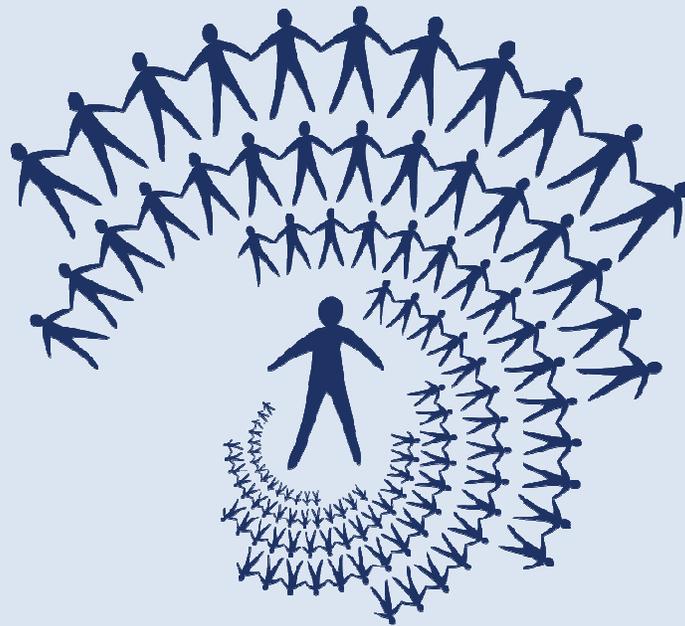


*The New Hampshire Governor's Commission on Alcohol and  
Other Drug Abuse Prevention, Treatment, and Recovery*

## **STATE FISCAL YEAR 2015 ANNUAL REPORT**



*Implementing collective action for collective impact in reducing the misuse of alcohol and other drugs  
and promoting recovery from substance use disorders*

# SFY 2015 Members of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery

## Legislative Branch Members

Senator Jeanie Forrester  
Senator Molly Kelly  
Representative William Hatch  
Representative John Tholl

## Public Members

Marty Boldin - Recovery Representative  
Monica Edgar - Treatment Professional  
Rebecca Ewing - Non-Professional Public Member  
Traci Fowler - Prevention Professional  
Tim Lena – Prevention Professional  
Chris Placy - Non-Professional Public Member  
Stephanie Savard - Treatment Professional

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## Legislatively Mandated Members

Virginia Barry - Commissioner, NH Department of Education  
John J. Barthelmes - Commissioner, NH Department of Safety  
Lorraine Bartlett - Director, NH Division for Children, Youth & Families  
Cheryl Ann Coletti – NH Business and Industry Association  
Joseph Foster - Attorney General/NH Department of Justice  
Ross Gittell - Chancellor, Community College System of New Hampshire  
Honorable Edward Gordon (designee of Honorable Edwin W. Kelly) - Administrative Judge of the District and Municipal Courts  
Joseph P. Harding, Executive Director - Director, NH Bureau of Drug and Alcohol Services  
James MacKay - Chairman, NH Suicide Prevention Council  
Joseph Mollica - NH Liquor Commission  
Major General William N. Reddel, III - The Adjutant General, NH National Guard  
Timothy Rourke, Chairman - New Hampshire Charitable Foundation  
Seddon Savage, MD - NH Medical Society  
Roger A. Sevigny - Commissioner, NH Department of Insurance  
Nicholas A. Toumpas - Commissioner, NH Department of Health and Human Services  
William L. Wrenn - Commissioner, NH Department of Corrections  
Vacant - NH Nurses Association

## Introduction

State Fiscal Year 2015 was a year of continued progress in the midst of continuing challenges for the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery (the Commission) and its legislated mission to *significantly reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor regarding the delivery of effective and coordinated alcohol and drug abuse prevention, treatment and recovery services throughout the state.*

The year marked continuing efforts to overcome barriers to accessing effective services and improvement in the prevention and treatment of substance use disorders (SUDs). Successes have included the continued roll out of SUD benefits for those enrolled in the state's Health Protection Program for the expanded Medicaid population; the passage of legislation expanding access to the opioid overdose reversal medication naloxone; the distribution of free naloxone through the state's Community Health Center system; legislation expanding the use of the Prescription Drug Monitoring Program (PDMP) data base; and a new media campaign aimed at educating the public about the opioid crisis and ways to access treatment and recovery.

In the midst of these forward movements; however, this year marked a continued, alarming rise in opioid-related overdoses and overdose deaths and little movement in the substance misuse trends among young adults in the state.

This report highlights progress, challenges, and opportunities for the Commission and its collective efforts to address the misuse of alcohol and other drugs, particularly opioids, and to promote treatment and recovery. Financial reporting represents state fiscal year 2015 (July 1, 2014 – June 30, 2015) while programmatic and activity reporting includes information through December 2015 for some task forces and agencies. As with the Commission's annual report last year, this report is organized into parts that correspond to Governor Hassan's request for specific information and in recognition of the legislative mandate relative to the Commission's annual report. The following report components are a culmination of feedback from member agencies, task forces, and the Senior Director of Substance Misuse and Behavioral Health for the Governor's Office:

- I. Successes, Challenges, Priorities & Recommendations
- II. Additional Recommendations per Governor Hassan's Request for Information
- III. Updates per Governor Hassan's Request for Information
- IV. Substance Use Related State Fiscal Year 2015 Expenditures by State Agency

## I. Successes, Challenges, Priorities & Recommendations

The efforts of the Commission, its members, task forces and stakeholders have been substantial this year as a direct result of leadership and commitment within the Governor's office, state agencies, the legislature, provider systems, regional public health networks, communities, advocacy organizations, recovery groups, law enforcement and health care, and many other stakeholders.

Please note that the following successes, challenges, and priorities emerged through the traditional Commission reporting structure; however, *additional recommendation detail and information* are presented in the next section per the Governor's request for recommendations and updates.

### Successes

Successes have been the result of significant efforts by the task forces of the Governor's Commission, by state agencies working on the opioid crisis, and specifically by the NH DHHS' Bureau of Drug and Alcohol Services which is the single state authority (federal designation) for addressing substance misuse, SUD services, and SUD health and safety impacts. Most notable successes include but are not limited to the following:

- The expanded service array for the Substance Use Disorder benefit within NH's Health Protection Program;
- The purchase and initial distribution of free naloxone kits to friends and families of those at risk for an opioid overdose;
- The launch of a statewide public awareness campaign, "Anyone Anytime NH"<sup>1</sup>;
- New federal funding awarded in the amount of \$500,000 to enhance the NH Prescription Drug Monitoring Program;
- New federal funding awarded in the amount of \$2.1M per year for five years to address youth and young adult prevention services;
- Evidence of reductions in youth substance misuse as evidenced by data collected through the Youth Risk Behavior Survey;
- Funding and technical assistance to support Screening, Brief Intervention and Referral & Treatment (SBIRT) in all Community Health Centers in the state;
- Early development of capacity expansion for Medication Assisted Treatment;
- Expansion of treatment capacity is in various states of progress. Office-based MAT has expanded significantly this year and residential treatment beds increased by 20 (from 208 beds) with another 42 under construction. For 2016, a 30% increase in residential beds and a 50% increase in withdrawal management (detox) capacity in Manchester are minimum projections;
- The Governor's office worked with the NH Health and Human Services and the Office of the Fire Marshal to change licensing regulations to maintain and expand opportunities for treatment and to make it easier for some existing facilities to become licensed;
- Addition of a Continuum of Care facilitator, supported by federal funding, in each of the thirteen Regional Public Health Networks in the state to assist local communities in identifying and building additional

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<sup>1</sup> [Anyoneanytimenh.org](http://Anyoneanytimenh.org)

capacity for a full continuum of services (prevention, early intervention, treatment and recovery support services) to effectively address the misuse of alcohol and drugs;

- The inclusion of regionally accessible integrated substance use, mental health, and primary care services in the state's Medicaid Transformation Waiver under consideration;
- Expanding law enforcement resources and coordination with federal partners to address drug trafficking investigation and prosecution;
- Continuing efforts to study and improve prescribing practices to prevent opioid misuse and opioid use disorders;
- The first Commission funding to support peer recovery support services and infrastructure; and
- Increased education of the media through collaborative forums with SUD service providers and resulting improvements in media coverage and public education through media activities.

## Challenges

Challenges to service and system capacity for substance misuse and SUDs continue to be rooted primarily in stigma; a lack of SUD knowledge within the safety and health care system; and historical reductions of funding, lack of third-party payer coverage, and under-resourcing of services, systems, and state agencies which affect service adequacy across the continuum of prevention, early identification, treatment, recovery support, law enforcement and interdiction.

For context, 25 years ago, the state had fourteen comprehensive residential treatment programs, several hospital-based, that provided withdrawal management (formerly known as detoxification) and treatment with robust staffing that included medical direction, licensed clinical staff, full nursing services, and ancillary family services. It is generally recognized that this critical service infrastructure was lost due to reductions and/or loss of third-party coverage for comprehensive SUD services. Please see Appendix B for a listing of prior service providers.

Additionally, the state continues to identify resources and initiatives to rebuild services and systems lost in 2012, when state budget reductions led to the loss of \$1M in treatment services and the loss of all direct service prevention program funding in the state.

This historical context can be considered in addition to the following current challenges:

- The increase in opioid-related overdoses and other impacts of opioid dependence in the state, including the significant increase in overdose deaths associated with non-pharmaceutical fentanyl;
- Increased treatment demand taxing an historically under-resourced service system;
- Barriers to third-party coverage of SUD services, including patient enrollment, prior authorization/patient eligibility for services, provider registration, and provider reimbursement;
- The dearth of resources to establish a robust network of recovery support services in the state;
- Inadequate workforce to meet service demand across the continuum of SUD and co-occurring mental health services;
- Limited real-time, easy access to data relative to arrests, drugs confiscated, emergency service calls, emergency room visits, and overdose deaths; and
- Limited coordinated and integrated law enforcement and health care efforts across state borders and across state systems of care.

## Priorities & Recommendations

### *Services Across the Continuum*

- Expanded treatment capacity, particularly medication-assisted treatment for opioid dependence.
- Significant resource and technical support for community-based peer recovery support services to establish capacity for this identified service gap for an effective continuum of care not typically covered by insurance or other fee-for-service infrastructures.
- Real-time access to a fully staffed 24/7 live warm line for the public to call to receive information and consultation on treatment and recovery support services available and to receive support accessing those services, including assistance in making contact with service agencies to schedule intakes, etc. This line must be answered by a live voice 24 hours a day, 7 days a week.
- Reauthorization of the New Hampshire Health Protection Program and its substance use disorder (SUD) benefit.
- The addition of a robust SUD benefit into the state's Medicaid plan and in the private insurance marketplace to provide SUD treatment services to a larger insured population, complementing state funding of treatment services for the under- and uninsured.
- Funding of a staffed perinatal/primary care collaborative to develop protocols and services for prevention, early identification and specialty, integrated SUD treatment and primary care services for pregnant and postpartum women.
- Expanded comprehensive prevention and early identification and intervention across multiple systems, including Student Assistance Programs (SAPs) in schools, and targeting high-risk groups across the lifespan, including but not limited to young adults.
- Additional licensed alcohol and drug counselors in all DCYF regions of the state.

### *Public Education and Awareness*

- Continued expanded public and professional sector messaging about the risk and harm of addiction and effective prevention, treatment, and recovery supports available; additionally and specifically, immediate messaging to opioid users relative to fentanyl. It is also recommended that naloxone-related messaging increase its emphasis that calling 911 is essential in that with the stronger opioids available, such as fentanyl, two doses may not be adequate to reverse an opioid overdose.

### *Data Utilization*

- Improved data access, including elevated roles for the State Epidemiological Outcome Workgroup (SEOW) and the NH Information Analysis Center to provide a comprehensive set of data indicators to measure and monitor change in substance misuse and SUD-related health and safety impacts and outcomes, and including real-time access to opioid and other substance misuse data.
- Continued efforts to increase utilization of the Prescription Drug Monitoring Program (PDMP), including the consideration of mandatory use by prescribers when prescribing opioids.

## Priorities & Recommendations – Continued

### *Prescribing and Medication Storage & Disposal Practices*

- Continued and increased efforts and/or mandates to improve prescribing practices, to include that a process be established and carried out by the state’s licensing boards to address rule changes, education and other actions to improve opioid prescribing practices to reduce the likelihood of diversion and to prevent the development of addiction. This process should include consideration of prescriber utilization of the state’s PDMP.
- Encouragement of safe storage and disposal of prescription opioids through 1) expanding drop boxes to more law enforcement agencies and to non-law enforcement entities such as hospitals and/or pharmacies and 2) through the promotion and sale of lock boxes and/or deactivation products.

### *Service and System Financing*

- Adequate resourcing of drug courts across the state to provide treatment and recovery support services to individuals in the justice system as a result of a substance use disorder.
- State agencies addressing substance misuse able to request and expend funds at budget levels that are sufficient to meet the need for adequate law enforcement, forensic testing, investigation and prosecution, prevention, early identification, treatment, recovery support services and related efforts without reductions and fluctuations in budgets that compromise the systems’ ability to adequately address substance misuse and substance use disorders.
- Increased resourcing and utilization of the prescription drug monitoring program (PDMP) to support effective prescribing practices, to reduce doctor shopping and to inform substance misuse policies and programming.
- Full funding of the state’s Alcohol Fund as legislated in 2000, providing 5% of the state’s revenues from liquor sales to be directed to prevention, treatment, and recovery support services not otherwise covered under public or private insurance financing. As substance misuse is a long-standing and underserved public health and safety issue that will continue even after the opioid crisis abates, this recommendation reinforces the necessity that the Alcohol Fund be provided at its original formula each year without budget footnotes or other legislative action that suspend or reduce the formula amount.

### *Workforce Development*

- Funding, staffing, and targeted strategies to expand and develop a skilled workforce to meet service demand across the continuum of care for SUDs and co-occurring mental health disorders.

## II. Additional Recommendations per Governor Hassan's Request for Information

Below are responses to Governor Hassan's October 2015 request for recommendations. The responses are a summary composite of responses provided by state agencies, members, and task forces of the Commission. For verbatim responses provided by respondents, please see Appendix A.

### RECOMMENDATIONS – Data Collection

What recommendations do you have for a comprehensive set of data points for the NH Information and Analysis Center to collect and disseminate to support our efforts to combat drug abuse and inform policy and programming at a state and regional level?

Responding agencies and task forces recommend the following:

- ✓ Youth Risk Behavior Survey (YRBS) data collection at the middle school level
- ✓ YRBS data collection in all NH high schools
- ✓ Analyses of YRBS data that are more comprehensive than standard 30-day use prevalence rates, such as studying mental health indicators and their relationship with substance misuse indicators
- ✓ Analyses of cases of individuals seeking but unable to find timely treatment and recovery services, of individuals seeking treatment in other states as a result of barriers in NH, and of the gap between available services and treatment need across all services in the continuum of care
- ✓ The financial impact of unmet needs within the continuum of care for substance use disorders
- ✓ Emergency room visits and EMS calls that involve alcohol or other drug use/misuse
- ✓ The number of recovery service providers by type and location; recovery service client flow, census, type, and frequency; treatment and recovery program delivery evaluation and patient outcomes; and the return on investment for adequate services
- ✓ Data on parents in treatment for SUDs who have been reunified with children involved with DCYF
- ✓ Criminal justice recidivism post-SUD treatment
- ✓ The number of pregnant and postpartum women who receive treatment at Opioid Treatment Programs (methadone) in the state; the number of pregnant and postpartum women seen in emergency rooms for substance misuse, addiction, and/or mental health disorders; the prevalence of newborns diagnosed with Neonatal Abstinence Syndrome; and the prevalence of women with substance use disorders (SUDs) being referred to SUD treatment from primary/prenatal care
- ✓ School climate and culture data; poverty, employment, and graduation rates; DCYF, JPPO, CASA and juvenile court diversion cases involving alcohol or drug misuse
- ✓ Location and frequency of drug arrests and the type and quantity of drugs being seized
- ✓ Include the following data in aggregate in NH Information and Analysis Center (NHIAC) reports: the number of Division of Children, Youth & Families (DCYF) cases involving parental substance abuse;

the number of parent deaths as a result of parental substance abuse for open cases; and the number of children impacted by parental substance use in DCYF cases

- ✓ Regular monthly reporting of overdose death data from the Medical Examiner's Office to the NHIAC; mandated reporting of all felony drug arrests to the NHOAC; regular reporting to NHIAC of all overdose cases reported by EMS
- ✓ Beginning in 2016, reporting denied insurance claims relative to substance use disorder services
- ✓ Leverage and integrate the roles and purveys of the SEOW and NHIAC to coordinate and integrate a comprehensive set of data indicators to measure and monitor change in substance misuse and SUD-related health and safety impacts and outcomes

## RECOMMENDATIONS – Prescription Drug Monitoring Program (PDMP)

What recommendations do you have relative to the type of reporting that should be available as a best practice for prescribers, dispensers, public health agencies, legislators, and the public?

Responding agencies and task forces recommend the following:

- ✓ Expedient access to de-identified, aggregate data available to an expanded range of stakeholders to address opioid concerns
- ✓ PDMP data should be available in real time and used by prescribers, should be mandatory for opioid prescribing.
- ✓ Use of aggregate PDMP data to inform substance misuse policies and programming

## RECOMMENDATIONS – Safe Prescribing

What recommendations do you have to ensure that prescribers are following best practices in the prescribing of opioids and what third-party payers, providers or other health care entities are doing to support those practices?

