

**GOVERNOR'S COMMISSION ON ALCOHOL & DRUG ABUSE  
PREVENTION, INTERVENTION AND TREATMENT**

**August 28, 2015  
LEGISLATIVE OFFICE BUILDING  
CONCORD, NH**

**MINUTES**

**Members Present:**

Lorraine Bartlett, *Division of Children, Youth and Families*  
Marty Boldin, *Recovery Representative*  
Mary Bubnis, *Department of Education*  
Cheryl Ann Coletti, *Business and Industry Association*  
Rebecca Ewing MD, *Public Member*  
Jeanie Forrester, *Senator*  
Joseph Foster, *Attorney General*  
Traci Fowler, *Partners in Prevention*  
Ned Gordon, *Circuit Court*  
Joe Harding, *Executive Director*  
Scott Kalicki, *Community College System of NH*  
Timothy Lena, *Prevention Professional*  
Jennifer Patterson, *NH Insurance Department*  
Chris Placy, *Public Member*  
Dan Potenza, *Dr.*  
William N Reddel III, *Major General*  
Timothy Rourke, *Chairman and Director of Program, NH Charitable Foundation*  
Seddon Savage MD, *Medical Society*  
Stephanie Savard, *Treatment Professional*  
Mary Steady, *Department of Education*  
John Tholl, *Representative*  
Nick Toumpas, *Department of Health and Human Services*  
Jim Wilson, *New Hampshire Liquor Commission*  
Jack Wozmak, *Governor's Office- Senior Director of Substance Misuse and Behavioral Health*  
William Wrenn, *Department of Corrections*

Tym Rourke opened the meeting and introductions were done around the table.

Review of the June 26, 2015 minutes. Minutes approved.

**Opiate Response Update**

- Naloxone Distribution Plan
  - Two different efforts going forward.
    - a. Health and Human Services working with the Department of Safety around procurement, distribution and training.
    - b. Complimentary effort going on with the Taskforces of the Governor's Commission related to obtaining prescriptions that can be filled at pharmacies.
  - Naloxone is a medication used to reduce overdose.
  - State Effort.
    - a. Responding to the two new laws HB 271 and HB 270 which has allowed dispensation of Naloxone and also there are "Good Samaritan" rules around that. Friends and family can also be prepared to administer Naloxone. The New Hampshire Department of Health and Human Services and the Department of Safety throughout the summer purchased and now are planning how to train and distribute for the administration of Naloxone. We have ordered 4,700 Naloxone kits. Each kit contains

two doses of Naloxone. Understanding that many individuals who are in an overdose situation do not respond to one dose. We are prepared for two doses which are nasal administrators. The kit has the nasal atomizer, latex gloves and directions on how to administer. We do plan to eventually get it into the hands of laymen.

- b. We are working primarily with our law enforcement. Bureau of Emergency Medical Services has been vital in this project. They are doing the training work and also we have enlisted Community Health Centers throughout the state to participate as well.
- c. Our first strategy is to work with first responders and Community Health Centers throughout the state. The Bureau of Emergency Medical Services to complete training with law enforcement officials. There is a shortened training that the layman can get. They are bundling the administration of naloxone into the trainings that also include CPR and the defibrillator. It will be a complete training for law enforcement officials who have not been trained.
- d. We want to make sure that the sheriff's departments are also involved in this. We know that sheriff's departments cover very rural areas and they might get to a caller long before the EMS team.
- e. Once trained the available 4,700 naloxone kits will be made available to them.
- f. The Emergency Management Services will also be training in five different Training of Trainers programs.
- g. EMS throughout the state will not have access to these Naloxone kits as they already have Naloxone through their hospital systems.
- h. As soon as we have individuals in the Community Health Centers that are trained we will start the distribution process to those centers.
- i. The distribution will be done by the Emergency Services Unit.
- j. The second set to be trained are social service agencies who may have contact with people who are at risk and their families.
- k. We want to get this out to treatment centers, homeless shelters, to any of the areas that are easily accessed by folks who are at risk for this addiction.
- l. We also think there may be a place for public training. The Public Health Networks will be able to gather folks together and come in and be trained.
- m. Trainings should start in September.

