designated-acute-psychiatric-bed-data
[311] (Timmins 2023)
[312] (McLaughlin 2023)
[313] https://nhcsoc.org/about-csoc/what-is-csoc/
[314] https://www.nhcf.org/what-were-up-to/new-data-point-to-behavioral-health-challenges-among-young-people/

education and care, empowering families, identifying and mitigating the effects of Adverse Childhood Experiences, and improving access to health, behavioral health, and specialized medical services."[315]

Yet despite prevention-focused efforts, the state is experiencing significant service shortfalls. A New Hampshire Public Radio report from July 2023 stated that the Mental Health Center of Greater Manchester has a waitlist of 350 families and an intake wait of six months.[316] The state's efforts to aim to address acute needs alongside prevention include continued investments in community mental health, efforts to integrate mental health supports into school-based settings, and new workforce preparation options, including a graduate program for school social workers at the University of New Hampshire. The 2021 purchase of Hampstead Hospital is helping address immediate needs too,[317] and although staffing remains a challenge, the state posits that keeping state control of the hospital allows it to provide children with short- and long-term care, as well as smoothing transitions back into the community.[318]

[315] Page 28 in (City of Manchester Health Department 2022).
[316] (Cuno-Booth 2023b)
[317] (Timmins 2021)
[318] (Timmins 2021)

Criminal Justice

ACLU
New Hampshire

Criminal Justice

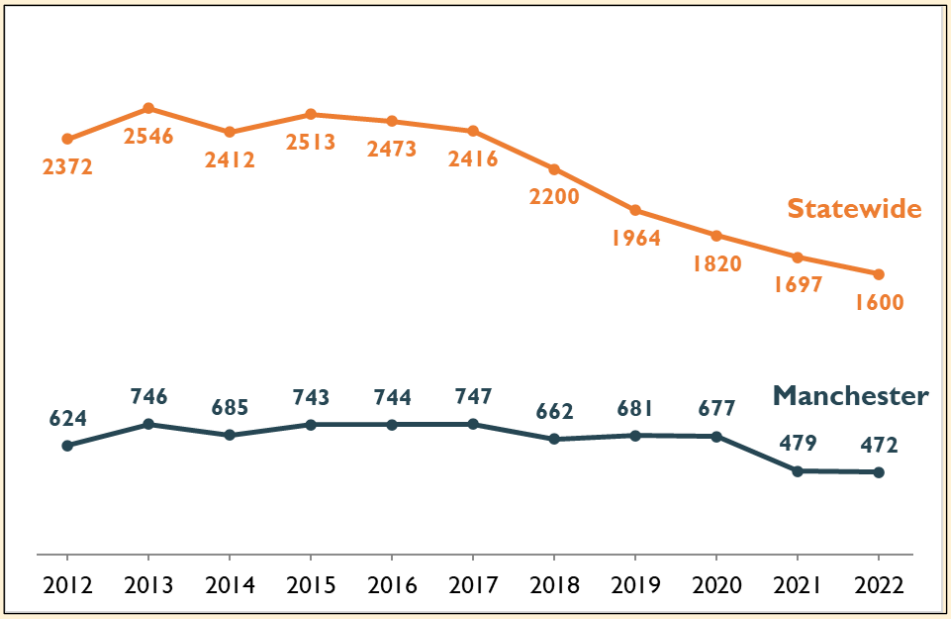
Overview

Violent crime is relatively low in New Hampshire

The rate of violent crime offenses per 100,000 is much lower in New Hampshire than nationally—in 2022 there were 125.6 violent crimes per 100,000 people in New Hampshire as compared to 380.7 nationally.[319] Violent crime rates have also been generally decreasing in New Hampshire over the past decade, with a 2012 violent crime rate of 215.0 per 100,000 people.

However, violent crime in Manchester in 2022 is closer to the national rate, at about 368.7 violent crimes per 100,000 people. The rate of violent crime has also decreased over the last decade in Manchester, as the rate of violent crime was an estimated 568.4 per 100,000 people in 2012.[320] Figure 25 shows how the total number of reported incidents of violent crime reported statewide and by the Manchester Police Department have decreased over the last decade. Still, in 2022 about 30 percent of all violent crimes statewide were reported by Manchester Police Department.