Responding agencies and task forces recommend the following:

- ✓ Mandatory use of the PDMP as a component of safe prescribing
- ✓ The continuation of efforts with the Board of Medicine to establish safe prescribing practices in light of the opioid crisis, including setting restrictions on opioid prescribing, exams to demonstrate provider knowledge of prescribing guidelines, and increasing prescriber training.
- ✓ Increased consumer education and information on risks as well as safe storage and disposal
- ✓ Mandatory annual prescriber training on addiction potential, prevention and prescribing guidelines
- ✓ Pharmacies could be mandated by law to advertise treatment and recovery support services

## RECOMMENDATIONS - Prevention Messages

What recommendations do you have relative to how New Hampshire's efforts to educate and publicize our prevention messages can be synchronized with other states' efforts in our region?

Responding agencies and task forces recommend the following:

- ✓ Special messaging for opioid users relative to the dangers of street fentanyl and certain myths related to use is critical. The Attorney General's office reports that there will be over 400 drug-related deaths in 2015, with many associated with the powerful illicit drug fentanyl. Opioid Task Force members reported that misinformation "on the street" needs to be counteracted with immediate and effective messaging relative to the following:

Fentanyl is 100 times more potent than heroin. The variability of the potency of street opioids when fentanyl and heroin are mixed in unidentified proportions is leading to unintended overdose deaths in all parts of the state and is the #1 contributor to the continued escalation in opioid overdose deaths in 2014 and 2015.

Fentanyl is being sold in various forms on the street, sometimes openly as fentanyl and sometimes as other opioids. It is being cut into or sold as heroin. Also, the Attorney General's office has reported that fentanyl has been pressed into pill form, stamped, and sold as oxycodone/Oxycontin to be able to garner a higher street value and/or to make the drug appear safer to use.

Snorting opioids of any kind rather than injecting does not reduce the risk of overdose nor reduce the likelihood of addiction.

Injection drug use can cause life-threatening infectious diseases including HIV/AIDs, Hepatitis C and bacterial endocarditis (potentially devastating heart infection) and can create other skin and system infections such as endocarditis that require medical attention. Messaging should continue to address stigma and how it impacts media coverage, health care, criminal justice and other domains.

- ✓ Messaging should educate the public about the biology/physiology of addiction.
- ✓ Messaging should promote recovery support services available.
- ✓ Education and outreach should be targeted to early childhood settings such as Early Headstart and Headstart to increase awareness of substance misuse and prevention and early identification services available. Awareness of services to improve family stability such as housing, employment, and parenting support are also important messages.
- ✓ Agencies and organizations across multiple sectors could commit to conducting at least one national awareness activity each month to promote prevention and education and to improve health outcomes overall; this combined support for message campaigns can show solidarity and support.
- ✓ Messages should target all age ranges from prenatal and neonatal through youth, adults and older adults.
- ✓ A speakers' bureau could be cultivated to promote guest speakers in schools, churches, hospitals, mental health clinics, police departments and other domains to spread consistent messages about prevention, early identification, treatment and recovery. This approach can engage the recovery community and help to reduce stigma.

- ✓ Standards, protocols and best practices relative to safe and appropriate messaging regarding substance misuse and addiction are needed. An initial action for this recommendation has been a “do’s and don’ts” document from SAMHSA’s Center for Applied Prevention Technology. The prevention task force recommends further work in this area, including a review of other states’ approaches to effective public education and awareness campaigns. Topic areas relative to preventing youth access to therapeutic cannabis and prescription medications should be included in message campaigns.
- ✓ A media blitz on heroin and fentanyl dangers is needed.
- ✓ A regional approach to public awareness facilitated by HRSA Region One Administrator is needed.
- ✓ Communication between states through linked databases using software such as CopLink and other resources that can address cross-border drug trafficking, health outcomes and other indicators is recommended.
- ✓ Expanded NHIAC data products in real-time are recommended.

## RECOMMENDATIONS - Treatment Programs

What recommendations do you have to identify opioid treatment programs to expand capacity for medication-assisted treatment services in border areas where additional service capacity is needed, and to determine whether New Hampshire’s treatment programs and service may be enhanced or improved by access to cross-border services?

- ✓ Full integration of recovery support services as an adjunct to treatment services should be mandated by state licensing and certification standards. Expand treatment and recovery services to ensure accessible, integrated service that meets demand across the state. See “Other Recommendations” on the following page relative to financial and technical support to expand peer recovery services.
- ✓ Expand clinical and other best practices for medication-assisted treatment (MAT) and use existing prescribers of medications to assist with SUD treatment as “champions of change.” Provide training and technical assistance to support MAT and remove “first fail” and prior authorization barriers to support appropriate clinical treatment.
- ✓ Integrate prenatal care with SUD treatment (including opioid treatment program), social supports and “life coaching” for pregnant and postpartum women with opioid use disorders as pregnancy presents high motivation for treatment. Such an approach to wrap around care in one integrated system for OBGYN/Midwifery/Family Practice and SUD treatment will improve care and outcomes for women and their newborns.
- ✓ Workforce development for prevention, early identification, treatment and recovery support services for both SUDs and mental health disorders, including a workforce working within other systems such as schools.
- ✓ Allow for people seeking opioid treatment (methadone) programs to receive services across state borders for Medicaid beneficiaries and those served by managed care organizations.
- ✓ Embed licensed alcohol and drug counselors in health care settings.

## RECOMMENDATIONS - Law Enforcement

What recommendations do you have relative to how communication, reporting, and information sharing between states can enhance the effectiveness of law enforcement activities as they relate to public health and safety concerns?

Responding agencies and task forces recommend the following:

- ✓ All community-level police, safety, State Police including highway safety should collect a common set of data points at the community, county, and regional level then aggregated to state level. A few years ago, NH had several suicides of men soon after being arrested for a DUI. This is an example of the risk intersection of substance misuse, mental health, and the legal system, and points to the need for collaboration and communication between the law enforcement community, Department of Transportation and the Public Health Network system. Such data analyses could utilize geo-mapping of substance misuse violations to share with the prevention community, relying on HIDTA and other federal partners to share their methods.
- ✓ The New Hampshire Attorney General's Drug Task Force continues to investigate and assist in the prosecution of drug traffickers. Many of the drug cases cross over into our neighboring states. The law enforcement community does a good job of communicating with one another regarding pending investigations. However, data relating to arrests and potential prosecution is not traditionally shared, either in-state or across state borders. A greater emphasis on data sharing and use of the New Hampshire State Police Information and Analysis Center (IAC) would greatly assist in protecting the public from drug-related crimes.

## RECOMMENDATIONS - Other

Responding agencies and task forces recommend the following:

- ✓ Financial and technical assistance investment in a robust, sustainable peer recovery support service network available in local communities, including investment in a facilitating organization to support recovery community organizations with administrative functions and reporting requirements.
- ✓ NH DHHS/DCYF requests an appropriation of funds to have Licensed Alcohol and Drug Counselors (LADCs) hired for additional offices in the north, east and west regions of the state. DCYF currently has LADCs in two offices, Manchester and Southern Nashua.
- ✓ Continue to disseminate and support the *Top 5 Actions for Schools* publication and Life of an Athlete program to support school-based prevention and policy development, with educator involvement in recommendations and technical assistance.

### III. Updates Per Governor Hassan's Request for Information

Below are responses to Governor Hassan's October 2015 request for activity updates. The responses are a summary composite of responses provided by state agencies, members, and task forces of the Commission. For verbatim responses provided by respondents, please see Appendix A.

#### UPDATES – SUD Services

What is the status of substance use disorder services and coverage in the state?

##### *Prevention & Early Identification*

- The state's Regional Public Health Network (RPHN) continues to provide environmental prevention efforts, mobilizing communities and supporting best practice adoption across multiple community sectors in the thirteen regions of the state. Federal block grant funds support full-time prevention coordinator positions in each region.
- Twenty-five schools have Student Assistance Programs (SAPs) for school-based prevention education and early identification and referral for students at high risk for substance misuse as result of federal Partnership for Success (PFS) funding. Two colleges also participated in PFS activities over the last several years. New funding in the amount of \$2.1M per year beginning this fall will fund additional SAP programs and an assessment of young adult risk behavior, a population of highest risk behavior in the state. Based on assessment findings, federal funding will go to community-based young adult prevention and early identification.
- SAP counselors are also available in three high-need schools (Rochester, Laconia, and Concord) through the Department of Education's Safe School Healthy Student initiative, a multi-year, federally-funded grant program.
- Life of an Athlete continues to be supported by the New Hampshire Interscholastic Athletic Association with funding from the Commission and the New Hampshire Charitable Foundation. It is currently operating in over 50 schools.
- Screening, Brief Intervention and Referral to Treatment (SBIRT), a best practice for a public health approach to substance misuse prevention and early identification, will be operational in all state Community Health Centers (CHCs) in 2016. This best practice adoption has been supported financially and through technical assistance by the NH DHHS Bureau of Drug and Alcohol Services (BDAS).

##### *Treatment Services*

- The New Hampshire Health Protection Program (NHHPP) provides a comprehensive array of SUD treatment services, including outpatient, intensive outpatient, partial hospitalization, low and high intensity residential and other treatment services as well as ambulatory and inpatient withdrawal management (detox) and medication-assisted treatment. NHHPP provides these services for those at or below 138% of the federal poverty level and who register for the program.

Current coverage (NHHPP bridge program) is through Medicaid Managed Care entities (MCOs); however, starting in January of 2016, the NHHPP population will be covered through qualified health plans (QHPs), which are private market insurance plans. The QHPs are required as part of the Essential Health Benefits to cover SUD treatment services, but the terms of coverage (networks, preauthorization requirements, etc.) will be those of the insurance carrier offering the QHP, subject to regulation by the NH Insurance Department.

Thus, the process for NHHPP enrollees to access these services in 2016 will likely be somewhat different from the process for accessing them under the bridge program. NH DHHS has convened a workgroup to extend this SUD benefit array to the regular Medicaid program in SFY 2016.

- Medication-Assisted Treatment (MAT), a best treatment practice particularly for opioid use disorders, has expanded in the public and private landscape. Six of the state's CHCs are currently offering MAT to some degree (Perinatal Substance Exposure Task Force). BDAS initiated an expert panel of health care providers with expertise with MAT to design a guidance document for medical practices to use to move toward integrated MAT. This guidance and companion technical assistance and financial support will be available in 2016. BDAS has also provided funding this year to existing treatment programs to expand services to include MAT.
- NH DHHS made resources available for the first time for Medication Assisted Treatment (MAT) in new substance use disorder treatment service contracts slated to commence April 1, 2016, will be releasing an RFP in early 2016 for capacity development for specialty SUD treatment services and in January of 2016 will be releasing an RFP for community-based recovery support services.
- A success this year was the inclusion of licensed alcohol and drug abuse counselors in the state's tuition loan repayment program that went into effect this summer. Over time, this may support an expanded work force needed to expand treatment access. However, the Treatment Task Forces notes that the transition to third-party reimbursement for state-funded SUD treatment providers has been arduous, and providers will need continued support during the transition to the private insurance marketplace.
- The Division for Children Youth and Families (DCYF) has two licensed alcohol and drug abuse counselors (LADCs) in two district offices. Juvenile Probation and Parole Officers (JPPOs) have the authority to ask the court to order random drug screening for substance use, and the Sununu Youth Center screens and provides treatment for substance use disorders at their facility.

#### *Recovery Support Services*

- Recovery support services remain the most inadequate and vulnerable of services that are critical for an effective service array to help those affected by substance use disorders (SUD). Although prevention and treatment services are also inadequate in the state, recovery support services do not have a structure within which to develop sustainable funding, work force development, and accessible services. The state needs a comprehensive plan with requisite technical assistance, designed by those in recovery, to establish and fund such a system.

#### *Other Services and Supports*

- The state purchased approximately 5,000 naloxone kits that are being made available for free through the state's CHCs, some hospital emergency rooms, and through community events being held in partnership with the RPHN system. This naloxone training and distribution initiative is a joint effort of NH DHHS and the Department of Safety.
- The Department of Insurance oversees commercial insurance policies and their compliance with the Mental Health Parity and Addiction Equity Act coverage requirements for treatment mental health and substance use disorders as any other illness.
- This spring, additional funding was allocated to the RPHN to fund full-time facilitators in each region to identify and address gaps across the continuum of care including treatment and recovery support services.
- AnyoneAnytimeNH is a comprehensive public awareness campaign that began development in SFY 2015. The campaign provides information to the public and opioid addiction, treatment and recovery as well as the state's naloxone distribution initiative to reverse opioid overdose.

## UPDATES – Law Enforcement

What is the status of law enforcement initiatives relative to opioid addiction?

- The Department of Education is in early communications with the state police chief's association and local enforcement to create a two-year school resource officer initiative.
- The NH Department of Justice has continued training and outreach with the medical provider community to build awareness of drug diversion, harmful access, safety impacts, and coordinated response to protect the public.
- The Attorney General's office and the NH Board of Medicine has worked together to draft rules related to opiates.
- The Attorney General's Drug Task Force continues to investigate drug traffickers, allocating federal Byrne grant funds to the state forensic lab to address the backlog of drug testing needed for court matters. Funding from this grant has also been directed to Operation Granite Hammer which targets drug crimes in the City of Manchester.
- The Administrative Prosecution Unit continues to investigate drug diversion and on-the-job impairment of licensed health care professionals for disciplinary action by licensing boards.
- The Medicaid Fraud Control Unit continues to investigate and prosecute fraud by providers that treat Medicaid beneficiaries and to prosecute instances of drug diversion by health care professionals.
- The Department of Safety's Division of State Policy and Narcotics and Investigations Unit are addressing the opioid crisis through enforcement and undercover operations. Small-, mid-, and upper-level dealers and drug traffickers are all a focus for investigation and enforcement. The drug diversion unit works closely with the PDMP to move toward greater law enforcement access to the program.
- A Mobile Enforcement Team (MET) of three troopers focusing on criminal patrol in known opioid trafficking hot spots in the state. Two troopers are also assigned to work with the New England High Intensity Drug Trafficking Area (HIDTA) initiative to reduce drug availability by disrupting drug trafficking organizations. One trooper is assigned to the U.S. Drug Enforcement Agency (DEA)'s Tactical Diversion Squad in Portsmouth to investigate, disrupt, and dismantle those suspected of violating federal, state or local statutes pertaining to the diversion of illicit pharmaceutical controlled substances.

## UPDATES – Prescription Drug Monitoring Program (PDMP)

What is the status of prescription drug monitoring program?

- NH's PDMP went live on October 16, 2014, and licensed practitioners (pharmacists and all prescribers with a DEA number) were required to register with the NH PDMP and receive credentials to access patient control history prior to prescribing and/or dispensing schedule II, III and IV control substances.
- Licensed dispensers began to register with the system and to upload data in two phases: Sept. 2, 2014 and Sept. 30, 2014. Data collection was retroactive six months to March 1, 2014.
- At the time of the PDMP Annual Report in Sept. 2, 2015 – just shy of the first year of implementation, the following number and percentage of practitioners were registered: 928 or 99% of dentists; 5,478 or 87% of physicians; 1,456 or 82% of APRNs; 463 or 75% of physician assistants; 198 or 73% of optometrists; 63 or 61% of podiatrists; 203 or 22% of veterinarians; and 1,665 or 65% of pharmacists

- Furthermore, 237 of the 311 (76%) resident pharmacies were registered and reporting into the database and 200 of 614 (33%) non-resident pharmacies were registered and reporting into the database.
- The total number of patients that filled Schedule II, III, IV prescriptions between April and June of 2015 was 263,031. The total number of Schedule II, III, IV doses dispensed between April and June 2015 was 30,397,408.
- Number of Patients meeting or exceeding five prescribers and five pharmacies between April and June 2015 was 25.
- Funding was awarded by the Harold Rogers federal grant for another 18 months in the amount of \$500,000. The focus for the next grant period includes:
  1. Interstate Data Sharing
  2. Education Reports to prescribers and pharmacists
  3. Data collection of de-identified/aggregate data for public health reporting
  4. Pilot project with Drug Courts
  5. On-going registration and data compliance

## UPDATES - Prescribing Standards

What is the status of prescribing standards for opioids?

- The Attorney General’s office has worked with the Governor’s office and Board of medicine in drafting emergency rules related to opiate prescribing. Following the adoption of the emergency rules, the Board of Medicine began drafting permanent rules. The Commission is supportive of this ongoing process.

## UPDATES - Addiction Education

What is the status of addiction education?

- Recovery coach training is active in the state and being facilitated by a variety of individuals and entities. A messaging training developed by Faces and Voices of Recovery, “Our Stories Have Power,” is being provided in the state to increase advocacy activity.
- A new public awareness poster relative to Fetal Alcohol Spectrum Disorders, or FASD, was developed and is being disseminated to all state liquor stores and eventually to other alcohol retailers. This was a joint project of the NH DHHS’ Department of Public Health Services, the NH Liquor Commission and the March of Dimes NH chapter.
- Through the Department of Education’s Safe School Healthy Student project and the NH DHHS’ Bureau of Drug and Alcohol Services (BDAS) Partnership for Success project, Student Assistance Program (SAP) counselors provide prevention education to students in a universal approach as well as intensive supports to high-risk groups and individual counseling. These programs are in a combined 28 schools and two colleges. These efforts are hampered; however, by a noted shortage in a workforce. The NH DHHS’ BDAS provided thirteen trainings on addiction and recovery to 662 participants this fiscal year. BDAS also contracts with the NH Training Institute on Addictive Disorders who provided 25 training events for SUD service practitioners to a total of 1,125 participants. The training contractor also offered and archived five webinars that are available on demand. BDAS’ Clearinghouse and Lending Library also provided print audiovisual and curricula materials for community events.