*Questions: How much enthusiasm or interest have you had from the law enforcement community? My understanding is that many have not elected to take the training. If that is true I am wondering if there are efforts to generate interest.*

The interest has not been overwhelming but there are some police departments that are interested. One of the things about doing this under the Public Health Networks is it included the Emergency Preparedness folks also includes our substance misuse prevention coordinators and new continuum of care facilitators that can engage local law enforcement and encourage it.

*In terms of risk management I have heard that when some people are given Naloxone that they wake up violent and that you should have two people present when dosing is this accurate? The other piece is that we have to think more broadly about this moment of opportunity we have when we are training folks because as many of us know these overdoses happen and there is a small baby in crib. In that moment we can't just be training people on medical administration of Naloxone but we have to be providing resources for the family.*

The department will provide you with as much information as it can and we will look to all of the resources that we have. As a member of the public health network are perfectly positioned to answer some of those additional questions.

- One of the things we want to be able to do is you just don't administer the Naloxone and call 911 and have them go to the emergency department there is an opportunity at that point to try and engage the person to access treatment.
- There will be some information about available resources that will be given out at the emergency departments.
- There is a concurrent Public Awareness Campaign that is going on. We do want to do more than just administer the Naloxone. In Rhode Island they have peer recovery support workers going to the emergency rooms and engaging the folks, if they want to, and give them the information on resources and possibly have a discussion with them so people can get the help that they need.

*Question: I would like to get a gauge from the department on distribution. We have a network of family support groups. We have some family support groups who are trying to pilot ways of getting prescriptions, how to get it done, and where roadblocks and obstacles exist. It seems like this would be a phenomenal opportunity to dispense relatively*

*quickly deploy to a very high risk population through a system that the state has at its disposal through each of the parent work groups. They have trained volunteers who run it. There are some groups that are already working on it. Many of those groups were the groups that championed the inclusion of this bill the ability to access for families. It seems that we are going into the emergency response first and families later. I am concerned that it might shortchange the family groups. We have family groups that are trying to get Naloxone to families today. Is there an option to the infrastructure around training and some of the early scaling, could this include some of the members to these family groups?*

Our first effort is going to be with the Community Health Centers as they are our first line medical folks around each of the different regions. Then the calls with the Regional Public Health Networks were for them to identify are their organizations in their community across the sectors that we talked about that are willing and able to do this, that are coming in frequent contact with people who are at risk for opioid overdose or their families and friends that could play a role in this. Connected to this that we haven't talked about yet and the Attorney General's office is working on this, is the standing order. Ideally we would like to be able to do is for a local organization to have a physician write a standing order that they can disseminate to their patients or clients or that they can hold a public event and get a training and they would get a kit. That could be the family support centers or any number of organizations. Whatever makes sense in each of the regions or communities to get this out. This is really are first and best effort on the passage of HB271. It will be up to the communities to decide to identify what is their capacity.

*Comment: The message right now to those organizations would be to connect with their local Public Health Network as step one.*

*Question: I have heard about Naloxone having temperature sensitivity and expiration dates. If we have a certain amount of product out there that is sitting a shelf at a certain point are we talking to folks about if they have not used it by a certain time what to do with it?*

We do need to take a look at that. At the state level where we are storing it there is an agreement with the manufacturer that in the event that there is some sitting on the shelf at their expiration time that they would turn it over for us and give us new stuff. Naloxone has a shelf life of about a year and a half.

- Healthcare Taskforce
  - There are two documents that have been passed out.
  - One is on the Healthcare Task Force to look at where Naloxone fits in to the overall strategy for the healthcare community to really engage in in reducing opiated related harm.
  - Naloxone is an end stage intervention.
  - Once we have it launched we can go back and try and stop this at earlier stages.
  