Figure 25. Number of All Violent Crime Incidents Reported in New Hampshire and by Manchester Police Department, 2012-2022



Source: FBI Uniform Crime Reporting (UCR) Program, Summary Reporting System (SRS), 2012-2022
Note: Violent crime includes the offenses of robbery, aggravated assault, rape, murder, and nonnegligent manslaughter.

In 2022, there were a total of 472 'violent crime' incidents reported by the Manchester Police Department, a category that includes homicide, rape, robbery, and aggravated assault. In 2022, the most common violent crime was aggravated assault, with 330 incidents reported by the Manchester

[319] FBI Uniform Crime Reporting (UCR) Program, Summary Reporting System (SRS). Note that violent crime includes the offenses of robbery, aggravated assault, rape, murder, and nonnegligent manslaughter.
[320] FBI Uniform Crime Reporting (UCR) Program, Summary Reporting System (SRS). Based on all violent crime incidents reported by the Manchester Police Department in 2022. Rates calculated by authors using ACS 5-year population estimates.

Police Department. That same year, there were 87 reported robberies, 50 reported rapes, and 5 reported homicides.[321]

Domestic violence was a factor in more than half of all homicides

Between 2020 and 2021, there were 22 homicides in New Hampshire[322]—thirteen of which were domestic violence homicides (59 percent of homicides). Hillsborough County had the highest number of domestic violence homicides, with six of the 13 total occurring there (the county with the second highest number was Cheshire County with two). Of the 13 domestic violence homicides, five were committed by intimate partners. While it was most common for domestic violence homicides to occur in a personal residence, most non-domestic violence homicides happened in non-residence locations like on the street or at work.[323]

Gun violence

Firearms were the leading cause of death in homicides in New Hampshire in 2020-2021.[324] Using CDC WONDER data, Everytown reports that between 2018-2021 in New Hampshire an average of 141 people died and 133 were wounded by guns each year.[325] New Hampshire is ranked low nationally, with the 43rd highest rate of gun deaths with a rate of 9.7 deaths per 100,000 people (compared to 13.0 deaths per 100,000 people nationally).[326]

The majority of gun deaths in New Hampshire over this period were suicides—88 percent of gun deaths were suicides, eight percent were homicides, two percent were shootings by police, less than one percent were unintentional, and less than one percent were undetermined.[327] Everytown estimates that "gun deaths and injuries cost New Hampshire $2.2 billion each year, of which $22.4 million is paid by taxpayers."[328]

High utilizers of jail services in New Hampshire

As reported by the Council of State Governments Justice Center's Justice Reinvestment Initiative in New Hampshire, a small number of "high utilizers" of jail services are using a substantial amount of resources at a high cost.[329] For example, in calendar year 2019 it cost New Hampshire jails an average of $26,436,527 to incarcerate the 2,622 identified high utilizers (an average of $10,082 per person), versus an average cost of $65,1781546 to incarcerate the other 25,275 non-high utilizers (an average of $2,578 per person).[330] This section will explore the Justice Reinvestment Initiative in New Hampshire's analysis of jail administrative data and Medicaid claims data[331] and findings.

High utilizers of jail services are less likely to be booked for violent charges

High utilizers were characterized by frequent contact with NH jails—on average, high utilizers had five more jail entrances than non-high utilizers. Jail administrative data showed that these high utilizers were also less likely to be booked for violent charges. In fact, they were more likely to be booked for