## UPDATES - Data Collection

### What is the status of data collection?

- HOPE for NH Recovery reports collecting data relative to recovery support services being delivered in NH; however, these data have not yet been shared. The Department of Education is collecting data via the Youth Risk Behavior Survey (YRBS) to evaluate programming and monitor youth risk behavior and perception trends in the state.
- The NH BDAS incorporates National Outcome Measurements (NOMs) in its procurements for prevention, treatment and recovery services to understand the effectiveness of programs. BDAS also collects data for the federally mandated Treatment Episode Data Set (TEDS), a national census data system of annual admissions to substance abuse treatment facilities. BDAS also supports the YRBS, a program of the U.S. Centers for Disease Control and Prevention (CDC) that monitors six categories of health risk behaviors among youth including tobacco use, alcohol and other drugs. BDAS is working in collaboration with the Department of Education and the Division of Public Health Services to publish these data. BDAS also collects and analyzes data via the Web Interactive Treatment System (WITS) that provides information on prevention and treatment process and outcome measures, supported by the State Epidemiological Outcome Workgroup (SEOW).
- NH DHHS makes these and other substance use related data available through the new alcohol and drug module on the WISDOM data site.
- BDAS is also one of several entities that provide data to the NH Information and Analysis Center (NHIAC) at the Department of Safety that provides a comprehensive overview of substance misuse and intelligence on illicit drug threats on a quarterly basis.
- The Department of Safety's NHIAC through the NH Drug Monitoring Initiative analyzes data collected by NH DHHS relative to emergency department visits related to heroin use; by the Bureau of Emergency Management Services relative to Narcan administrations; BDAS relative to treatment admissions for heroin and other opiates; and the NH Medical Examiner's office for drug overdose deaths. NHIAC is also in the early stages of an initiative to collect felony drug arrest data from local police departments.

## IV. Substance Use Related Expenditures for State Fiscal Year 2015

### SECTION IV: FINANCIAL EXPENDITURE QUESTIONS

Each year state agencies and departments represented on the Commission are required to report on state and federal expenditures related to alcohol and other drug services and initiatives. The tables below show expenditure information as reported by the Commission member agencies for SFY 2015.

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2015 in whole or in part by state or federal funds.

| Commission Agency Response                            | Name of Program or Service               | Primary Service Category | Address Rx/ opioid abuse? | SFY 2015 Funds allocated to this program or service | Is this Federal or State/ General funding? | Estimated or actual? | Description Notes/Comments  |
|---|--|--------------------------|---------------------------|---|--|----------------------|---|
| DHHS-Division for Children, Youth and Families (DCYF) | Individual Outpatient Counseling         | Treatment                | Yes                       | \$6003.39   | General                                    | Actual               |   |
|   | Residential Treatment Facilities         | Treatment for Juveniles  | Yes                       | \$114,441.06  | Federal \$93,206.82<br>General \$21,234.54 | Actual               |   |
|   | Drug Testing                             | Intervention             | Yes                       | \$31,446.17   | General                                    | Actual               |   |
|   | Licensed Alcohol & Drug Abuse Counselors | Intervention             | Yes                       | 121,385.31  | Federal Title B subpart 1                  | Actual               |   |
| Attorney General/ Department of Justice (DOJ)         | Enforcing Underage Drinking Laws         | Prevention               |                           | \$100,335*  | Federal                                    | Actual               | Expired   |
|   | Residential Substance Abuse Treatment    | Treatment                |                           | \$51,068 (*67%)                                     | Federal 67%<br>State 33%                   | Actual               | Ends 9/30/2018  |
|   | Swift & Certain Sanctions                | Recovery                 |                           | \$370,000 (*55%)                                    | Federal 55%<br>State 45%                   | Actual               | Ends 9/30/2016  |
|   | Prescription Drug Monitoring Program     | Intervention             |                           | \$400,000*  | Federal                                    | Actual               | Ends 3/31/2016  |
|   | Regional Drug Task Force                 | Prevention               | Yes                       | \$379,710   | General 46%<br>Federal 54%                 | Actual               |   |
|   | Drug Task Force                          | Prevention               | Yes                       | \$514,956   | Federal                                    | Actual               |   |
|   | National Forensic Science Improvement    | Intervention             |                           | \$31,500*   | Federal                                    | Actual               | Ends 9/30/2016; provides overtime for drug analysis backlogs – state forensic lab |
| Department of Corrections (DOC)                       | Licensed Alcohol Drug Counselors         | Treatment                |                           | \$737,041   | General                                    | Actual               |   |

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2015 in whole or in part by state or federal funds.

| Commission Agency Response                             | Name of Program or Service             | Primary Service Category                            | Address Rx/ opioid abuse? | SFY 2015 Funds allocated to this program or service | Is this Federal or State/ General funding? | Estimated or actual? | Description Notes/Comments  |
|--|--|---|---------------------------|---|--|----------------------|---|
| Department of Education (DOE)                          | Safe School Health Students Initiative | Prevention<br>Intervention<br>Treatment<br>Recovery | Yes                       | \$2.2 million*                                      | Federal                                    |                      | This is obligated funds to 3 local education agencies (LEAs).   |
|  | Project AWARE                          | Prevention  | Yes                       | \$1.75 million*                                     | Federal                                    |                      | This is obligated funds to 3 LEAs<br>Note: Project AWARE is heavily prevention focused. There is a large focus on developing a positive school climate and culture, coordinating efforts across agencies to connect youth and family with appropriate services, and training. These all develop protective factors which impact prevention, intervention, treatment and recovery. |
| DHHS Bureau of Drug and Alcohol Services (BDAS)        | Treatment Services                     | Treatment   | Yes                       | \$8,978,909   | Federal 57%<br>General 43%                 |                      |   |
|  | Prevention Services                    | Prevention  | Yes                       | \$3,415,258<br>(*75%)                               | Federal 75%<br>General 25%                 |                      |   |
|  | ATR services                           | Treatment   | Yes                       | \$770,976*  | 100% Fed                                   |                      |   |
| Department of Safety (DOS)<br>Division of State Police | DARE Program                           | Prevention  | No                        |   |  | N/A                  | This program is run with donations and often taught by officers with many other collateral duties. The program should be state funded with professional instructors.<br><br>This school focuses on alcohol and tobacco use. This program should also focus on marijuana and opioid abuse.   |
|  | Marijuana Eradication Grant            | Enforcement   | No                        | \$0   | Federal                                    | \$20,000             | Strictly for Marijuana Grow related investigations; ends 12/31/2015   |
|  | Pharmacist Board Compliance Inv./Insp. | Enforcement   | Yes                       | \$104,265   | State – No<br>General funding              | Actual               | Provides funding for a Pharmacist who assists with Diversion Investigations   |

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2015 in whole or in part by state or federal funds.

| Commission Agency Response   | Name of Program or Service                            | Primary Service Category | Address Rx/ opioid abuse? | SFY 2015 Funds allocated to this program or service | Is this Federal or State/ General funding? | Estimated or actual? | Description Notes/Comments  |
|--|---|--------------------------|---------------------------|---|--|----------------------|---|
|  | NHSP Forensic Laboratory                              | Enforcement              | Yes                       | \$2,139,000   | State - No General funding                 | Estimated            | Provides analytical results for all drug case submissions (raw material) and impaired driving/post-mortem testing   |
| Adj. General/ NH National Guard  | Counterdrug Task Force                                | Prevention               | Yes                       | \$126,000   | Federal                                    | Estimated            | Counterdrug Task Force Civil Operations Specialist working with BDAS, Regional Public Health Networks, and Community Coalitions to reduce the demand for illicit drugs. |
|  | Counterdrug Task Force                                | Intervention             | Yes                       | \$524,000   | Federal                                    | Estimated            | Counterdrug Task Force Criminal Analysts working with federal, state, and local law enforcement agencies to reduce the supply of illicit drugs.                         |
| NH Liquor Commission   | Buyers Beware Campaign<br>Make Right Choices Campaign | Prevention/<br>Awareness | No                        | \$100,000   | General                                    | Actual               | Included in the NHSLC marketing and advertising budget.   |
| <b>TOTAL ALL</b>   |   |                          |                           | <b>\$22,859,956</b><br>(\$17.23 per capita)         |  |                      |   |
| <b>TOTAL NON-DISCRETIONARY</b><br>(Less competitive federal grants noted*) |   |                          |                           | <b>\$16,670,313</b><br>(\$12.56 per capita)         |  |                      |   |

## Dedication & Acknowledgements

The Commission dedicates this report to the hundreds of individuals who have lost their lives to substance misuse and addiction and to the families who grieve for them. We recognize that substance misuse and addiction are not a disorder or disease of an isolated few but a life-threatening disease that affects many from every walk of life. We stand committed to continuing to reduce the stigma that has long challenged the resourcing and attention required to effectively prevent and treat this disease and to continuing a collective call for significant leadership, resources, and other investments to protect the well-being and safety of our citizens and communities.

The Commission extends its deepest gratitude to Governor Hassan and the New Hampshire Legislature for the leadership and commitment exhibited relative to the state's opioid overdose crisis and the on-going challenges of providing adequate substance use disorder services across the continuum of care. The Commission also extends its heartfelt gratitude to its members, task forces, stakeholders, state agency staff, advocates, people in recovery, family members of those experiencing addiction, and so many individuals who have provided testimony and input into the challenges faced by our citizens and into the opportunities we all have to make a difference in preventing addiction and promoting recovery. The Commission also thanks the NH Center for Excellence staff at the Community Health Institute for data gathering, coordination, and drafting of this report.

# APPENDIX A: AGENCY AND TASK FORCE AGGREGATE RESPONSES TO ANNUAL REPORT QUESTIONNAIRE

## SECTION I: GOVERNOR PRIORITY QUESTIONS *(State Agencies/ Departments and Task Forces).*

**PLEASE NOTE:** The Opioid Task Force and its Health Care Workgroup provided its response to the request for information for the annual report in alternative formats. Their input is included at the end of this section.

### STATUS UPDATES REQUESTED

| 1. What is the status of substance use disorder services and coverage in the state? |   |
|---|---|
| Recovery Task Force   | <p>Recovery Services are not adequate to meet New Hampshire’s need. The same is true of addiction treatment and prevention services. It is important to note; however, that treatment and prevention services have established funded and fundable relationships with a variety of partners including but not limited to NH DHHS and the Governor’s Commission. Since the delivery of actual recovery support services as a viable and sustainable enterprise is in its embryonic stages without the fiscal infrastructure in place to sustain these services as a permanent part of the prevention, treatment, and recovery continuum, the state of recovery services in New Hampshire is not only insufficient to meet the needs of New Hampshire residents, it is also in an extremely vulnerable position. As a result, it is recommended that delivery and infrastructure needs of recovery services be given acute attention over the next several years. It is important to recognize that the establishment and sustenance of recovery support services relies heavily on grassroots supports and the development of a peer-recovery support model. Without recovery capitol, any recovery-based services will falter or fail. In order for the recovery support services to succeed in New Hampshire, significant efforts need to be made to enable organization growth and strengthening. Peer-based recovery capitol and recovery support services are mission critical for New Hampshire to correct its course and provide improved addiction remedy services in New Hampshire. It would be wise to convene a group of key stakeholders from the recovery community and discuss the development of a systematic plan for ongoing development of these services in the state. Long-term technical assistance needs to be offered to the development of a consumer-driven model of recovery service delivery. History has offered NH a unique opportunity to grow and develop peer-based recovery support services that could actually affect significant outcomes that improve the addiction remedy system in the state. Persons associated with the recovery movement across the state have reported concern about the lack of services for persons seeking treatment. Individuals have also indicated that they encourage persons seeking detoxification services to go to neighboring states and provide inaccurate information about residency and housing status as a way of accessing detoxification services in those states. This practice can be seen as a significant data point for consideration. There must be significant effort to address the issue of insufficient medical detoxification resources in the state. A more scientific response to this question would rely on data that either does not exist or has not been made available to Governor’s Commission. It is recommended that NH officials measure the gap between treatment services available and treatment need across the continuum of treatment and recovery modalities (i.e. recovery support centers, recovery supportive housing, adult and adolescent detox, IOP, inpatient, outpatient, housing services, etc.). This data would enable communities to develop more strategic responses to their specific and identified needs. Further, it would also be helpful to measure emergency room presentations and PD/FD/EMT calls for service that involves alcohol and drug misuse. The compilation and analysis of this data would permit a more accurate and meaningful response to this question. Without that data, respondents are relying on anecdote and innuendo to inform policy and practice. Given the intensity of need and the seriousness of substance misuse in NH, it would appear that serious attention should be given to shared data among and between all task forces, state departments, and other key</p> |

| 1. What is the status of substance use disorder services and coverage in the state? |   |
|---|---|
|   | <p>stakeholders. SAMHSA makes data available to quantify the gap between treatment need and treatment services. There are approximately 24,000,000 people in need for treatment and 2.4 million treatment slots available. The 90% gap between need and services is an issue of social justice. Further, the disparity between need and services could also contribute to increased need. If people who need services cannot get services, then the medical, social, and economic impact of their untreated substance misuse will increase in magnitude thereby putting more burden on an already underfunded system. Some questions remain for consideration. Is the treatment need/treatment service availability gap in NH greater or lesser than the national average? Are there any states that are closing the gap? If so, how? What is the best course of action for New Hampshire to close the gap? What services are needed in what communities that will have the most significant impact on closing this gap? How will progress be measured and reported? / Data driven responses to these questions is essential for the NH to more accurately appraise the state of addiction in New Hampshire. The development of a scientific response to addiction in New Hampshire is not beyond our reach. All that is left is for us to agree to move forward with intention and diligence until we have struck a balance between need and resource that encourages us toward a more encouraging future for addiction remedy in the state.</p> |
| Treatment TF  | <p>Treatment Taskforce continues to work on workforce development in order to increase the status of SUD services available across the state. The Taskforce worked closely with the Department of Public Health to assist in initiating the addition of SUD professionals (MLADC and LADC) to the state's Educational Loan Reimbursement Program. This initiative will increase the workforce capacity by providing incentives for employment with a SUD provider, thereby increasing the capacity for treatment programs. SUD Treatment Providers across the state have worked diligently with the support of the NH Providers Association, Governor's Commission Treatment Taskforce, NH Center for Excellence and the Medicaid Stakeholders Workgroup to support and educate in the process of becoming Medicaid providers over the past year. This transition to third-party reimbursement has been an arduous transition for most SUD treatment providers; however, with technical support treatment providers have been able to transition to accepting NHHPP eligible participants in need of SUD services. Continued support is on-going as the treatment providers are now transitioning to the private insurance marketplace for NHHPP participants.</p>  |
| Perinatal Substance Exposure TF   | <p>SBIRT is implemented in all Community Health Centers.<br/>MAT is now available in six of 15 Community Health Centers.</p>  |
| DOE   | <p>Through the Safe Schools/Healthy Students grant there are SAP counselors in Rochester, Laconia and Concord school districts. Rochester and Concord SDs have funding to be able to support LADCs in their school system; however, due to the critical workforce shortage they are unable to fill these positions. Also, via the SS/HS and PA grants there are behavioral health counselors embedded into the school system. They support all students (universal), identified small groups of students (intensive supports) and individuals (treatment).</p>  |
| DHHS-DCYF   | <p>DCYF assesses parental substance use as part of the assessment of reports of child maltreatment. Parents are referred to treatment services when substance use/abuse is impacting safety of their child. When danger is identified, children may be removed from parental care if it is determined the parents use/abuse is placing them in danger or the child is very likely to suffer serious impairment. DCYF has LADCs in two district offices, Manchester &amp; Southern (Nashua), who provide consultation to assigned Child Protection Workers (CPSWs). They serve as a bridge to local treatment for clients who avail themselves of their service.<br/>DCYF Juvenile Probation &amp; Parole Officers (JPPOs) have the authority to ask the court to order random drug screening of youth involved in the juvenile justice system. DCYF Sununu Youth Services Center assesses all youth upon admission for substance use and provides substance abuse treatment at the facility.</p>  |
| DHHS-BDAS   | <p>Prevention Services: Regional Public Health Networks (RPHNs) are completing their three-year strategic prevention plan as of 1/1/2016 and Community Health Improvement Plans (CHIPs). Both plans align with the Ca/CI and State Health Improvement Plan (SHIP). Plans. Each region has two full-time staff: Substance Misuse and Continuum of Care. Statewide Public Awareness Campaign (Anyone Anytime NH) being implemented that provides information to the general</p>   |