- Naloxone Task Force
  - Grew out of the Healthcare Taskforce.
  - To look at how we distribute Naloxone through healthcare channels to persons who could intervene in an opioid overdose.
  - First thing we needed was clarification of what the law intents. We want a confirmation from the Attorney General's office. Formal statutory interpretation is still in process and should be forthcoming within days. What we understand what is like to occur in answering the question "to whom can a clinician prescribe Naloxone?" Normally we prescribe to the person who is using the drug not to the person who comes in and says "they are concerned about their loved one."
  - We have affirmation that the intent is we can prescribe not only to persons who will be using it but to anybody who is concerned about it.
  - So we can prescribe to third party.
  - Can we prescribe to people who we don't have a clinical relationship? Yes. We have affirmation that we can give it to anybody.
  - Can we write multiple doses to somebody who wants thirty kits so they can distribute to other people? Yes the law seems to permit that.
  - Documentation is an issue. Usually we write it in our records. If you don't keep a record on people we considered having a separate log you would write down all the people and the date.
  - On reviewing this with the Board of Medicine who is charged with writing policy and rules that govern clinician prescribing practices we determined that record of distribution by the pharmacy (whenever the pharmacy dispenses a drug there is documentation, the name of the person, the date and the prescriber), that shall be sufficient. The rules will say that we anticipate that will be the documentation.

- How do you educate that person? The taskforce has discussed this on whether it should be the prescriber or dispenser. The tradition that is evolving across this country when pharmacies dispense Naloxone is that education takes place at the level of the pharmacy.
  - When you get a prescription you receive a printout. With a Naloxone prescription the pharmacies tell us they spend 10-15 minutes going over the effects of the drug, how to recognize an overdose and how to use the particular delivery vehicle that is being given.
  - We needed more clarification on “what is the standing order?” The bill says that “directly to a patient or through a standing order prescribers can make this available.” Standing orders for most physicians/clinicians mean a long term relationship with a patient. We asked the Attorney General’s office on whether this means that we can write a standing order to a class of persons with the intent that it is being dispensed at will by a pharmacist. The Attorney General’s office has said “yes.”
  - This will enable the prescribers’ to identify and write to Community Health Centers and others. Not only to pharmacists but community members.
  - The glitch is people are beginning to ask for Naloxone at pharmacies and at their prescribers. There are cases where people are prescribed Naloxone at the appropriate dose and when they pick it up they get a little vial of Naloxone but no delivery system.
  - We are working on a single sheet that will serve to educate physicians, pharmacist and users.
  - There will be three options. On the sheet we are developing there will be the options.
    - a. One is for prescribing in case they do not know where to order it.
    - b. There will be very simple instructions for the person to administer Naloxone
    - c. Call 911, 2-3 rescue breaths, and administer naloxone and then how to recognize an overdose.
    - d. These will go out and will be posted at the Board of Medicine and Medical Society.
  - Anybody should be able to get Naloxone within 36 hours. Hopefully it will be one hour in the near future.
  - Information for treatment <http://nhtreatment.org/> should be on this sheet.
- **Naloxone Public Awareness**
    - Trying to put forth a comprehensive approach that includes populations strategies, prevention, early intervention, treatment and recovery supports.
    - We are working on a public education awareness campaign.
    - We have met with some of the family support groups. Getting information on what to use, what images to use, and what not to use.
    - We have fifty messages for about fifty different audiences that will go out to the public.
    - Once the tagline, image, message has been finalized it will cover the naloxone instruction kit to doctors, psychiatrists, TV, radio, websites, etc.
  - **Senior Policy Director Response**
    - Narcan
    - We are trying to find money to open up a Drug Court in Manchester.
    - We are looking at our first annual report for the Prescription Drug Monitoring Program. Hopefully we will be able to establish some baseline metrics in terms of the number of opioid prescriptions. To begin to get a baseline so that as our education efforts for physicians roll out we can measure some impact on the number of opioids prescribed.
    - A press release went out yesterday on a provider training program to address the opioid epidemic. This is a pivotal program. It will be moving educational program around the state and getting hosts from every hospital in the state so we can reach 13,000 prescribers who are licensed to issue opioid medications. You are advised to read the press release on that.  
<http://www.governor.nh.gov/media/news/2015/pr-2015-08-27-opioid-training.htm>
    - Commissioner Toumpas has said that he and his staff are examining the policies in Medicaid that have perverse incentives or other barriers around the reimbursement for opioids.
    - We’ve been working with the Insurance Department and others to develop some metrics with respect to tracking the number of people who are successfully or unsuccessfully accessing treatment and trying to get some detail on the level of care they are able to access. This will be useful as we build out the structure and the continuum care within each Regional Public Health Network.
    - We have begun work with Commissioner Barry and the Department of Insurance staff on the second half mainly of the major aspect of prevention. The first one is physician education. The second is incorporating/infusing prevention messaging within the school curriculums from kindergarten all the way through.