[321] FBI Uniform Crime Reporting (UCR) Program, Summary Reporting System (SRS).
[322] Includes homicides handled by the Attorney General's Office.
[323] (NH Domestic Violence Fatality Review Committee 2023)
[324] (NH Domestic Violence Fatality Review Committee 2023)
[325] (Everytown 2023)
[326] https://everystat.org/#NewHampshire
[327] (Everytown 2023)
[328] Page 1 in Ibid.
[329] (Justice Reinvestment Initiative New Hampshire 2023)
[330] (Justice Reinvestment Initiative New Hampshire 2023)
[331] Only 46 percent of individuals with administrative jail records were matched with FY 2015-2021 Medicaid claims data (meaning they were enrolled in Medicaid at least once during this period). However, 89 percent of high utilizers were matched to Medicaid claims data.

parole and probation violations, failure to appear/bail charges, or "lower-level public order crimes such as criminal trespassing" than non-high utilizers.[332]

High utilizers also made up almost all drug court bookings (92 percent of those booked in drug courts in Cheshire, Hillsborough, and Rockingham County jails).[333] New Hampshire drug and mental health courts vary by county.[334] Hillsborough County has two drug courts (North and South) and four mental health courts, including a Circuit Court District Division in Manchester which has the Veterans behavioral health track. These specialty court programs "combine community-based treatment programs with strict court supervision and progressive incentives and sanctions" and are designed to be an alternative to typical jail time.[335] A meta-analytic review of adult drug court literature found that drug courts were effective in reducing recidivism.[336] Some states also have homeless courts, but New Hampshire does not.[337]

There are serious racial disparities among both the general jail population and high utilizers

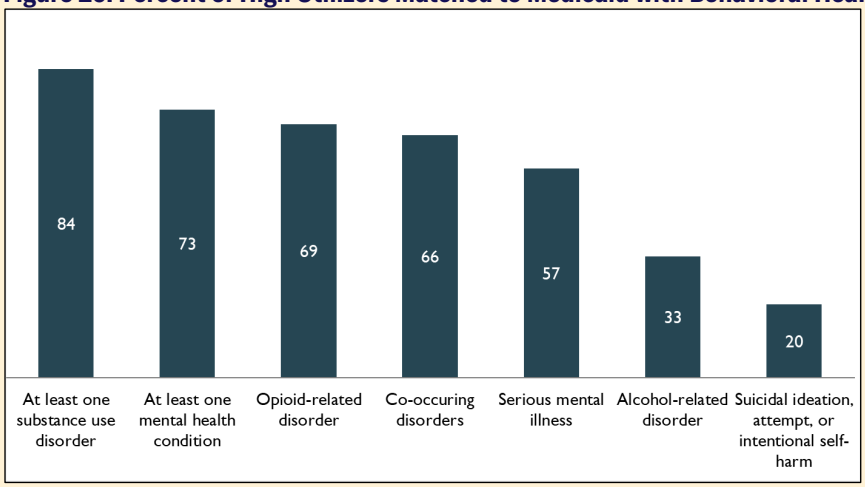
Racial disparities were also disturbingly clear: Black Granite Staters were 6.2 times more likely to be in jail than white residents. Hispanic/Latine Grantie Staters were 2.0 times more likely to be in jail than white counterparts. Black Granite Staters were also 2.8 times more likely to be to be high utilizers and Hispanic/Latine residents were 1.3 times more likely to be high utilizers than their white counterparts.[338]

High utilizers of jail services also have higher behavioral health needs

High utilizers also tend to also have more frequent and more complex behavioral health needs—which includes mental health and substance use-related services—than people who were not high utilizers. High utilizers were also more likely to have had a behavioral health-related visit to an emergency department or community mental health center (CMHC).[339]

[332] Page 16 in (Justice Reinvestment Initiative New Hampshire 2023)
[333] Data was only available for these counties.
[334] Nine counties have drug courts (all except for Sullivan County), six have mental health courts, and only two have a specific veterans behavioral health track. See: https://www.courts.nh.gov/our-courts/drug-mental-health-courts/court-locations
[335] https://www.courts.nh.gov/our-courts/drug-mental-health-courts
[336] (Mitchell et al. 2012)
[337] https://www.citizenscount.org/issues/homeless-and-panhandling-laws; For example, the City of Vancouver, Washington launched a Community Court that addresses low-level offenses, including unlawful camping and unlawful storage of personal property in public. See: https://www.cityofvancouver.us/government/department/city-attorneys-office/community-court-program/
[338] (Justice Reinvestment Initiative New Hampshire 2023)
[339] (Justice Reinvestment Initiative New Hampshire 2023)