| 1. What is the status of substance use disorder services and coverage in the state? |   |
|---|---|
|   | <p>public about opioid addiction, treatment and recovery, as well as the state’s Naloxone initiative to reverse opioid overdose. The NH Health Protection Program (NHHPP) provides a comprehensive array of benefits for substance misuse early identification / intervention services and specialty substance use disorder (SUD) treatment services, including outpatient, intensive outpatient , partial hospitalization, low and high intensity residential treatment services, ambulatory and inpatient withdrawal management (previously known as medical detoxification services) as well as medication- assisted treatment (MAT), for individuals that qualify for this program (that are below 138% of poverty, etc.). The NHHPP program will be made available through qualified health plans (QHPs) starting in January of 2016. It’s not known at this time whether or not each of the QHPs will offer the same SUD benefit package as offered under the state run NHHPP. The NH Department of Health and Human Services has convened a workgroup to extend the SUD benefit made available under the NHHPP to the regular Medicaid program in state fiscal year 2016. NH DHHS/BDAS provided all of the Community Health Centers (CHCs) to develop capacity to provide SBIRT for adult patients. All of CHCs are or will begin offering SBIRT in SFY16. RFP for NH DHHS/BDAS SUD Treatment contracts posted (for period beginning 4/1/16). Medication-Assisted Treatment (MAT) to address opioid addiction included in NH DHHS/BDAS SUD treatment contracts for the first time for period starting 4/1/16. NH DHHS/BDAS, with support from Center for Excellence technical assistance contractor has convened an expert panel of physicians to outline s strategy for developing capacity for medication-assisted treatment (MAT) services in the state and will be releasing a guidance document titled “Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire” in sometime in December or early January of 2016. NH DHHS/BDAS will be releasing an RFA for Peer Recovery Support Services in January of 2016 with Federal Block Grant and Governor’s Commission funding (part of a public /private venture with the New Hampshire Charitable Foundation (NHCF) to build capacity for peer recovery support services in New Hampshire). NH DHHS/BDAS will be contracting for a pilot Regional Access Point for SUD treatment services with funding allocated for this purpose by the Governor’s Commission. NH DHHS/BDAS will be releasing an RFP for SUD Treatment Expansion in January 2016. NH DHHS (Drug &amp; Alcohol Services /Emergency Services Unit/Public Health) is working closely with the Bureau of Emergency Services (BEMS at the Department of Safety) and external stakeholders (with support from the Attorney General’s Office) to implement the statewide “Naloxone Training and Distribution Initiative”, utilizing federal funding administered by the Bureau of Drug and Alcohol Services. This effort was put in place following the passage of HB 271 (making Naloxone more broadly available through prescriptions and standing orders and offering certain immunities from liability), with the objective of making Naloxone kits and related training more readily available to police departments that choose to become certified, community-based health and social services agencies that come in frequent contact with individuals at risk for opioid overdose, these individuals themselves, their families and friends. Five thousand Naloxone kits have been purchased and are in the process of being distributed by the Emergency Services Unit at NH DHHS to the institutions identified above and at community events facilitated by the RPHNs under contract with NH DHHS.</p> |
| Insurance Dept.   | Commercial insurance policies for individual, small group and large group issued must be compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA) coverage requirements that treat Mental Health and Substance Abuse (MH/SA) as any other illness.   |

| 2. What is the status of law enforcement initiatives relative to opioid addiction? |  |
|--|--|
| Recovery TF  | Officer Eric Adams efforts with the Laconia Police Department appear to be an effective response to substance misuse in the Lakes Region. Further integration of recovery-based services within this model should be explored. |
| DOE  | Early communications with state police, Chief of Police Association and local law enforcement on creating a two-year project for school resources officers. Impact of Opioid addiction will be                                 |

| 2. What is the status of law enforcement initiatives relative to opioid addiction? |   |
|--|---|
|  | part of the project.  |
| AG/DOJ   | The New Hampshire Department of Justice has continued training and outreach within the medical provider community to build their awareness of drug diversion, harmful access, safety impacts and to develop coordinated responses that protect the public. In supporting that goal, members of the department have worked closely with the Governor's office and the Board of Medicine in drafting rules related to opiates. The New Hampshire Attorney General's Drug Task Force continues to investigate drug traffickers, which increases public safety and decreases access to diverted and/or illicit drugs. Moreover, this helps in reducing illegal and harmful access to addictive substances, including opiates—heroin, fentanyl and prescription drugs. The Drug Prosecution Unit continues to prosecute drug-related cases, with a primary focus on opiate cases. Most recently, the department allocated funding from the Byrne JAG grant to the New Hampshire Department of Safety Forensic Laboratory to address the backlog of drugs that needed to be tested for court matters. The funding has allowed the laboratory to work additional hours to attempt to alleviate the backlog. The department used additional monies from the aforementioned grant for Operation Granite Hammer, which targets drug crimes in the City of Manchester. The Administrative Prosecution Unit continues to investigate drug diversion by and on-the-job impairment of, licensed health care professionals and to seek disciplinary action by the licensing boards. Finally, the Medicaid Fraud Control Unit continues to investigate and prosecute fraud by providers that treat Medicaid beneficiaries, and prosecute instances of drug diversion by health care professionals.  |
| Dept. of Safety  | The Department of Safety, Division of State Police continues to address opioid addiction through enforcement initiatives and has had significant successes on many fronts. The Narcotics and Investigations Unit conducts undercover operations into the trafficking of opioids in the state. This unit has been focusing on not only mid- to upper-level dealers but is also targeting smaller dealers who are often times trafficking narcotics in order to support their own addictions. The Drug Diversion Section of the Narcotics and Investigations Unit, which is comprised of sworn personnel and a civilian pharmacist, routinely provides training to local agencies who request it as well as the medical community in regards to identifying diversion and abuse. Furthermore, the Drug Diversion Section is working closely with the Prescription Drug Monitoring Program (PDMP) in order to tighten up the current law which would allow law enforcement more access to the program. Several dozen cases involving prescription fraud were investigated during SFY2015 as a result of focusing on diversion activities involving prescription medications. Additionally, the Division has established a Mobile Enforcement Team (MET) consisting of three troopers who are focused on criminal patrol including the transportation of opioid type drugs. The MET continues to provide support to local law enforcement agencies in known hot spots throughout the state. The Division also has assigned two troopers to the New England High Intensity Drug Trafficking Area (HIDTA), which is tasked with reducing drug availability by disrupting drug trafficking organizations, and one trooper to the DEA's Tactical Diversion Squad (TDS) in Portsmouth, which provides an innovative effort to investigate, disrupt and dismantle those suspected of violating federal, state or local statutes pertaining to the diversion of licit pharmaceutical controlled substances. The DOS and NHSP administration have attended numerous round tables and town hall meetings that have been held over the past year to offering guidance, support and suggestions for improvement on issues involving substance abuse. |

| 3. What is the status of prescription drug monitoring? |  |
|--|--|
| PDMP   | New Hampshire's PDMP went live on October 16, 2014, and licensed practitioners (pharmacists and all prescribers with a DEA number) were required to register with the NH PDMP and receive credentials to access patient controlled history prior to prescribing and/or dispensing schedule II, III and IV control substances. Licensed dispensers began to register with the system and to upload data in two phases: Sept. 2, 2014 and Sept. 30, 2014. Data collection was retroactive six months to March 1, 2014. |

**3. What is the status of prescription drug monitoring?**

|  |   |
|--|---|
|  | <p>At the time of the PDMP Annual Report in Sept. 2, 2015 – just shy of the first year of implementation, the following number and percentage of practitioners were registered: 928 or 99% of dentists; 5,478 or 87% of physicians; 1,456 or 82% of APRNs; 463 or 75% of physician assistants; 198 or 73% of optometrists; 63 or 61% of podiatrists; 203 or 22% of veterinarians; and 1,665 or 65% of pharmacists. Furthermore, 237 of the 311 (76%) resident pharmacies were registered and reporting into the database and 200 of 614 (33%) non-resident pharmacies were registered and reporting into the database. The total number of patients that filled Schedule II, III, IV prescriptions between April and June of 2015 was 263,031. The total number of Schedule II, III, IV doses dispensed between April and June 2015 was 30,397,408. Number of patients meeting or exceeding five prescribers and five pharmacies between April and June 2015 was 25.</p> <p>Funding was awarded by the Harold Rogers federal grant for another 18 months in the amount of \$500,000. The focus for the next grant period includes:</p> <ol style="list-style-type: none"> <li>1) Interstate Data Sharing</li> <li>2) Education Reports to prescribers and pharmacists</li> <li>3) Data collection of de-identified/aggregate data for public health reporting</li> <li>4) Pilot project with Drug Courts</li> <li>5) On-going registration and data compliance</li> </ol> |
|--|---|

**4. What is the status of prescribing standards for opioids?**

|        |  |
|--------|--|
| AG/DOJ | Members of the department have worked closely with the Governor’s office and the Board of Medicine in drafting rules related to opiates. |
|--------|--|

**5. What is the status of addiction education?**

|                     |   |
|---------------------|---|
| Recovery TF (RTF)   | <p>At this point recovery coach training is being done by a variety of individuals and entities throughout the state. There are also several individuals who are doing versions of a messaging training developed by Faces and Voices of Recovery: “Our Stories Have Power” is a training designed to increase advocacy activity. At this point, there is little evidence that either of these training programs are being disseminated in any kind of strategic fashion. Outcome data, if it exists, is not being shared with RTF or the Governor’s Commission. It would be wise to explore whether or not these trainings produce measurable outcomes or effect positive impact on access to treatment, increased advocacy activity, stigma reduction, increased public awareness and education. Further, it would also be recommended that persons who are interested in these trainings be connected to other education and public awareness initiatives, like the Partnership for a Drug Free New Hampshire. A longitudinal study tracks training outcomes is warranted. Tracking the number of people who are trained, where they are trained, post-training, recovery coach activities, local impact, and other key attribute data related to this work must be collected and made available for analysis. Without having a plan or reasoning the outcome of the necessary recovery support education efforts, those effects are at best confined to outcome statements based on anecdote and at worst doomed to a preventable failure. In many cases, organizations fail because they did not collect and review important information about the nature of their efforts and the outcomes of those efforts. The burgeoning recovery services education movement in New Hampshire can ill afford that predictable and preventable outcome. At a minimum, program evaluation should be implemented. These trainings are using significant resources. Before further dissemination, specific aims and outcomes from the trainings should be elucidated. Further, training for recovery coaches may provide a pool from which future addictions professionals could be recruited. Coordination between recovery coach trainers, addiction counselor education organizations and RTF could provide meaningful data about the numbers of persons who might be invited more prescriptively to become formally engaged in addiction counselor training protocols.</p> |
| Perinatal Substance | New Fetal Alcohol Spectrum Disorders (FASD) posters are now available at all NH Liquor and  |

| 5. What is the status of addiction education? |   |
|---|---|
| Exposure TF                                   | Wine Outlets  |
| DOE   | Through the Safe Schools/Healthy Students grant there are SAP counselors in Rochester, Laconia and Concord SDs. Rochester and Concord SDs have funding to be able to support LADCs in their school system; however, due to the critical workforce shortage they are unable to fill these positions. Also, via the SS/HS and PA grants there are behavioral health counselors embedded into the school system. They support all students (universal), identified small groups of students (intensive supports) and individuals (treatment). SS/HS & PA state management team will be looking at how to embed prevention messages across the curriculum. NHDOE, Office of Student Wellness will be supporting a strand at the Opioid Conference this spring.      |
| AG/DOJ  | Members of the department have worked closely with the Governor's office and the Board of Medicine in drafting rules related to opiates.  |
| DHHS-BDAS                                     | BDAS' Resources and Development (RAD) Unit staff provided 13 training events on addiction and recovery to a total of 662 participants. BDAS' contracted Training Institute on Addictive Disorders provided 25 training events for SUD service practitioners to a total of 1125 participants. They also developed, offered and archived five webinars that continue to be available on demand. BDAS provided public information on current and emerging SUD issues through drugfreenh.org. Materials were provided by the BDAS Clearinghouse and many of them were then widely distributed at events and in local communities. People borrowed audiovisuals and curricula from the BDAS Lending Library for professional use and for screening at public events. |

| 6. What is the status of data collection? |  |
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| Recovery TF                               | Hope for New Hampshire Recovery is collecting data related to recovery support services being delivered in NH. To date this data has not been shared with RTF. Further, no other data from other recovery organizations (recovery centers, family recovery support providers, or sober living service providers) is being shared with RTF. In order for RTF to provide responsible feedback to the Governor's Commission, data on the state, nature, and outcome of recovery support services must be made available. It is recommended that funding for recovery support services be tied to monthly reporting requirements. Further, it is necessary that data be shared with RTF and the Governor's Commission at each meeting.   |
| DOE                                       | Through the SS/HS and PA grant we are required to evaluate our project. This is done via the Youth Risk Behavior Survey.   |
| DHHS-BDAS                                 | The Bureau of Drug and Alcohol Services (BDAS) incorporates the National Outcome Measurements (NOMs) in its procurements for prevention, treatment and recovery services which focuses on the effectiveness of programs. The BDAS is required to collect Treatment Episode Data Set (TEDS) a national census data system of annual admissions to substance abuse treatment facilities. The Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence on a variety of health risks via a biannual national school-based survey model provided by the Centers for Disease Control and Prevention (CDC) and state. The YRBSS monitors six categories of priority health-risk behaviors among youth and young adults including tobacco use; alcohol and other drug use. NH DHHS (BDAS and the Div. Public Health) works in collaboration with NH Dept. of Education in publishing this data. NH DHHS makes this data available in its WISDOM data (web-based interactive system for data and outcomes measures). NH DHHS/BDAS also collects analyses and utilizes data via its Web Interactive Treatment System (WITS) that provides information on prevention and treatment process & outcomes and through its State Epidemiological Outcomes Workgroup (SEOW). BDAS, among a number of state entities, provides data to the NH Information and Analysis Center out of the Department of Safety that provides a comprehensive overview on the misuse of drugs and intelligence on illicit drug threats on a quarterly basis. |
| Dept. of Safety                           | The New Hampshire Information & Analysis Center (NHIAC) through the NH Drug Monitoring Initiative (DMI) analyzes data collected by : NH DHHS, Division of Public Health Services in  |

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| 6. What is the status of data collection? |   |
|   | reference to emergency department visits related to heroin use, Bureau of EMS in reference to incidents of Narcan Administration by EMS statewide, BDAS in reference to treatment admissions for heroin and prescription opiates and NH Medical Examiner’s Office in reference to drug overdose deaths, regular data submission has not been established from the Medical Examiner’s Office. The NHIAC is also in the infancy stages of an initiative to collect felony drug arrest data from local police departments. |

**RECOMMENDATIONS REQUESTED**

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| <b>DATA COLLECTION</b>  |  |
| 1. What recommendations do you have for a comprehensive set of data points for the NH Information and Analysis Center to collect and disseminate to support our efforts to combat drug abuse and inform policy and programming at a state and regional level? |  |
| <b>Prevention TF</b>  | Support Middle School Youth Risk Behavior Survey (YRBS): Based on the National Survey of Drug Use and Health (NSDUH) and YRBS data, we know that youth substance use starts prior to high school yet we don't have any statewide middle school data to further explore priority health indicators in this population. Support the administration of YRBS in all NH's high schools. Currently, there are school districts that do not participate in the YRBS – more efforts are needed to encourage these districts and educate them about the value of this data and the importance of their participation in the statewide effort. Considering the Resiliency and Recovery Oriented Systems of Care (RROSC) model, we would like to see a more comprehensive data set (beyond past 30-day use) from the YRBS utilized at the statewide level to inform policy and programming. Namely, mental health indicators, of which there are several key YRBS questions.  |
| <b>Recovery TF</b>  | Please see recommendations made in previous sections of the report. At a minimum, data should be collected in the following areas: Numbers of recovery service providers by type and location. Client flow, census, types and frequencies of presentations, program evaluations and outcome evaluations. Further, data needs to be collected on return on investment for resources to be expended in the field. Strategic goals to attain future goals need to be data driven. Qualitative work to further define and clarify NH's conceptual framework around recovery services is essential. Client flow among and between treatment and recovery service providers should be collected and distributed to key stakeholders on a regional basis. Emergency room data regarding emerging trends in substance misuse across the state should be included in an early warning system. To be clear, most of these data are in existence. The methodology for data collection and analysis are yet to be determined. A Data Dashboard is needed for key stakeholders. |
| <b>Treatment TF</b>   | Data on parents in SUD Treatment who have been reunified with their children involved with DCYF. Data regarding criminal justice recidivism post-SUD treatment.  |
| <b>Perinatal Substance Exposure TF</b>  | Regarding pregnant and newly delivered or postpartum(PP) women in NH the task force would like to see data kept on the number of pregnant/PP who receive treatment at one of the Opioid Treatment Programs (OTP) each year. We would also like to see data kept on the number of women who are seen in emergency departments with a discharge diagnosis of substance use disorder or addiction/mental health disorder. We hope to continue collecting data regarding newborns who receive the diagnosis of Neonatal Abstinence Syndrome (NAS). We would like to track the number of pregnant women who are screened using SBIRT. We would like to track the number of those women who are referred for treatment.  |
| <b>DOE</b>  | Youth Behavior Risk Survey data, school climate and culture data, poverty, employment, graduation rates, DCYF cases, JPPO,CASA cases, and juvenile diversion services  |
| <b>AG/ DOJ</b>  | Where is Narcan being administered throughout the state; and b) Where are the drug arrests occurring, what drugs are being seized, and the quantity of the drugs seized? This will assist the department in allocation of resources.   |
| <b>DHHS-DCYF</b>  | If not already doing so, NHIAC should collect aggregate data provided by DCYF regarding number of protective reports received that include allegations of parental substance abuse; number of parent deaths  |

| <b>DATA COLLECTION</b>  |   |
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| 1. What recommendations do you have for a comprehensive set of data points for the NH Information and Analysis Center to collect and disseminate to support our efforts to combat drug abuse and inform policy and programming at a state and regional level? |   |
|   | as result of parental substance abuse in open cases; number of children in those reports impacted by parental substance abuse.  |
| <b>DHHS-BDAS</b>  | Continue collecting, collating and publishing the quarterly NH Drug Information Report. This report provides much needed critical data on an array of metrics by geographical area, including drug overdose deaths, Naloxone administration, opioid-related emergency department visits / admissions, opioid-related substance use disorder treatment admission, etc., all-in-one document that is being used to inform alcohol and drug services needs by area and policies. |
| <b>Dept. of Safety</b>  | Regular monthly reporting of overdose death data from the Medical Examiner's Office to the NHIAC for analysis and inclusion in the monthly Drug Monitoring Initiative products. Mandated reporting of all felony drug arrests to the NHIAC. All NH agencies use the NHIAC as a conduit for target and event de-confliction. Regular reporting of all overdoses to the NHIAC by EMS agencies with jurisdiction in NH.  |
| <b>Insurance Dept.</b>  | The NH Insurance Department (NHID) continues to work with NH DHHS on Comprehensive Health Information System (CHIS) reporting. Effective in 2016, for 2015 denied claims activity are to be included within the data set submitted.   |

| <b>PRESCRIPTION DRUG MONITORING</b>   |  |
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| 2. What recommendations do you have relative to the type of reporting that should be available as a best practice for prescribers, dispensers, public health agencies, legislators, and the public? |  |
| <b>Recovery TF</b>  | See above.   |
| <b>DOE</b>  | It is crucial to look across data system. For instance, YRBS data states that Berlin's youth are 94% above state average for heroin use, 92 % of Coos County CASA cases are to related SUD, and 11-15 doses of Narcan were administered in Berlin. By looking across data sets you can really identify needs and put into place a system and services to address the needs.  |
| <b>AG/ DOJ</b>  | Expedient access to de-identified/aggregate data would be beneficial.  |
| <b>DHHS-BDAS</b>  | A bill was passed this past year (SB 31) that will allow the PDMP program under the Board of Pharmacy to share aggregate / population-level data. The director at the Bureau of Drug and Alcohol Services (BDAS) at NH DHHS serves on the PDMP Advisory Council and its Evaluation workgroup. This workgroup will develop reports that help inform alcohol and drug policy by providing aggregate data that will identify areas of the state in which prescriptions for controlled drugs are being written at higher rates as well as demographic data that can be used to target both prescribers and their patients. |
| <b>Dept. of Safety</b>  | The Prescription Drug Monitoring Program should be real time and mandatory use for prescribers.  |

| <b>SAFE PRESCRIBING</b>  |   |
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| 3. What recommendations do you have to ensure that prescribers are following best practices in the prescribing of opioids and what third-party payers, providers or other health care entities are doing to support those practices? |   |
| <b>Recovery TF</b>   | Recovery support services can and should be, as a part of law, advertised at pharmacies. This practice could guide people to local recovery support services that will enable alternatives to treatment, access to treatment, and support treatment outcomes. Further, family members and other collaterals can gain access to recovery support services that are sculpted to their individual needs. |
| <b>DOE</b>   | I feel that prescribers should be required to use the system that is in place. Not just register with the system. My recommendation would for the person doing the intake with the individual to pull up the system so it is ready to be used by the prescriber.  |
| <b>AG/ DOJ</b>   | As noted above, the department continues to work closely with stakeholders related to Board of  |