- We are contemplating with some language with respect to legislation that might require or provide for some hospitalization and an opportunity for initial treatment for anybody who is a victim of overdose. This would remove any prior authorizations required by Insurance Companies.
- Vivitrol in the correctional setting. Generally they are administering Vivitrol to some people leading up to discharge in the hopes that Vivitrol that it can be administered to people going out the door. It can last up to 30 days. They then would have to connect to treatment providers in the community to maintain the therapeutic alliance which has to be present in order for Vivitrol to be effective. Policies and medical protocol are being finalized.
- We would like to establish a hotline for addiction. 211 may be an opportunity for that. We've looked at the services they offered. There may be some opportunity with more training which would strengthen our response.
- Expanding treatment options. We have had conversations with 11 different treatment providers with respect to their willingness to expand to provide a strong continuum of care. We may be able to announce the increase in the number of detox beds in the state.
- Our goal is to standardize assessment centers for addiction. There would be an 800 number and a standardized assessment you would be able to get an independent assessment about your substance use disorder in order to determine the appropriate level of care for that person.
- Take back boxes. It is a conversation that will happen down the road.
- Housing. We have met with people who have an interest in creating transitional housing primarily for women. Women seem to be an underserved population particularly for people coming out of the prisons.
- There has been a recent announcement at the Federal level of more money available for the New England and other regions for high intensity drug trafficking. This will help begin to connect public health with law enforcement efforts to bring those closer together.
- We will be reaching out to folks at Dartmouth and others to create a statewide coordinated system.
- We need more recovery houses.

*Comment by Chairman Rourke: I am inclined to keep a standing agenda item on opiates as a class of our work. Recognizing it with multiple task forces, multiple partners and multiple ways. We may not take an hour every meeting. This issue commands it. As we are watching what rolls out I will be attentive to how we spend our collective time together. I want to thank everybody for all of this incredible work.*

## **Budget**

- Everybody knows where the state budget is at and the process is underway. The fall will bring furtherance of that conversation. As we get clarity around where the fiscal policy lands on the alcohol fund and other factors we will collectively pay a visit to the fiscal documents that we created at the end of last year. We would have priorities but we need to be attentive to what is going on. An event horizon has taken place where we are at a pause in terms of financial decision making. I expect as begin to get more clarity as to how the budget process may play out. I may ask for some meetings off this month with some other folks, or we may take our agenda in October and really go deep into some of those recommendations if we are ready to make some decisions on that.
- It is August which means that by December 1 this Commission is required by statute to send a report to the Governor, the Speaker of the House and Senate President. That will include some programmatic updates on our work and we will work through the taskforce chairs to facilitate all of that. It also involves some budgetary analysis of expenditures across state agencies for substance use services.
- Jack will be taking on the role of working with Lisa at the Center for Excellence who has traditionally done this. State agencies can expect to hear from Jack and Governor's office to really make sure we pull as accurate and robust data array around financing.
- It is important to recognize that state financing is only part of what constitutes the state's fiscal input into this issue. There federal dollars. There are resources that don't go this commission, that don't go to HHS (Health & Human Services) that may go to safety or the AG's office that are very much drug and alcohol related money even though we do not call it that.