Figure 26. Percent of High Utilizers Matched to Medicaid with Behavioral Health Primary Diagnoses, 2019-2022



Source: Analysis conducted by and presented in (Justice Reinvestment Initiative New Hampshire 2023).
Notes: High utilizers were characterized by frequent contact with NH jails—on average, high utilizers had five more jail entrances than non-high utilizers. This only includes high utilizers who were matched to Medicaid claims data, meaning those people were enrolled in Medicaid at least once from fiscal years 2015 to 2021 and were incarcerated in New Hampshire jails between fiscal years 2019 and 2021. Estimates based on primary diagnoses in Medicaid claims data. Methods notes per notes and definitions provided on page 22 of (Justice Reinvestment Initiative New Hampshire 2023).

High utilizers of jail services were more likely to have experienced homelessness

Among high utilizers who were matched to Medicaid, 40 percent had experienced homelessness at least once in the past.[340] This was higher than non-high utilizers, among whom 23 percent had experienced homelessness—still quite high. For comparison, a 2018 study estimated that the prevalence of lifetime homelessness—defined as ever having experienced homelessness for at least one month—was 4.2 percent nationally.[341]

Reported recommendations

In April 2023, the Justice Reinvestment Initiative findings were presented to the NH Governor's Advisory Commission on Mental Illness and the Corrections System. Key recommendations included increasing reentry services, increasing jail behavioral health services and care coordination across behavioral health and jail systems, expanding criminal justice data collection and monitoring, and pursuing additional funding to support these changes, among others. The Governor's Advisory Commission plans to identify which, if any, recommendations to pursue.[342]

A punitive approach to SUD is ineffective, costly, and can create more harm

In addition to the perceived otherness of people with SUD made visible through stigma, the deviance-centered approach to SUD also has significant implications for people with SUD in the creation and application of legal controls under a punitively focused approach. According to the Federal Bureau of Investigation's Uniform Crime Report, "drug abuse violations" made up the largest category of arrests made in 2019, accounting for more than 15 percent of all arrests.[343] This pattern is similar in

[340] During Medicaid enrollment from fiscal year 2015-2021, (Justice Reinvestment Initiative New Hampshire 2023)
[341] (Tsai 2018)
[342] https://csgjusticecenter.org/2023/05/01/new-hampshire-governors-commission-reviews-justice-reinvestment-initiative-data-analysis-and-proposed-policy-recommendations/
[343] (Federal Bureau of Investigation 2020)

Manchester, where drug abuse violations were the third largest category of arrests made in 2022, accounting for over 20 percent of all arrests.[344]

Despite intensive legal oversight, there is little evidence that a punitive approach to handling substance use is effective. Research from the Pew Charitable Trusts suggests that imprisonment is not only ineffective in reducing drug-related challenges or improving public safety, but also very costly.[345] Those researchers found "no statistically significant relationship between state drug imprisonment rates and three indicators of state drug problems: self-reported drug use, drug overdose deaths, and drug arrests."[346]

Critically, deviance-centered approaches to substance use fuel racist stereotypes that enable racist enactment of legal control. The National Institute on Drug Abuse notes that "treating drug use as a criminal activity may also contribute to the stereotype of people who use drugs as being dangerous and a risk to society. It can further marginalize disadvantaged groups. For example, in the United States, punitive policies disproportionately affect Black people and communities of color, who are more likely to be arrested for illegal drug use."[347]

A 2020 research report from the ACLU finds that Black people were 3.5 times more likely to be arrested for marijuana possession than white people in 2018, despite similar rates of reported lifetime or past-year use.[348] This pattern is not specific to marijuana, with significant evidence that Black, Latine, and American Indian/Alaska Native persons are more likely to be incarcerated than white persons for arrests related to drugs in general.[349] Research suggests that "difference in drug offending, nondrug offending, or residing in the kinds of neighborhoods likely to have heavy policy emphasis on drug offending" do not explain these disparities.[350]