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|                        | Medicine rule changes. We are also recommended rules be adopted by the other relevant boards.   |
| <b>DHHS-BDAS</b>       | The Governor's Office and the Attorney General's Office, working with the Board of Medicine, are leading an effort to establish safe prescribing practices in New Hampshire. Tentatively, this initiative will include setting certain restrictions on opioid prescribing and will include prescriber training. BDAS supports safe prescribing practices, storage and disposal and increased consumer education on the risks associated with prolonged use and importance of safe storage and disposal. |
| <b>Dept. of Safety</b> | Prescribers should be required to attend annual training on addiction potential, prevention and prescribing guidelines.   |

| <b>PREVENTION MESSAGES</b>   |   |
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| 4. What recommendations do you have relative to how New Hampshire's efforts to educate and publicize our prevention messages can be synchronized with other states' efforts in our region? |   |
| <b>Prevention TF</b>   | Standards, protocols and practices around "Safe & Appropriate Messaging" re: substance misuse and addiction is a critical need in our state, and in our New England region. At the request of the Prevention Task Force, Northeast CAPT created some initial "Do's and Don'ts" document. However, the Prevention Task Force also developed some additional (general) recommendations. We welcome the opportunity to work with the other task forces and state agencies to develop a comprehensive set of recommendations that can be released on behalf of the Commission. Much can be learned from other states – for instance: what statewide efforts have been endorsed, how are they structured, how do they recruit and engage, what are their strategies, successes, and best practices. Are there any other states that have something similar to our Partnership for a Drug-Free NH (PDFNH), if so, how can we link for purposes of sharing? Do other states have a Governor's Commission similar to NH's? What is their focus and what have been their challenges/successes? If there are other efforts focused on prevention that states embrace, they can be valuable resources as NH continues its education and publicizing messages on this issue. SAMHSA, NH DHHS, CADCA, CDC are important resources. The PDFNH Check the Stats campaign was important; however, its reach could probably be extended through other avenues yet to be explored – what other states have accomplished could assist here, are there unique partnerships that can be cultivated, etc.? The public can become overwhelmed by data- it can be scary and often people can become numb to it. Creative and educational methods are necessary to encourage people to make safe choices at all points in their lives. Regional and state resources should always emphasize where to go for help – that there is help available and there are groups for people to join, even though at the current time we are in desperate need of more resources for treatment and tragedies are occurring on a daily basis. The message of hope needs to be a strong one. We should be reviewing prevention/media material from states that have therapeutic cannabis (and legalization) to develop our own campaign to be released in conjunction with the opening of NH dispensaries. Primarily, we should be developing and promoting messages around safe storage (lock it up) to help prevent child poisonings, youth access - just as we do with prescription medication. |
| <b>Recovery TF</b>   | Addiction stigma is a significant issue. There needs to be a systematic program that addresses stigma among and between media, criminal justice, healthcare, mental health/addiction, education, and faith-based organizations. Further, the science of addiction stigma should be brought into public discourse. A training on addiction stigma and micro aggressions should be made available to the Governor's Commission. Recovery support services should be included in local plans to implement secondary and tertiary prevention programming.   |
| <b>Treatment TF</b>  | Education and outreach to the parents of children in early childhood settings, i.e. Early Headstart and Headstart, to raise awareness of substance misuse and resources for support, as well as for providing services to assist in improving family stability by addressing various family needs such as employment, housing, parenting, etc. To provide educational opportunities along w/Narcan kits so they are more readily available at variety of locations (i.e. pharmacies; medical offices; EDs, substance treatment facilities, schools, businesses, etc.) - understanding there may be obstacles internal to each location prior to instituting). Providers to commit to conducting at least one national awareness activity each month to promote prevention/education and improve health  |

| <b>PREVENTION MESSAGES</b>   |   |
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| 4. What recommendations do you have relative to how New Hampshire’s efforts to educate and publicize our prevention messages can be synchronized with other states’ efforts in our region? |   |
|  | <p>outcomes overall. Participation in trainings on site and cross trainings between providers to include special focus topics (parenting; family connections; alcohol, drug awareness and medications signs/symptoms of intoxication-impairment and withdrawal); Reinforcing campaigns (National/State NIDA, NH DHHS-Public Health, SAMSHA, CSAT) even though we may not participate, it is a way to show solidarity and support. Expanding prevention messaging to all ages across the developmental spectrum will ensure that there is no one left out of our efforts (i.e. prenatal-neonatal-child-youth-adult-elderly) to promote health/wellness with focus on reducing alcohol and drug misuse, support treatment, intervention, education and recovery strategies for all persons with a focus on family involvement. The state and community providers could avail themselves to be guest speakers at local schools, churches, hospitals, medical/mental health clinics; Primary Care Providers-Specialists and police departments to ensure integrated and coordinated concerns, and strategies in commitment of NH’s efforts in all sectors. More public participation from recovery community who are currently receiving treatment to open up about addiction and paths to treatment emphasizing diversity/variety of successful outcomes and options. We need to focus efforts on cross-border states to be able to provide services and accept payment for those services located in adjacent states for SUD/MH services. Support for mandatory drug court monitoring. Local judges could benefit by trainings on efficacy and comparisons of MAT (methadone/bup) to address opioid crises vs. sentencing/incarceration when rendering decisions.</p> |
| <b>Perinatal Substance Exposure (PSE) Task Force</b>   | <p>Regarding pregnant and postpartum women the PSE task force supports continued support for the work of the Vermont Oxford Group and the March of Dimes and the National Organization on Fetal Alcohol Syndrome in their regional projects to improve care for women suffering from addiction and substance misuse disorders.</p>  |
| <b>DOE</b>   | <p>Recommend that we begin by coordinating prevention messaging within the State of NH. At present, the approach to prevention seems to be disjointed and segmented. The creation of a centralized hub for resources and education with a comprehensive, strategic communications plan and supporting tactics and tools would go a long way in eliminating silos. BDAS is the logical entity to fulfill this role; however, they would require additional financial and human resources. A comprehensive strategic communications plan would include: an online information repository, printed brochures, and an email listserv for weekly or bi-weekly updates and announcements. We would also like to recommend that the responsibility for youth-focused prevention education be moved from BDAS to the DOE. It makes sense that if we are using schools to disseminate prevention messaging that we integrate the process within all aspects of education planning. The current approach lessens the impact of efforts because they are not coordinated or infused within existing academic curriculums and seen as “separate” from the true work of schools. For example, the Top 5 document, published out of the Prevention Taskforce, was created without input from districts despite being meant to serve as a tool for schools. The DOE has worked to support the distribution of the plan; however, BDAS and the DOE would continue to partner and coordinate</p>   |
| <b>AG/ DOJ</b>   | <p>The department would recommend a “media blitz” that would directly target opioids, with a strong focus on heroin and fentanyl.</p>   |
| <b>DHHS-BDAS</b>   | <p>New Hampshire has developed and implemented a tested public awareness campaign with the theme Anyone / Anytime (anyone anytime can become addicted...save a life...can recover...etc.). This campaign includes television, radio, print ads and printed materials. A discussion was initiated among the northeast contingent at the 50 state opioid meeting convened by U.S. HHS Secretary Burwell’s, facilitated by HRSA Region One Administrator, to consider a regional public awareness campaign. Follow up discussions are pending.</p>   |

**TREATMENT PROGRAMS**

5. What recommendations do you have to identify opioid treatment programs to expand capacity for medication-assisted treatment services in border areas where additional service capacity is needed, and to determine whether New Hampshire’s treatment programs and service may be enhanced or improved by access to cross-border services?

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| <b>Recovery TF</b>                     | Full integration of recovery support services as an adjunct to treatment services should be mandated by NH’s licensing and certification standards. Recovery support services can provide alternatives to treatment that will reduce the strain on treatment services. Further recovery support services can assist in facilitating access to treatment and thereby reduce the likelihood for attrition on waiting lists. Finally, recovery support services can provide post-treatment supports for persons seeking to sustain recovery after treatment.   |
| <b>Treatment TF</b>                    | Provide clinical and operational best practices specific for each medication-assisted treatment, and tailored to each clinician’s role. Use existing prescribers as “champions of change” and create opportunities for connections to all primary care settings in NH. Provide training and technical assistance to increase the number of prescribers of providers of medication-assisted treatment (MAT) and create opportunities of connecting these prescribers to current SUD treatment providers to increase and/or expand capacity in regions in need across the state. Implement medication-assisted treatment induction programs in emergency departments of hospitals for those being served due to opioid overdose. Update all treatment resource guides such as BDAS Resource guide, 211 and <a href="http://www.nhtreatment.org">www.nhtreatment.org</a> to include all medication-assisted treatment options and practices, i.e. Naltrexone (Vivitrol). Per one of the 22 recommendations by Governor Hassan and Senior Policy Director of Substance use and Behavioral Health, support the removing the “first-fail” barriers and certain prior authorization practices that delay the initiation of appropriate clinical treatment. |
| <b>Perinatal Substance Exposure TF</b> | Our visits to the opioid treatment facilities suggest that pregnant and postpartum women could benefit profoundly if it were possible to embed prenatal care and social service –“life coaching” supports so that they would be accessible when patients make their daily visits to the OTP. This appears to be a window in the disease when patients are particularly motivated for change and healing. We would do well to maximize the access to supports while the opportunity presents. As there are not wait lists for pregnant women – opening new methadone programs is not as important as improving the wrap around care at the current site. Regarding buprenorphine: embedding buprenorphine management (prescribing plus robust counseling) by qualified addiction trained providers into our OB/GYN, midwifery, and family practice provider practices would assure that women whose opioid dependence issues are appropriate to be managed with that level of care, can receive standard of care treatment without needing to change medications to Methadone in order to avoid withdrawal. Technical assistance and other supports should be offered to community health centers to promote MAT within the context of primary care. |
| <b>DOE</b>                             | Although Methadone clinics have their place, I feel the focus needs to move toward having a workforce that is dually certified in mental health and as LADCs. This would allow schools that are looking to implement a comprehensive school mental health system ensure that all student populations are receiving appropriate services.  |
| <b>DHHS-BDAS</b>                       | Similar to the regional approach to prevention messaging, significant discussion took place at the 50 state meeting among the Northeast contingent about the potential for making opioid treatment programs (OTP) in border areas available to residents with opioid use disorders from neighboring states. This would require providers in neighboring states to enroll in that state's Medicaid program and to contract with that state's managed care organizations. Further discussion pending.   |

**LAW ENFORCEMENT**

6. What recommendations do you have relative to how communication, reporting, and information sharing between states can enhance the effectiveness of law enforcement activities as they related to public health and safety concerns?

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**Prevention TF** It would be useful if ALL community-level police/safety and State Police (including highway safety) collected a common set of data points that would be collected at the community, county, and regional level then aggregated to state level. There would need to be agreement on how the data would be collected, into what system and how this would be managed. From a public health perspective, we know that people facing arrest/incarceration/court are at great risk for suicide and certainly when that involves drug/alcohol-related charges. A few years ago, NH had several suicides of men soon after being arrested for a DUI. This is an example of the risk intersection of substance misuse-suicide and the legal system, and points to the need for collaboration and communication between the law enforcement community, Department of Transportation and the Public Health Network system. Utilize geo-mapping of substance misuse violations (not just arrest data) to share with the prevention community in each state. HIDTA is able to do this. Are systems in place to support, and encourage, cross-sharing between juvenile diversion programs (and other providers) in border communities?

**Recovery TF** See above

**AG/ DOJ** As addressed above, the New Hampshire Attorney General’s Drug Task Force continues to investigate and assist in the prosecution of drug traffickers. Many of the drug cases cross over into our neighboring states. The law enforcement community does a good job of communicating with one another regarding pending investigations. However, data relating to arrests and potential prosecution is not traditionally shared, either in-state or across state borders. A greater emphasis on data sharing and use of the New Hampshire State Police IAC would greatly assist in protecting the public from drug-related crimes.

**Dept. of Safety** The NHIAC recommends increased communication between states through interpersonal information sharing and linking databases via obtaining the appropriate software such as CopLink. The NHIAC is currently sharing the Drug Monitoring Initiative (DMI) reports with our surrounding states and is working towards sharing additional information relative to out-of-state residents arrested for drug-related offenses in NH and NH residents arrested for drug-related offenses in other states. One of the goals of the NHIAC is to increase the amount of information that comes into the Center from agencies and organizations throughout the state. Ultimately, this will enable the NHIAC to analyze this information and assist in the development and use of meaningful, real-time metrics in the effective and efficient deployment of public safety resources.

**OTHER RECOMMENDATIONS OR UPDATES**

Please share any other updates, recommendations or other information you would like included in the report to the Governor.

**Prevention TF** We want to encourage the sharing of the "Top 5" document as a resource and success the state has had with Life of an Athlete implementation.

**Recovery Task Force (RTF)** New Futures made significant efforts to include recovery support services as fundable under the New Hampshire Health Protection Program. Those efforts need to be sustained and seen to fruition. In order for recovery support services to develop and flourish in New Hampshire, access to protected funding streams is essential. Recovery Support Programs must evidence active and full participation in the New Hampshire Health Protection Program. This evidence will provide foundational develop to organizational capacity for those recovery support service programs which choose to be competitive for other funding streams as those services mature. Until such time as recovery services are developed to scale in NH, the Governor’s Commission should provide additional administrative and infrastructure support to the RTF. These resources are necessary to provide an equal and democratic seat at the table for advocates in the recovery community. Simply put, other task forces are made up of individuals who bring substantial infrastructure and support to those groups. Necessarily, RTF is different. RTF seeks to aid in the development and

| Please share any other updates, recommendations or other information you would like included in the report to the Governor. |   |
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|   | implementation of a locally-supported recovery support services network. Such a group should not be centered and driven from the state capitol. Rather, that group needs significant assistance in developing and maintaining the statewide efforts of what is essentially a highly skilled set of volunteers who have remarkable ability to affect outcomes for people suffering in their local communities. Because this group of people has already found a way to sustain recovery in their local community, they offer an extremely valuable type of resource to their community. As such, the RTF should be offered support to encourage and sustain the development of this rare and precious natural resource. Finding, nurturing, and utilizing recovery capitol is necessary if NH is going to make a significant difference in the lives of individuals and families who suffer from alcohol and other drug misuse. In the most recent version of the biennium budget, approximately \$400,000 of the \$1,450,000 budget for recovery supports is being spent to purchase services from a facilitating organization (FO). This FO is going to help provide support services to the recovery support services entities that are developing and evolving across NH. It is recommended that the recommendations made above be tasked to the FO and that the selected agency report be required to report its progress toward those goals to the RTF and the Governor's Commission at every meeting. As compared to budget allocations for treatment and prevention, the recovery services budget is less. Since 27.5% of that budget is going toward and FO, it is recommended that significant performance and reporting indicators be put in place. That data needs to be made available on a regular and reliable basis to members of the recovery community. As such, the FO could serve the recovery community well to provide clear and regular reports to the interesting recovering people across the state. The planning for forward movement and progress toward those plans will rely on the volunteer efforts of hundreds and thousands of people. At a minimum, those people who have provided countless hours of support to the still suffering need to be meaningfully included at the tables where decisions are made about the development and implementation of recovery support services in New Hampshire. |
| <b>Treatment TF</b>   | Support Governor Hassan and Senior Policy Director of Substance use and Behavioral Health recommendations to initiate and support a pilot program with Department of Corrections to implement the use of Naltrexone (Vivitrol) in correctional settings as inmates transition into the community.   |
| <b>Perinatal Substance Exposure TF</b>  | Continue to increase access to naloxone within primary care, urgent care and community settings.  |
| <b>DHHS-DCYF</b>  | DCYF has LADCs in two offices, Manchester & Southern Nashua.<br>DHHS/DCYF would request appropriation of funds to have LADCs hired for additional offices in the north, east and west regions of the state.   |
| <b>DHHS-BDAS</b>  | BDAS recommends making data and other information on the misuse of alcohol and drugs to inform policy and programming at the state and regional levels, including, real-time state wait list information for all treatment services, data to evaluate the cost effectiveness/program effectiveness of alcohol and drug abuse prevention, recovery, and treatment programs which receive state general funds or federal funds, Population data to best support the targeted location of prevention, treatment, and recovery support services in the State of New Hampshire, ability to integrate cross state agency data (expand WISDOM interoperability) to unify data collection efforts that best provide the most integral picture of drug abuse in the State of New Hampshire (i.e. corrections data/mental health data/ behavioral health data/substance use disorder data etc.)   |

## SECTION II: OPIOID TASK FORCE & HEALTH CARE WORK GROUP RECOMMENDATIONS

The following recommendations were determined through consensus of Opioid Task Force members.