## **Laconia Prevention, Enforcement and Treatment Project (PET) (Chief Adams)**

- The program is still in its early stages.
- Background on Laconia
  - Laconia has a history with substance abuse.
  - We are talking about the heroin abuse now but we are realizing we need to get away from talking about a specific drug and talk about addiction.

- Ten years ago we had the methadone and cocaine.
- We actually changed our philosophy in policing about ten years ago.
- Instead of being reactive we became proactive. Instead of just responding we started thinking about “why are we responding? Who are the stakeholders? What can be done to improve on those conditions?”
- We had a POP (Problem Oriented Policing) project for overdoses. At the time it began because of methadone overdoses.
- The PET program is a natural evolution of the POP program and that thought process.
- Ten months we came up with the idea to address this further as “police cannot arrest their way out of this.” That is a very true statement.
- The majority of the people that we deal with even if they do sell illegal drugs mainly do it to feed their addiction which is heroin at this time.
- The city of Laconia agreed to fund a position and the program for half a year with the understanding that we would present to them and then they would decide to continue.
- Next step was to hire a person – Officer Eric Adams. We wanted a police officer as we feel it sent a message to the community that the police are a part of the community and that they are dedicated to recovery, treatment and not just arresting people.
- This position focuses on prevention and treatment coordination, heavy on outreach and recovery.
- This position gets the family, spouses, etc. immediately connected with the services that are out there in the community although recovery and treatment services are severely lacking here in New Hampshire.
- Infrastructure and Collaboration with the Community and throughout the State of New Hampshire (*Officer Eric Adams*)
  - All the officers carry my contact information to hand out as called for.
  - I am available 24 hours a day.
  - Goals:
    - a. Serve as liaison between clients that are overdosing, or any substance misuse with any resources available in the community. Two of the biggest things for someone who is suffering are housing and transportation.
    - b. Strengthen network systems and help improve knowledge on how to access resources.
    - c. Provide support for clients and families dealing with substance misuse and addiction. The position created is the support.
    - d. Receive referrals from community partners.
    - e. Increase number of clients accessing treatment.
    - f. Identify avenues to assist the individuals to finding funds for resources.
    - g. Advocate for policy support of prevention and treatment.
    - h. Participate in local prevention initiatives.
  - First Steps
    - a. Establish some community connections.
    - b. Connect with the Public Health Network. Get acquainted with the local coalition and the National Guard as well who is working with our local coalition.
    - c. Get acquainted with our local treatment provider to learn more about treatment and resources.
    - d. Connect with the Faith Community. The Faith Community is very important. It seems they have gotten lost along the way and getting connected with someone in the Faith Community is very powerful for them.
    - e. Continue further training in various areas of prevention, treatment, and recovery.
  - Networks for Referral.
    - a. Self-initiated.
    - b. Recovery court.
    - c. Criminal justice.
    - d. School systems. Working very closely with the Middle School right now.
    - e. Local treatment providers.
    - f. County jail as well as any other outside agencies needing our help.
  - Method
    - a. When I get a call for an overdose and I am on duty I go respond. What happens first is we treat it as a crime scene. Make sure the client is being cared for.
    - b. Once person is revived we stress that they then get transported to the hospital.
    - c. This is when I meet with them. Within the first 24 hours is the most critical time when a client will be most agreeable to getting into treatment of some sort. I offer up the resources that are available in our

community and then speak with the EMS/Officer to find out if there were friends/family members or children present.