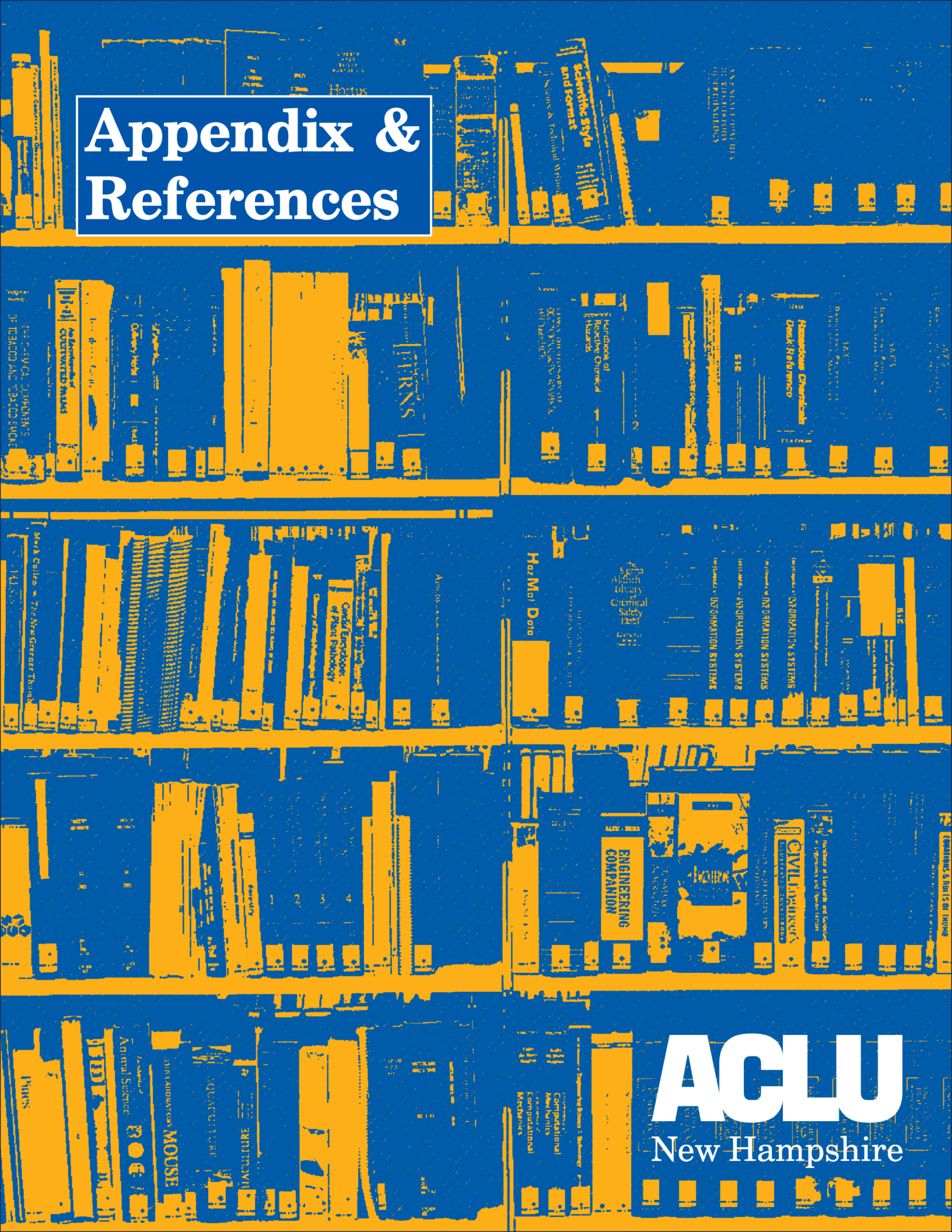
Investing in social and public health services can reduce crime