1. **Special messaging for opioid users relative to the dangers of street fentanyl and certain myths related to use.** The Attorney General's office reports that there will be over 400 drug-related deaths in 2015, with many associated with the powerful illicit drug fentanyl. Task force members reported that

misinformation “on the street” needs to be counteracted with immediate and effective messaging relative to the following:

- i. Fentanyl is 100 times more deadly than heroin. The variability of its potency is leading to unintended overdose deaths in all parts of the state and is the #1 contributor to the continued escalation in opioid overdose deaths in 2014 and 2015.
  - ii. Fentanyl is being sold in various forms on the street, sometimes openly as fentanyl and sometimes as other opioids. It is being cut into or sold as heroin. Also, the Attorney General’s office has reported that fentanyl has been pressed into pill form, stamped, and sold as oxycodone/Oxycontin to be able to garner a higher street value and/or to make the drug appear safer to use.
  - iii. Snorting opioids of any kind rather than injecting does not reduce the risk of overdose nor reduce the likelihood of addiction.
  - iv. Injection drug use can cause life-threatening infectious diseases including HIV/AIDs, Hepatitis C and bacterial endocarditis (potentially devastating heart infection) and can create other skin and system infections such as endocarditis that require medical attention.
2. **Real-time access to a fully staffed warm line for the public to call to receive information and consultation on treatment and recovery support services available and to receive support accessing those services**, including assistance in making contact with service agencies to schedule intakes, etc. This line must be answered by a live voice 24 hours a day 7 days a week.
3. **Additional staffing and other resources within the Attorney General’s office to prosecute cases of drug trafficking and sales.** (Task force member from the AG’s office abstained from this recommendation)
4. **Full funding of the Alcohol Fund at the original formula level of 5% of state profits from the sale of alcohol to support prevention, treatment and recovery support services.** As substance misuse is a long-standing and underserved public health and safety issue that will continue even after the opioid crisis abates, this recommendation includes the necessity that the Alcohol Fund be provided at its original formula each year without budget footnotes or other legislative action that suspend or reduce the formula amount.
5. **State agencies addressing substance misuse must be allowed to request and expend funds at budget levels that are sufficient to meet the need for adequate law enforcement, forensic testing, investigation and prosecution, prevention, early identification, treatment and recovery support services and other services** without reductions and fluctuations in budgets that compromise the systems’ ability to adequately address substance misuse and substance use disorders.
6. **Increased resourcing and utilization of the prescription drug monitoring program (PDMP)** to support effective prescribing practices and to reduce doctor shopping.
7. **Adequate resourcing of drug courts across the state** to provide treatment and recovery support services to individuals in the justice system as a result of a substance use disorder.
8. **A process be established and carried by the state’s licensing boards to address rule changes, education and other actions to improve opioid prescribing practices to reduce the likelihood of**

**diversion and to prevent the development of addiction.** This process should include consideration of prescriber utilization of the state's PDMP.

9. **Safe storage and disposal of prescription opioids should be supported through consideration of 1) expanding to drop boxes to more law enforcement agencies and to non-law enforcement entities such as hospitals and/or pharmacies and 2) through the promotion and sale of lock boxes and/or products such as Deterra™ at pharmacies** for individuals to use to safely store opioids and other medications in their home, or, in the case of Deterra™, to deactivate opioids until proper disposal is possible.
10. **Reinforce messaging relative to naloxone distribution that calling 911 is essential** as a companion to naloxone administration in that with the stronger opioids available, such as fentanyl, two doses may not be enough to reverse an opioid overdose.

The following information, updates, and recommendations were provided by the Health Care Work Group of the Opioid Task Force.

| <b>Roles for Healthcare</b>                                 | <b>Activity</b>   | <b>Potential Opportunities</b>   |
|---|---|--|
| <b>Best practices in opioid prescribing for pain</b>        |   | <ul style="list-style-type: none"> <li>• Prescribing exam for controlled substances DEA vs PDMP (supported by Healthcare TF &amp; recommended to BOM &amp; legislature by NH Medical Society)</li> </ul> |
| Chronic pain  | <ul style="list-style-type: none"> <li>• PDMP enhancements and mandatory checks supported (with exemptions)</li> <li>• Best practices education</li> <li>• Clinical tools online</li> <li>• Recommendations for prescribing rules submitted to Board of Medicine Nov 2015 (attached)</li> </ul> | Stimulate greater <ul style="list-style-type: none"> <li>• Use of PDMP</li> <li>• Use of education ops</li> <li>• Use of tools</li> </ul>  |
| Acute pain  | <ul style="list-style-type: none"> <li>• Prioritized. Recommendation in process December 2015</li> </ul>  | <ul style="list-style-type: none"> <li>• Develop prescribing guidelines</li> <li>• Disseminate info on med storage, disposal, take-back to all patients</li> </ul>                                       |
| <b>Screening, brief intervention &amp; referral (SBIRT)</b> |   |  |
| PCP, OB/GYN   | <ul style="list-style-type: none"> <li>• State funding for CHCs</li> <li>• CF Youth SBIRT projects</li> <li>• OB/GYN project DHMC</li> </ul>  | <ul style="list-style-type: none"> <li>• Dissemination to non-CHC practices</li> <li>• Incentivization</li> </ul>  |
| ER  | <ul style="list-style-type: none"> <li>• Screening adopted by ACEP as standard</li> </ul>   | <ul style="list-style-type: none"> <li>• Implementation projects</li> </ul>  |
| Healthcare trainees   | <ul style="list-style-type: none"> <li>• SNH-AHEC grant supporting nursing, pharmacy, dental, med student, mental health counselor for SBIRT training</li> </ul>  | <ul style="list-style-type: none"> <li>• Link students with other initiatives for internships</li> </ul>   |
| <b>Support recovery</b>                                     | <ul style="list-style-type: none"> <li>• PCP referrals from Tx</li> <li>• Hope for NH</li> <li>• Coop PCP research group piloting recovery support tool</li> </ul>  | <ul style="list-style-type: none"> <li>• Build SBIRT-R model</li> <li>• Recovery resources to HC settings</li> </ul>   |
| <b>Treatment</b>  | <ul style="list-style-type: none"> <li>• Nhtreatment.org awareness campaign</li> <li>• Support for one call in number for assistance in finding assessment ops</li> </ul>   | <ul style="list-style-type: none"> <li>• Continued promotion</li> </ul>  |
| Psychosocial  | <ul style="list-style-type: none"> <li>• Expanded assessment with referral to level of care ops</li> </ul>  | <ul style="list-style-type: none"> <li>• Embed MH/LDAC providers in HC clinics</li> </ul>  |
| Expand buprenorphine  | <ul style="list-style-type: none"> <li>• CHC proposal submitted</li> <li>• Symposium held exploring models</li> </ul>   | <ul style="list-style-type: none"> <li>• Campaign for non-CHC providers</li> <li>• Expand to ARNPs (Fed)</li> </ul>  |

|   |   |  |
|---|---|--|
|   | <ul style="list-style-type: none"> <li>• BDAS work group in process</li> </ul>  |  |
| Methadone   | <ul style="list-style-type: none"> <li>• Existing system with wait lists</li> </ul>   | <ul style="list-style-type: none"> <li>• Enhanced oversight (requires funding)</li> </ul>  |
| Naltrexone (depot)  | <ul style="list-style-type: none"> <li>• Emerging</li> </ul>  |  |
| <b>Naloxone prescribe/dispense</b>                          |   |  |
| Addiction tx patients                                       |   | <ul style="list-style-type: none"> <li>• Promote to MMT clinics</li> <li>• Promote to bup/nx providers</li> </ul>  |
| At risk persons<br>Opioid addicted<br>At risk pain patients | <ul style="list-style-type: none"> <li>• Legislation passed</li> <li>• NHMS dissemination in process</li> </ul>   | <ul style="list-style-type: none"> <li>• Raise HC awareness</li> </ul>   |
| Families & friends & community                              | <ul style="list-style-type: none"> <li>• Legislation passed</li> <li>• Ad Hoc Naloxone TF formed, active launch Sept, Oct, Nov 2015.</li> </ul>                                       | <ul style="list-style-type: none"> <li>• Continuing efforts to engage pharmacies in stocking, filling prescriptions and distribution by standing orders.</li> <li>• Effort to raise prescriber awareness of law</li> </ul> |
| <b>Post-clinical supply reduction</b>                       |   |  |
| Take back   | <ul style="list-style-type: none"> <li>• Permanent sites</li> <li>• DOJ listing of sites</li> </ul>   | <ul style="list-style-type: none"> <li>• Disseminate info to HC offices, ERs</li> </ul>  |
| Disposal  | <ul style="list-style-type: none"> <li>• Enabling federal legislation passed</li> </ul>   | <ul style="list-style-type: none"> <li>• Consider reverse distribution in state</li> <li>• Disseminate info on ops</li> </ul>  |
| Lock boxes in pharmacies                                    | <ul style="list-style-type: none"> <li>• Patchy availability at police stations in state</li> <li>• Info distributed to prescribers &amp; patients through medical society</li> </ul> | <ul style="list-style-type: none"> <li>• Campaign of awareness</li> <li>• Legislation?</li> <li>• Continued work on raising awareness is needed.</li> </ul>  |

**SECTION III: STATE PLAN PRIORITY QUESTIONS** (*State Agencies/Departments and Task Forces*)

| INCREASING LEADERSHIP                              |                |   |   |   |
|--|----------------|---|---|---|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations   |
| <b>Recovery TF</b>                                 | Moderate       | NF, Hope for New Hampshire Recovery, and FEDCAP have all hired recovery personnel at the Director Level   | As yet, these organizations have not been involved in formal, data driven dialogue with RTF. Therefore, the fruit of the labor is as yet unquantifiable. Anecdotally, these organizations encourage hope. | The Recovery Organization meets monthly. Recommendations should not be limited to short-term goal attainment.                                     |
| <b>Perinatal Substance Exposure TF</b>             | Low            | Senator Ayotte's Bill/Gov. Hassan's special session   | Legislative disconnect  | This is a chronic issue. Medicaid Reimbursement for those who care for patients with chronic disease does not match reimbursement for acute care. |
| <b>Adjutant General/ NH National Guard</b>         | High           | Provided training to potential counterdrug community coalitions and their core members, increasing the knowledge, skills, and abilities of those members to reduce drug use in their communities. |   |   |
| <b>DOE</b>   | Moderate       | Strengthening relationship with BDAS, getting SAPs into schools and early discussions to get dually certified (MH, SAP and LADCs) into schools  | Trying to break down silos  | Strategic communication of their efforts, shared responsibilities   |
| <b>AG/ DOJ</b>                                     | High           | See above. The department continues to be on the forefront in providing a public message regarding the dangers of opioids.  | Time and resources.   | Continued public education on drugs, specifically opioids, and the inherent dangers.  |
| <b>DHHS-BDAS</b>                                   | High           | Senior staff at the Governor's Office are meeting with  |   |   |

| INCREASING LEADERSHIP                              |                |  |            |                 |
|--|----------------|--|------------|-----------------|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations |
|  | High           | Leaders from several state agencies to closely monitor and coordinate alcohol and drug policies and services to address the opioid epidemic<br><br>The Director of the Bureau of Drug and Alcohol Services is working Closely with the Chair of the Governor's Commission and the Governor's Sr. Policy Advisory as sr. staff at New Futures to coordinate activities to address NH's Opioid epidemic. |            |                 |
|  | Moderate       | BDAS is working closely with Dept. of Ed, Office of Student Wellness   |            |                 |

| INCREASING FINANCIAL RESOURCES                     |                |  |  |   |
|--|----------------|--|--|---|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges   | Recommendations )   |
| <b>Recovery TF</b>                                 | Moderate       | Funded services for the first time   | To date, significant resources are being spent on administration | Initiate performance indicators to evidence a clear plan for service implementation |
| <b>Perinatal Substance Exposure TF</b>             | Low            | Parity in Medicaid Expansion population  | See Above  |   |
| <b>Adjutant General/ NH National Guard</b>         | High           | Provided coaching and facilitation activities and workshops to counterdrug community |  |   |

**INCREASING FINANCIAL RESOURCES**

| <b>STATE PLAN STRATEGY AREA &amp; BEST PRACTICE PROMOTION</b> | <b>Activity Level</b> | <b>Successes</b>  | <b>Challenges</b>   | <b>Recommendations )</b>  |
|---|-----------------------|---|---|---|
|   |                       | coalitions, increasing their effectiveness as counterdrug agents in their communities, and thereby making them more desirable recipients of anti-drug grants and other financial supports |   |   |
| <b>DOE</b>  | Moderate              | Providing resources directly to school systems  | Coordinating efforts with Public Health Networks                            | DHHS relies heavily on the Public Health Networks, however, NHDOE uses a different system so it would be helpful to use one system. |
| <b>DHHS-BDAS</b>  | High<br>Moderate      | Partnership for Success 2015<br><br>BRSS-TACS   | Lack of internal capacity to pursue, manage, and disburse additional grants | More efficient process for accepting funds and disbursing state funds to sub-recipients   |

**PROFESSIONAL DEVELOPMENT AND TRAINING**

| <b>STATE PLAN STRATEGY AREA &amp; BEST PRACTICE PROMOTION</b> | <b>Activity Level</b> | <b>Successes</b>   | <b>Challenges</b>  | <b>Recommendations</b>   |
|---|-----------------------|--|--|--|
| <b>Recovery TF</b>  | Moderate              | See above  | See above  | See above  |
| <b>Treatment TF</b>   | High<br><br>Moderate  | State of NH Public Health Dept. expanded Educational Loan Reimbursement Program to MLADC & LADC professionals.<br><br>Outreach to mental health provider guilds and licensing boards to educate on SUD training opportunities and core competencies necessary to provide SUD treatment in various practice settings. | Reaching <u>all</u> key stakeholders endorsing message that treatment works, treatment is available, and recovery is attainable; providing relevant CEUS/CME's to attract them | Consideration of behavioral health licensing boards to recommend/require continuing education (CEUs) for licensure related to treatment of substance use disorders.<br><br>Make specific elements of identified topics mandatory for licensure/re-licensure to a broader spectrum of providers (medical/clinical/ education) just like the recommendation the TF made to NH Alcohol and Drug Licensing Board |

PROFESSIONAL DEVELOPMENT AND TRAINING

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations  |
|--|----------------|---|---|--|
|  |                | There have been successful trainings and additions provided in partnership with others in State (i.e. NHTIA, NHADACA; BDAS; AMA;COE   |   | re: Suicide Assessment Training) with basic-intermediate-advanced training options related to co-occurring and SUD disorders ; providing relevant CEUS/CME's to attract them and have BDAS conduct a determined # for no cost to participants (grants or Charitable Foundation donations) as much in advance so individuals can selectively choose and plan to attend in advance in multiple locations within the State. |
| <b>Perinatal Substance Exposure TF</b>             | Moderate       | Strong support by the NH Providers Assn. and the Medical Society  | It is difficult to recruit a strong treatment infrastructure without salary support |  |
| <b>DOE</b>   | High           | We have trained well over 2100 individuals in behavioral prevention and promotion, over 300 individuals in the workforce in behavioral health prevention and promotion, and 27 individuals trained as YMHFA instructors and over 400 individuals certified in YMHFA | Coordinating training efforts, the creation of LADCs                                | To look at LADC certification process and work with our Universities' to increase participation in credentialing process   |
| <b>DHHS-DCYF</b>                                   | High           | All new staff participate in 6hrs of BDAS training on addiction & recovery;<br>Multiple advanced/specialized trainings offered thru out year focus on drug recognition; case mgt & safety planning with families & addiction;<br>Trainings are provided for         |   |  |

| PROFESSIONAL DEVELOPMENT AND TRAINING              |                |   |            |                 |
|--|----------------|---|------------|-----------------|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations |
|  |                | foster/adoptive parents   |            |                 |
| <b>DHHS-BDAS</b>                                   | High           | NHTIAD training;<br>SUD competencies for licensed mental health professionals;<br>Broad training on the continuum of care; Student Loan Repayment program for MLADCs and LADCs;<br>NEIAS Scholarships |            |                 |

| PUBLIC AWARENESS AND EDUCATION                     |                |   |            |                 |
|--|----------------|---|------------|-----------------|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations |
| <b>Recovery TF</b>                                 | Moderate       | See above   | See above  | See above       |
| <b>Treatment TF</b>                                | High           | <p>Involvement with the collaborative forum in October 2015 between the media and SUD prevention, treatment and recovery providers. Provided education on how SUD is presented in the media and problem solve collaborative methods to increase public education in a positive manner.</p> <p>There have been more political related news articles, public messaging, in person presentations at local community events and forums and broadcasts devoted to issues associated w/ SUD than in past w/ good attendance from Community and Provider</p> <p>Call to Action Email Alerts ( New Futures-Advocacy group) assisting with legislative updates and advocacy tips is tremendously helpful);</p> <p>People movie and the like are made available</p> |            |                 |