- d. I will then go and speak with the friend/family members. We try to provide options for counseling if warranted.
  - e. Provide some supplemental options for treatment. We try to set something up before they get released.
  - f. How we are keeping track: active compliant; post compliant; active relapse; post relapse. Active compliant are the people that are actively working with me, sober and following the plan. Post compliant are the people that have reached the point in their recovery who have moved on from checking in on a regular basis and using other support efforts. Active relapse are the individuals that are working with me but they relapsed. Post relapse are the individuals that just seem unreachable.
- Current Program Information
- a. 42 clients that have been referred to some form of treatment.
  - b. 20 of the clients have successfully entered into treatment and actively involved.
  - c. Half of the clients are not quite ready for the treatment step.
- Local Policies
- a. When a prosecutor wants to come up with some type of bail that they can use where the individual can still meet with me and stay connected, typically high risk clients.
  - b. This is sometimes used and is working.
  - c. When someone goes into treatment one of the things that we want to do is make sure that I have access to their one specific portion of their treatment. That is their appointment schedules.
  - d. Formalize a system to actually track overdoses. January 1 our department came up with a separate clear code strictly for overdoses. It doesn't break it down with the details of the overdose or what they were exposed to but I then go through the call lists to determine the details of the overdose.
  - e. We have developed a resource guide for our patrol officers to carry when they identify individuals in crisis.
  - f. On the card I have 211, the Suicide Prevention Hotline, nhtreatment.org. Our officers know the formalities on how to talk someone through that and obtaining treatment.

## Task Force Updates

- Perinatal Substance Exposure Task Force (*Dr. Ewing*)
  - Target audience pregnant women or women contemplating pregnancy because alcohol is not safe to consume anytime during pregnancy.
  - We will be distributing posters in all NH Liquor Stores.
  - There will be 11" x 17" poster in the front window at each outlet.
  - We would also like to make this available electronically.
  - There will be a soft launch of this campaign at the NH NOFAS Awareness Day, in Keene on September 9.
  - We would like to have a more formal announcement of it at the Liquor Outlets sometime in the fall with a press release.
- Prevention Task Force
  - There are two things we will be asking for feedback on during the month of September and that is: 1. SB106 Synthetics Bill. We are charged with providing recommendations to the legislators' public awareness and strategies. We are putting together recommendations to you and we will have until the end of September to get that to the legislators'.
  - Based on feedback that we have received from the field and the Center for Excellence on the Model School Document (which now it is not called that) we don't have the official name on what it is yet. Going in and talk to schools even though policy is a huge component it is a dead end. This draft we are working on is a shortened version and has five recommendations that schools can do with policy being the last one.
  - We do want to collect feedback from you and we want this endorsed by the whole commission.
- Treatment Task Force
  - Since we are constantly working on workforce development we expand capacity we need the workforce to do that, one really great thing happened by the State the Division of Public Health approved LADC's and MLACS's to have the State Educational Loan Reimbursement Program. This will help our professionals pay some loans off.
  - We are going to work really hard on how to get that information out and help folks understand it.
- Recovery Task Force

- A major presidential candidate had a forum on substance abuse. There were people from the recovery community and this is the first time that issues related to recovery and peer support services were brought up at that level.
- September 26, 2015 there is a Recovery Rally at White Park here in Concord. We strongly suggest you go or get out word about that.
- On October 8, 2015 New Futures is having its annual meeting and the keynote speaker is Dr. John Kelly who is a Harvard Professor and on staff a Massachusetts General Hospital. He is the world acknowledged expert in recovery research. He is a phenomenal speaker.
- The Recovery Taskforce is meeting again on September 11 between 10 and 12 at the Center for Excellence in Concord. I am asking people here at this meeting to encourage active people from the recovery community to come to the meeting. There will be two major dialogues. One is using BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy) bringing recovery support services to scale in the state which is something we have been talking about for a while. The other is a discussion on Medicaid Reimbursement for recovery services.

***The next meeting for the Governor's Commission on Alcohol and Drug Abuse Prevention and Recovery is Friday, October 23, 2015 at the Legislative Office Building from 9:30 am to 11:30 am in Room 301-303.***