There are many good reasons to invest in social and public health services, and evidence suggests that reducing crime may be among the benefits. An analysis of 42 U.S. states found that higher state-level spending on social and public health services was associated with significantly lower homicide rates.[351] In fact, these authors found that every additional $10,000 spent per person experiencing poverty was associated with a 16 percent decrease in the average homicide rate.[352]

There is also some evidence that improved access to health care can reduce crime. An investigation of Medicaid expansions[353] found that these expansions were related to substantial reductions in state rates of aggravated assault, robbery, and larceny theft. Further, authors estimate that much of these reductions were due to reducing substance use prevalence and increasing SUD treatment rates.[354] Similarly, two other studies examining Affordable Care Act (ACA) Medicaid expansion found that expansions were negatively associated with homicide, assault, vehicle theft, burglary, and robbery.[355]

[344] Via the FBI Uniform Crime Reporting (UCR) Program at: https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/arrest
[345] (The Pew Charitable Trusts 2018)
[346] Page 1 in (The Pew Charitable Trusts 2018)
[347] https://nida.nih.gov/research-topics/stigma-discrimination#affect
[348] (American Civil Liberties Union 2020)
[349] (Camplain et al. 2020; Volkow 2021)
[350] (Mitchell and Caudy 2015)
[351] (Sipsma et al. 2017)
[352] Ibid.
[353] Specifically, via expanding Health Insurance Flexibility and Accountability (HIFA) waivers.
[354] (Wen, Hockenberry, and Cummings 2017)
[355] (He and Barkowski 2020)

Appendix & References



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Appendix – List of Key Reports

2021 State of Homelessness in New Hampshire Report
NH Coalition to End Homelessness
https://www.nhceh.org/wp-content/uploads/2022/09/2022-NHCEH-Full-Report-6.2.2022_compressed.pdf

2022 Greater Manchester Community Health Needs Assessment
City of Manchester Health Department
https://www.mymanchesternh.com/Portals/6/SiteContent/2022_GMCHNA.pdf

2023 New Hampshire Statewide Housing Needs Assessment
Root Policy Research for New Hampshire Housing
https://www.nhhfa.org/wp-content/uploads/2023/04/2023-NH-Statewide-Housing-Needs-Assessment.pdf

Council on Housing Stability Strategic Plan 2021-2024
State of New Hampshire, Council on Housing Stability
https://nhchs.org/wp-content/uploads/2021/07/Council-on-Housing-Stability-2021%E2%80%942024-Strategic-Plan.pdf

Harm Reduction: Foundation & Community Collaboration
Makin' It Happen in collaboration with the City of Manchester Health Department.
https://makinithappen.org/wp-content/uploads/2021/05/FINAL-2_MIH-Harm-Reduction-Report-24pgs.pdf

Manchester Master Plan 2021
Plan Manchester
https://www.manchesternh.gov/Portals/2/Departments/PCD/MANCHESTER_MASTER_PLAN_FINAL_JULY_21.PDF

New Hampshire 2023 Residential Rental Cost Survey Report
New Hampshire Housing
https://www.nhhfa.org/wp-content/uploads/2023/07/NHH-2023-Res-Rental-Survey-Report.pdf

New Hampshire 10-Year Mental Health Plan
New Hampshire Department of Health and Human Services.
https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/10-year-mh-plan.pdf

New Hampshire's High Utilizer Justice Reinvestment Initiative
The Council of State Governments Justice Center's Justice Reinvestment Initiative in New Hampshire.
https://newhampshirebulletin.com/wp-content/uploads/2023/08/NH_JR-PH1_April-2023-Presentation_FINAL_Website_508.pdf

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Anderson, D. Mark, Benjamin Hansen, Daniel I. Rees, and Joseph J. Sabia. 2019. “Association of Marijuana Laws With Teen Marijuana Use: New Estimates From the Youth Risk Behavior Surveys.” *JAMA Pediatrics* 173(9):879–81. doi: 10.1001/jamapediatrics.2019.1720.

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