PUBLIC AWARENESS AND EDUCATION

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations   |
|--|----------------|---|---|---|
|  |                | and spread the word that recovery from addictions is possible while serving to applaud those who speak out to minimize shame associated w/ addictions.  |   |   |
| <b>Perinatal Substance Exposure TF</b>             | Moderate       | Media   | Identifying youth and disease at early stages                     | Aggressive prevention in schools and widespread use of SBIRT by all health care workers.<br>Promote FASD messages not only in NH Liquor and Wine Outlets, but in every retail location where alcohol is sold. |
| <b>DOE</b>   | High           | SS/HS project in the last year disseminated over 300 website resources and over 14,000 social media messages. In addition over 500 face-to-face meetings, trade shows, collaborative meetings and events. | Coordinating our efforts with other entities                      | Creating a central hub for messaging (see previous recommendations)   |
| <b>AG/ DOJ</b>                                     | High           | See above.  | Time and resources.   | See above.  |
| <b>DHHS-DCYF</b>                                   | Moderate       |   |   |   |
| <b>DHHS-BDAS</b>                                   | Moderate       | Issue briefs on heroin and other topics<br><br>Drugfreenh.com information on heroin and other topics  |   |   |
| <b>Dept. of Safety</b>                             | High           | DOS has been a partner in the NHDTZ (Driving Towards Zero) program, which promoted drug driving awareness in several media formats.   | One format that has not been used, due to expense, is television. | There should be a television media campaign on the dangers of drug abuse. This should be a public health campaign.  |

| DATA UTILIZATION                                   |                |   |  |  |
|--|----------------|---|--|--|
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges   | Recommendations  |
| <b>Recovery TF</b>                                 | Low            | See above   | See above  | See above  |
| <b>Perinatal Substance Exposure TF</b>             | Low            | Discharge Data  | The diagnosis must be associated with a code that is reimbursable or the event is missed   |  |
| <b>DOE</b>   | Moderate       | Obtaining grants based on data, schools administering YRBS, social emotional screening (approximately 2,300 were conducted), and coordinated efforts with schools and CMHC to share data for school and student programming | Understanding existing data systems such as WIZARD and how to educate schools in using it, Public perception of data collection, | Coordinated effort between state entities on data collection and use |
| DATA UTILIZATION                                   |                |   |  |  |
| <b>AG/ DOJ</b>                                     | Moderate       |   |  |  |
| <b>DHHS-BDAS</b>                                   | Moderate       | Development of SUD information in Wisdom, Phase I<br><br>Issue briefs as described above  | Lack of local enforcement data   | Better coordination of uniform local enforcement data collection     |

| EDUCATION SECTOR                                   |                |   |   |  |
|--|----------------|---|---|--|
| Student Assistance Programs                        |                |   |   |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations  |
| <b>Perinatal Substance Exposure TF</b>             |                |   |   |  |
| <b>DOE</b>   | High/Moderate  | We have increased knowledge and usage of these programs within the DOE, districts and amongst community partners. | Coordinating the use of these programs within schools despite the educational system having no input into their construction or implementation. | We recommend coordinating the responsibility for school based prevention and substance abuse programming with the DOE. |
| <b>DHHS-BDAS</b>                                   | High           | Increased SAP programming<br>Better collaboration with Safe Schools, Healthy Students programs                    | Implementing evidence based SAP program with fidelity   |  |

| EDUCATION SECTOR                                   |                  |  |            |                 |
|--|------------------|--|------------|-----------------|
| Life of an Athlete                                 |                  |  |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level ) | Successes  | Challenges | Recommendations |
| <b>DOE</b>   | Moderate         | See above  | See above  | See above       |
| <b>DHHS-BDAS</b>                                   | Moderate         | Expanded into additional schools<br>Produced good evaluation results |            |                 |

| EDUCATION SECTOR                                   |                |   |            |   |
|--|----------------|---|------------|---|
| School – and College-Based Prevention Education    |                |   |            |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations   |
| <b>Treatment TF</b>                                | Low            | Collaboration with Prevention Taskforce to ensure partnering on similar policies/ responsibilities that impact either system of |            | Ensure that prevention education is reaching the elementary school settings and their families to increase awareness of SUD issues. |

| EDUCATION SECTOR                                   |                |                                    |   |                 |
|--|----------------|------------------------------------|---|-----------------|
| School – and College-Based Prevention Education    |                |                                    |   |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes                          | Challenges  | Recommendations |
|  |                | SUD.                               |   |                 |
| <b>Perinatal Substance Exposure TF</b>             | Low-Moderate   | Improved training of professionals |   |                 |
| <b>DOE</b>   | Moderate       | See above                          | See above   | See above       |
| <b>DHHS-BDAS</b>                                   | No             |                                    | Lack of good relationships with higher education institutions |                 |

| EDUCATION SECTOR   |                |                              |            |                 |
|--|----------------|------------------------------|------------|-----------------|
| Model School and Higher Education Policies and Practices |                |                              |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION       | Activity Level | Successes                    | Challenges | Recommendations |
| <b>Prevention TF</b>                                     | High           | Completion of Top 5 document |            |                 |
| <b>DOE</b>   | Moderate       | See above                    | See above  |                 |
| <b>DHHS-BDAS</b>   | No             |                              |            |                 |

| EDUCATION SECTOR                                   |                |  |                                     |                 |
|--|----------------|--|-------------------------------------|-----------------|
| Youth Leadership Programming                       |                |  |                                     |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges                          | Recommendations |
| <b>DOE</b>   | Moderate       | See above  | See above                           | See above       |
| <b>DHHS-BDAS</b>                                   | Low            | RPHN contracts for substance use prevention provide a variety of youth leadership programs | Lack of coordination among programs |                 |

| HEALTHCARE SECTOR  |                |   |  |  |
|--|----------------|---|--|--|
| Screening in Brief Intervention and Referral to Treatment in Primary Care/ Hospitals |                |   |  |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION                                   | Activity Level | Successes   | Challenges                                 | Recommendations                                    |
| Treatment TF   | High           | Promotions and exposure in community, working programs in State   |  |  |
| Perinatal Substance Exposure TF  | Moderate       | Introduction into the Community Health Centers  | Needs to be available in all prenatal care | Continue support and monitoring of SBIRT programs. |
| DHHS-BDAS  | High           | SBIRT added to contracts with Community Health Centers identified as early adopters<br><br>Ground work for adding SBIRT to all community health center contracts for SFY16<br><br>Exposure education to hospital networks |  |  |

| HEALTHCARE SECTOR                                  |                |   |            |   |
|--|----------------|---|------------|---|
| Safe And Effective Opioid Prescribing Guidelines   |                |   |            |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations   |
| Treatment TF                                       | High           | Made recommendations to Legislature, Reviewed treatment guidelines re: acute postop vs. chronic pain and Rx's to treat pain |            |   |
| AG/ DOJ  | High           | As addressed above, working collaboratively with the relevant stakeholders to address rule changes.                         |            | See above. Also, continued dialogue to address how rule changes for all dispensers can affect and significantly impact the opiate problem in New Hampshire. |
| DHHS-BDAS  | No             |   |            |   |

| HEALTHCARE SECTOR                                  |                |  |            |                 |
|--|----------------|--|------------|-----------------|
| Prescription Drug Monitoring Program Utilization   |                |  |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations |
| Treatment TF                                       | High           | Actively utilized in many settings-however not mandatory and no inter-state access |            |                 |
| DHHS-BDAS  | Moderate       | Promote PDMP use   |            |                 |

| HEALTHCARE SECTOR                                  |                |   |   |   |
|--|----------------|---|---|---|
| Medication Assistance for SUD Treatment            |                |   |   |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations   |
| Treatment TF                                       | High           | Engagement of community health care centers in providing MAT in practice setting. Continue to work on improving collaboration with specialty providers and Community Health Centers for optimal treatment wrap-around services and to attract Office based Suboxone/Bup practices within State-Subcommittees working collaboratively to expand access to Treatment and Recovery community within identified Regions throughout State but need to revisit guidelines not clearly established re: counseling requirements | Ability to increase SUD treatment providers' capacity to provide MAT in cohesion with SUD services. Difficult to take capacity building risks when NHHPP continues to be a vulnerable program in the legislature. |   |
| Perinatal Substance Exposure TF                    | Moderate       | Pregnant women do get priority in MAT clinics   | These women in silo'd care  | This population needs wrap around care addressing prenatal care, life coaching, parenting, etc. |
| DHHS-BDAS  | Moderate       | On-going education and training with SUD providers, medical professionals and public around MAT   |   |   |

HEALTHCARE SECTOR

Other Expanded Access to Treatment and Recovery Supports

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges   | Recommendations   |
|--|----------------|--|--|---|
| <b>Recovery TF</b>                                 | Moderate       | Funding is now available for recovery support services for the first time  | 27.5% of the budget is being provided for the facilitating org. 1 of every 4 dollars is being provided for administration of services  | Re-evaluate the use of facilitating org dollars.  |
| <b>Treatment TF</b>                                | High           | Treatment Taskforce continues to work to engage all behavioral health providers in the state to provide SUD services when able to ensure quality of treatment based on knowledge of SUD treatment core competencies. | <p>There is much confusion re: process of selecting a QHP, which providers cover what specific services, differences between PAP, NHHPP and HIPP abound.</p> <p>Applicants/providers need clarity re: which services will be covered-reimbursed or if there will be required credentials/licensure associated with each QHP for reimbursement.</p> | <ol style="list-style-type: none"> <li>1. Increase the number of MLADC positions in Division of Children, Youth and Families to enhance the support parents need when involved with DCYF and are experiencing addiction. This MLADC can have direct collaborative links to the treatment centers in the region to assist in accessing necessary support for treatment and recovery.</li> <li>2. Create a system to provide an outreach MLADC/LADC to obstetrician settings, hospital neonatal ICU and maternity departments to provide support and treatment &amp; MAT connections for those mothers with addictions during pregnancy and before leaving hospital.</li> <li>3. Enhance the outreach and connection to community treatment centers for those inmates in jails/prisons while in the correctional system, opposed to waiting for discharge.</li> <li>4. Outreach SUD assessment</li> </ol> |

| HEALTHCARE SECTOR  |                |   |                           |   |
|--|----------------|---|---------------------------|---|
| Other Expanded Access to Treatment and Recovery Supports |                |   |                           |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION       | Activity Level | Successes   | Challenges                | Recommendations   |
|  |                |   |                           | teams to hospital or community settings for substance use assessments and community connections for those individuals treated with Narcan or other drug or alcohol symptoms.<br>5. Recommend reauthorization of NHHPP and maintaining plan for SUD services for existing Medicaid population to ensure ongoing SUD treatment access for Medicaid eligible citizens. Reauthorization will increase SUD provider's confidence/capacity to increase services across the state. |
| <b>Perinatal Substance Exposure TF</b>                   |                |   |                           | TA and other supports should be offered to community health centers to promote MAT within the context of primary care.  |
| <b>DHHS-BDAS</b>   | High           | BRSS-TACS<br>SMEs to the NHHPP<br>Nhtreatment.org<br>SUD Competencies for Behavioral Health Providers | Limited treatment network |   |

| HEALTHCARE SECTOR                                  |                |  |   |   |
|--|----------------|--|---|---|
| Third Party Payer Coverage for SUD Services        |                |  |   |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges  | Recommendations   |
| <b>Recovery TF</b>                                 | Low            | One of the recovery service organizations has had dialogue with insurance carriers | Capacity for the recovery service organizations to contract with those organizations is limited | Once in place, this should be a high priority for the FO. |

HEALTHCARE SECTOR

Third Party Payer Coverage for SUD Services

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges   | Recommendations   |
|--|----------------|--|--|---|
| <b>Treatment TF</b>                                | High           | Treatment Taskforce members work on the Medicaid Stakeholders Workgroup addressed barriers and problem-solved solutions to the roll out of NHHPP for SUD providers and behavioral health providers in the state. | Need to support SUD providers making the transition to private marketplace for NHHPP. This is another important step in ensuring that there is no gap in what SUD services are available currently in the managed care system for NHHPP. | <ol style="list-style-type: none"> <li>1. Recommend reauthorization of NHHPP to ensure ongoing SUD treatment access for 40,000+ NH citizens.</li> <li>2. Support a system to monitor and ensure compliance of parity in substance use and behavioral health.</li> </ol>   |
| <b>Additional Treatment TF member feedback</b>     | High           | More success in increasing authorizations for Residential LOC; better reimbursement rates than NHHPP however, still much lower than coverage for other tx.   | Parity law is not enforced across all insurance companies. UBH is a big culprit in as far as not utilizing ASAM like criteria called Interqual to authorize LOCs.  | <p>Pass legislation so that all insurance companies use ASAM consistently. Make official complaints/reports to the insurance commission regarding issues with 3<sup>rd</sup> party coverage.</p> <p>Make the DHHS regulations that dictate how AOD treatment is provided for NHHPP is changed to match what private insurance companies require, which is less restrictive. Current DHHS regulations limit/obstruct treatment</p> |
| <b>Perinatal Substance Exposure TF</b>             | Low            | Coverage for the “expansion population”  | No coverage for the Medicaid population or many third party payers   | Universal coverage for substance misuse and mental health disorders.  |
| <b>DOE</b>   | low            | SS/HS LEA pilot sites are creating contracts with CMHC that allow payment of co-pays for families that can’t afford services.  |  |   |
| <b>DHHS-BDAS</b>                                   |                | SMEs to NHHPP  |  |   |
| <b>Insurance Dept.</b>                             | High           | MHPAEA coverage required on all ACA compliant insured and self-insured plans   |  | Continued review for potential treatment gaps through the examination of CHIS data  |

| HEALTHCARE SECTOR                                  |                |   |   |  |
|--|----------------|---|---|--|
| Other  |                |   |   |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations  |
| <b>Perinatal Substance Exposure TF</b>             |                |   |   | Continue to increase access to naloxone within primary care, urgent care and community settings. |
| <b>DHHS-DCYF</b>                                   | High           | LADCs in two district offices, Manchester & Southern (Nashua), provide consultation to assigned Child Protection Workers (CPSWs).<br>DO based LADCs serve as a bridge to local treatment for clients who avail themselves of their service. | Insufficient access to LADCs Statewide  | Appropriate funds for additional LADCs to be positioned in all DCYF offices                      |
| <b>DHHS-BDAS</b>                                   |                |   | Accessing and working across and with new systems is a positive opportunity and also presents challenges as we learn to work together |  |

| SAFETY SECTOR                                      |                |  |            |   |
|--|----------------|--|------------|---|
| Drugged Driving Enforcement                        |                |  |            |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations   |
| <b>AG/ DOJ</b>                                     | High           | A prosecutor is assigned to assist law enforcement agencies in the investigation and prosecution of drugged driving matters, and to conduct training for law enforcement throughout the state. |            | On-going training for law enforcement. Because of high turnover, there is a constant need for training. |
| <b>Liquor Commission</b>                           | Moderate       | Continue to certify Drug Recognition Experts throughout the State of New Hampshire.  |            |   |

| SAFETY SECTOR                                      |                |   |   |  |
|--|----------------|---|---|--|
| Drugged Driving Enforcement                        |                |   |   |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges  | Recommendations  |
| DHHS-BDAS  | Moderate       | Oversight, technical assistance, and training to NH's IDCMPs  | See above re: cultural differences  |  |
| Dept. of Safety                                    | High           | The DOS has been engaged in grant funded drug driving enforcement patrols for several years. Recently the DOS has expanded the hours worked into the afternoon commute. The DOS has also recently begun a Mobile Enforcement Team (MET), which focuses on all crimes including drug transportation and DUI-D. The DOS has also continued to certify drug recognition experts currently totaling 37 Troopers or more than 10% of the Division. | Communities with high rates of drug abuse should follow the lead of the DOS in this regard. | Grant funding should be available for any agency (with qualified personnel), that can demonstrate a drugged driving problem through the use of data. |

| SAFETY SECTOR                                      |                |   |            |                                |
|--|----------------|---|------------|--------------------------------|
| Law Enforcement Patrols and Surveillance           |                |   |            |                                |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations                |
| Adjutant General/ NH National Guard                | High           | Provided Counterdrug analytical support to four law enforcement agencies across the state, aiding in those agencies abilities to reduce the supply of illicit drugs.                          |            |                                |
| AG/ DOJ  | High           | In 2015, the Drug Task force Unit seized an estimated 4,942 grams of Heroin, 1,894 grams of Marijuana, 748 grams of Cocaine, 15 grams of crack and 26 grams of Methamphetamine. These numbers | Resources. | See above regarding resources. |

SAFETY SECTOR

**Law Enforcement Patrols and Surveillance**

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges   | Recommendations   |
|--|----------------|---|--|---|
|  |                | are significantly higher than those seized in 2014. In 2015, other drugs that were obtained by the task force include 402 grams of bath salts, 55 depressant pills and 604 Oxycodone pills. These numbers are significantly higher than 2014 in which 282 OxyContin pills were obtained whereas the number of depressant pills had a slight drop at 128 depressant pills. |  |   |
| <b>Liquor Commission</b>                           | High           | Results in detainment of minors in possession of alcohol and adult providers of alcohol   |  | Funding for increasing this enforcement activity has been lost due to defunding of the Enforcing Underage Drinking Grant. |
| <b>Dept. of Safety</b>                             | High           | As previously stated the DOS has recently begun a Mobile Enforcement Team (MET, which focuses on all crimes including drug transportation and DUI-D. The members of this team work in problem areas around the state with local police partners, drug units, and the DEA. To date the unit has been highly successful   | The burden of funding such patrols cannot be based on highway safety grants alone. |   |

SAFETY SECTOR

**Juvenile Court Diversion**

| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations |
|--|----------------|--|------------|-----------------|
| <b>Prevention TF</b>                               | Moderate       | Advocated for Diversion funding to be included in GC budget; have written letters of support for grant funding for Diversion Network |            |                 |

| SAFETY SECTOR                                      |                |   |  |   |
|--|----------------|---|--|---|
| Juvenile Court Diversion                           |                |   |  |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges   | Recommendations   |
| <b>DOE</b>   | Low            | We have increased knowledge and usage of these programs within the DOE, districts and amongst community partners. | Coordinating efforts between state, school, JPPOs, law enforcement, and diversion to have a coordinated effort for student supports and services | Creating a state known system of care/continuum of services that include community supports and services. |

| SAFETY SECTOR                                      |                |  |            |  |
|--|----------------|--|------------|--|
| Drug Courts  |                |  |            |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations  |
| <b>Treatment TF</b>                                |                |  |            | Expansion of drug courts across the state so there is 100% deferment to drug courts for any persons who have not committed violent crimes. |
| <b>DHHS-BDAS</b>                                   | Low            | Providing support to drug courts and those seeking drug court funding and educating the public about drug courts |            |  |

| SAFETY SECTOR                                      |                |           |            |                 |
|--|----------------|-----------|------------|-----------------|
| Alternative Sentencing                             |                |           |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes | Challenges | Recommendations |
| <b>No reporting activity</b>                       |                |           |            |                 |

| SAFETY SECTOR                                      |                |           |            |                 |
|--|----------------|-----------|------------|-----------------|
| Certain and Swift Sanctions                        |                |           |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes | Challenges | Recommendations |
| No reporting activity                              |                |           |            |                 |

| SAFETY SECTOR  |                |                           |   |   |
|--|----------------|---------------------------|---|---|
| Other Expanded Access to Treatment and Recovery Supports |                |                           |   |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION       | Activity Level | Successes                 | Challenges  | Recommendations   |
| Recovery TF  | Low            | Laconia Police Department | Lack of a coordinated plan for criminal justice system to interact with recovery support services. For example, recovery support services are not mentioned (or funded) in the expanded in the current plan for increasing drug courts in NH. | Intentionally include and pay for recovery services as a part of expanded drug courts in New Hampshire. Then use that model as a way to open conversations between recovery support services and the criminal justice system / law enforcement. |

| SAFETY SECTOR                                      |                |  |   |   |
|--|----------------|--|---|---|
| Other  |                |  |   |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges  | Recommendations   |
| Department of Safety: NHSP Forensic Laboratory     | High           | Provides analytical results for the state and is a great source to review trends and anomalies | Sheer volume of monthly submissions are far greater than current resources to process the cases | A combination of additional staff and equipment would assist the throughput of cases and would lead to expeditious prosecution of dealers and disposition of users. |

| BUSINESS SECTOR                                    |                |                           |            |  |
|--|----------------|---------------------------|------------|--|
| Workplace Education and Policy                     |                |                           |            |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes                 | Challenges | Recommendations                                |
| Recovery TF  | Low            | BIA representative to the |            | Evaluate and, if appropriate, develop the idea |

| BUSINESS SECTOR                                    |                |   |            |                                    |
|--|----------------|---|------------|------------------------------------|
| Workplace Education and Policy                     |                |   |            |                                    |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes   | Challenges | Recommendations                    |
|  |                | Governor's Commission is a member of the Recovery Community         |            | of "Recovery Friendly" workplaces. |
| DHHS-BDAS  | Low            | Information and referral on drug free workplace policy and practice |            |                                    |

| BUSINESS SECTOR                                    |                |           |            |                 |
|--|----------------|-----------|------------|-----------------|
| Workplace Screening and Referral to Services       |                |           |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes | Challenges | Recommendations |
| None reporting activity                            |                |           |            |                 |

| BUSINESS SECTOR  |                |   |            |   |
|--|----------------|---|------------|---|
| Other Expanded Access to Treatment and Recovery Supports |                |   |            |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION       | Activity Level | Successes   | Challenges | Recommendations   |
| Recovery TF  | Low            | BIA representative to the Governor's Commission is a member of the Recovery Community |            | Evaluate and, if appropriate, develop the idea of "Recovery Friendly" workplaces. |

| COMMUNITY SECTOR                                   |                |  |            |                 |
|--|----------------|--|------------|-----------------|
| Rx Drug Take Back Events and Drop Boxes            |                |  |            |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges | Recommendations |
| Adjutant General/ NH National Guard                | High           | Directly supported Drug Take Back events by transporting ALL turned-in |            |                 |

| COMMUNITY SECTOR                                   |                |  |  |   |
|--|----------------|--|--|---|
| Rx Drug Take Back Events and Drop Boxes            |                |  |  |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges   | Recommendations   |
|  |                | prescription drugs from locations throughout the state to a central military armory, reporting and weighing materials, and then transporting them for destruction. |  |   |
| <b>DOE</b>   | Low            |  |  | This is an area that our grants are discussing  |
| <b>AG/ DOJ</b>                                     | High           | The DEA has reinstated the semi-annual drug collection events, and the number of permanent drug collection boxes continues to grow.                                | Lack of public awareness around the drug take-back efforts. Insufficient numbers of drug collection boxes. | Additional resources should be allocated in a concerted public message to make the public aware of the location of the permanent drug collection boxes. |
| <b>DHHS-BDAS</b>                                   | Low            | Promotion of events across the state   |  |   |
| <b>Dept. of Safety</b>                             | Moderate       | High Success   | 24 hr. locations   | Increase # of locations for drop boxes  |

| COMMUNITY SECTOR                                   |                |  |  |  |
|--|----------------|--|--|--|
| Recovery Support Services                          |                |  |  |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges   | Recommendations  |
| <b>Treatment TF</b>                                | Moderate       | 1. Partnering with Recovery Taskforce to ensure collaboration between treatment and recovery sectors to ensure quality transitions between either systems. | 1. Recovery systems are currently being initiated and beginning to develop, however in more rural settings of the state, more difficult for treatment providers to access Recovery Support systems to bridge individuals in recovery from treatment setting. | 1. Continue to support financial and with system development for significant capacity building in recovery supports across the state.<br>2. Ensure collaboration with new recovery supports centers/systems created and specialty treatment providers (as well as health care and behavioral health provider settings) in the region for a seamless transition in the continuum of care. |

| COMMUNITY SECTOR                                   |                |  |                            |  |
|--|----------------|--|----------------------------|--|
| Recovery Support Services                          |                |  |                            |  |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes  | Challenges                 | Recommendations  |
| <b>DOE</b>   | High           | We have created positive school culture and climate to support an array of student service and support needs. And strengthened the ability of the school community and local communities to support the engagement and success of all students | Sustainable funding source | A coordinated and multi-agency funding source that would support school communities in continuing the multi-tiered system framework that integrates law enforcement, DCYF, JPPO, CMHC, non-profits, families, and youth. |

| COMMUNITY SECTOR   |                |  |  |                 |
|--|----------------|--|--|-----------------|
| Other Expanded Access to Treatment and Recovery Supports |                |  |  |                 |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION       | Activity Level | Successes  | Challenges   | Recommendations |
| <b>Recovery TF</b>                                       | Moderate       | Groups are forming and sustaining, state funded secured for the biennium | Organizational capacity / lack of administrative infrastructure / data collection and analysis systems | See above       |

| COMMUNITY SECTOR  |                |  |  |   |
|---|----------------|--|--|---|
| Other   |                |  |  |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION  | Activity Level | Successes  | Challenges   | Recommendations   |
| <b>Recovery TF</b><br>Family Support Services & Integration of Recovery Support Services between Mental Health and Addiction Recovery Model | Low            | Family groups have emerged across the state / BRSS TASCs brought together Mental Health and Addiction Recovery Advocates | Both groups lack sufficient resources to implement programs as needed. | Continue BRSS TACS work and integrate plans for the further development and implementation of these programs in the plan for the state. |
| <b>Perinatal Substance</b>  |                |  |  | Increase access to naloxone within primary  |

| COMMUNITY SECTOR                                   |                |           |            |   |
|--|----------------|-----------|------------|---|
| Other  |                |           |            |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level | Successes | Challenges | Recommendations                           |
| Exposure TF  |                |           |            | care, urgent care and community settings. |

| OTHER  |                      |   |   |   |
|--|----------------------|---|---|---|
| Third Party Payer Coverage for SUD Services        |                      |   |   |   |
| STATE PLAN STRATEGY AREA & BEST PRACTICE PROMOTION | Activity Level       | Successes   | Challenges  | Recommendations   |
| Recovery TF  | Low                  | Four of the recovery service organizations has had dialogue with third party payers | Capacity for the recovery service organizations to contract with those organizations is limited | Once in place, this should be a high priority for the FO. |
| Perinatal Substance Exposure TF                    | Low                  | Benefits for the “expansion population”   | Lack of benefits for substance misuse and mental health disorders for most individuals          | Legislative enforcement of parity                         |
| DOE  | See previous comment |   |   |   |

**SECTION IV: FINANCIAL EXPENDITURE QUESTIONS** (State Agencies/Departments only)

Every other year state agencies and departments represented on the Commission are required to report on state and federal expenditures related to alcohol and other drug services and initiatives. If you are representing a state agency, please report in as much detail as possible.

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2013 in whole or in part by state or federal funds.

| Commission Agency Response                            | Name of Program or Service       | Primary Service Category | Address prescription drug or opioid abuse? | SFY 2015 Funds allocated to this program or service | Is this Federal or State / General funding?   | Estimated or actual? | If discretionary, note date funding period ends | Description Notes/Comments  |
|---|----------------------------------|--------------------------|--|---|---|----------------------|---|---|
| DHHS-Division for Children, Youth and Families (DCYF) | Individual Outpatient Counseling | Treatment                | Yes  | 6003.39   | GF  | Actual               |   |   |
|   | Group Outpatient Counseling      |                          |  |   |   |                      |   |   |
|   | Residential Treatment Facilities | Treatment for Juveniles  | Yes  | 114,441.06  | Federal 93,206.82 (81%)<br>GF 21,234.54 (19%) |                      |   |   |
|   | Drug Testing                     | Intervention             | Yes  | 31,446.17   | GF  | Actual               |   |   |
| Attorney General/ Department of Justice (DOJ)         | Counterdrug Task Force           | Prevention,              | Yes  | \$126,000   | Federal                                       | Estimated            |   | Counterdrug Task Force Civil Operations Specialist working with BDAS, Regional Public Health Networks, and Community Coalitions to reduce the demand for illicit drugs. |
|   |                                  | Intervention             | Yes  | \$524,000   | Federal                                       | Estimated            |   | Counterdrug Task Force Criminal Analysts working with federal, state, and local law enforcement agencies to reduce the supply of illicit                                |

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2013 in whole or in part by state or federal funds.

| Commission Agency Response                      | Name of Program or Service   | Primary Service Category                      | Address prescription drug or opioid abuse? | SFY 2015 Funds allocated to this program or service | Is this Federal or State / General funding? | Estimated or actual? | If discretionary, note date funding period ends | Description Notes/Comments  |
|---|--|---|--|---|---|----------------------|---|---|
|   |  |   |  |   |   |                      |   | drugs.  |
| Department of Corrections (DOC)                 | Licensed Alcohol Drug Counselors   | Treatment                                     |  | \$737,041   | General                                     | Actual               |   |   |
| Department of Education (DOE)                   | Title IV Part A, Safe and Drug-Free Schools and Communities - School District Federal Grants | We no longer receive funding for this         |  |   |   |                      |   |   |
|   | Safe School Health Students Initiative   | Prevention, Intervention, Treatment, Recovery | Yes  | 2.2 million   | Federally                                   |                      |   | This is obligated funds to 3 LEAs   |
|   | Project AWARE  | Prevention,                                   | Yes  | 1.75 million  | Federally                                   |                      |   | This is obligated funds to 3 LEAs Note: Project AWARE is heavily prevention focused. There is a large focus on developing a positive school climate and culture, coordinating efforts across agencies to connect youth and family with appropriate services, and training. These all develop protective factors which impact prevention, intervention, treatment and recovery |
| DHHS Bureau of Drug and Alcohol Services (BDAS) | Treatment Services   |   |  | \$8,978,909   | 57%Fed/43% Gen                              |                      |   |   |
|   | Prevention Services  |   |  | \$3,415,258   | 75%Fed/25% Gen                              |                      |   |   |
|   | ATR services   |   |  | \$770,976   | 100% Fed                                    |                      |   |   |

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2013 in whole or in part by state or federal funds.

| Commission Agency Response                             | Name of Program or Service                            | Primary Service Category | Address prescription drug or opioid abuse?  | SFY 2015 Funds allocated to this program or service | Is this Federal or State / General funding? | Estimated or actual? | If discretionary, note date funding period ends | Description Notes/Comments   |
|--|---|--------------------------|---|---|---|----------------------|---|--|
|  | Treatment Services                                    |                          |   | \$8,978,909   | 57%Fed/43% Gen                              |                      |   |  |
| Department of Safety (DOS)<br>Division of State Police | DARE Program  | Prevention               | No, this school focuses on alcohol and tobacco use. This program should also focus on marijuana and opioid abuse. | No  | No  | N/A                  | N/A   | This program is run with donations and often taught by officers with many other collateral duties. The program should be state funded with professional instructors. |
|  | Marijuana Eradication Grant                           | Enforcement              | No  | \$0   | Federally Funded                            | \$20,000             | 12/31/2015                                      | Strictly for Marijuana Grow related investigations   |
|  | Pharmacist Board Compliance Inv./Insp.                | Enforcement              | Yes   | \$104,265   | State – No General funding                  | Actual               | N/A   | Provides funding for a Pharmacist who assists with Diversion Investigations  |
|  | NHSP Forensic Laboratory                              | Enforcement              | Yes   | \$2,139,000   | State - No General funding                  | Estimated            | N/A   | Provides analytical results for all drug case submissions (raw material) and impaired driving/post-mortem testing  |
| Administrative Office of the Courts                    |   |                          |   |   |   |                      |   |  |
| NH Liquor Commission                                   | Buyers Beware Campaign<br>Make Right Choices Campaign | Prevention/<br>Awareness | No  | \$100,000   | General                                     | Actual               |   | Included in the NHSLC marketing and advertising budget.  |

Please list alcohol and drug abuse prevention, intervention, treatment and/or recovery services provided by or funded by your agency, bureau or division during SFY 2013 in whole or in part by state or federal funds.

| <b>Commission Agency Response</b>      | <b>Name of Program or Service</b> | <b>Primary Service Category</b> | <b>Address prescription drug or opioid abuse?</b> | <b>SFY 2015 Funds allocated to this program or service</b> | <b>Is this Federal or State / General funding?</b> | <b>Estimated or actual?</b> | <b>If discretionary, note date funding period ends</b> | <b>Description Notes/Comments</b>   |
|--|-----------------------------------|---------------------------------|---|--|--|-----------------------------|--|---|
| Adjutant General/<br>NH National Guard | Counterdrug Task Force            | Prevention,                     |   | \$126,000  | Federal  | Estimated                   |  | Counterdrug Task Force Civil Operations Specialist working with BDAS, Regional Public Health Networks, and Community Coalitions to reduce the demand for illicit drugs. |
|  |                                   | Intervention (Enforcement)      | Yes   | \$524,000  | Federal  | Estimated                   |  | Counterdrug Task Force Criminal Analysts working with federal, state, and local law enforcement agencies to reduce the supply of illicit drugs.                         |

# INSUFFICIENT TREATMENT SERVICES FOR US

AT LEAST **14** TREATMENT PROGRAMS HAVE CLOSED  
IN NEW HAMPSHIRE IN THE PAST TEN YEARS

ALICE PECK DAY PROGRAM { LEBANON }

BEECH HILL HOSPITAL { DUBLIN }

CHARTER BROOKSIDE { NASHUA }

CONCORD HOSPITAL INPATIENT PROGRAM { CONCORD }

LAKE SHORE HOSPITAL { MANCHESTER }

NATHAN BRODY INPATIENT PROGRAM AT LAKES REGION GENERAL HOSPITAL { LACONIA }

NEW START AT ST. JOSEPH'S HOSPITAL { NASHUA }

PROSPECTS AT FRISBEE HOSPITAL { ROCHESTER }

RIVERWAY AT CATHOLIC MEDICAL CENTER { MANCHESTER }

SEABORNE HOSPITAL { DOVER }

SEMINOLE POINT { SUNAPEE }

SPOFFORD HALL { SPOFFORD }

VA MEDICAL CENTER INPATIENT PROGRAM { MANCHESTER }

WHISPERING PINES AND SEAFIELD PINES { KEENE }

“CURRENT ALCOHOL AND OTHER DRUG NEEDS EXCEED  
THE EXISTING CAPACITY [FOR TREATMENT] WITHIN THE STATE  
**BY 2-10 TIMES.”**

source: NH Division of Alcohol and Drug Abuse Prevention and Recovery (2001) <sup>45</sup>