

New Hampshire

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 09/28/2015 2:56:09 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 11040545

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name New Hampshire Department of Health and Human Services

Organizational Unit Bureau of Drug and Alcohol Services

Mailing Address 105 Pleasant St.

City Concord

Zip Code 03301

II. Contact Person for the Grantee of the Block Grant

First Name Joseph

Last Name Harding

Agency Name New Hampshire Department of Health & Human Services, Bureau of Drug & Alcohol Services

Mailing Address 105 Pleasant St.

City Concord

Zip Code 03301

Telephone 603-271-6104

Fax 603-271-6105

Email Address joseph.p.harding@dhhs.state.nh.us

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Shannon

Last Name Quinn

Telephone 603-271-5889

Fax 603-271-6105

Email Address syquinn@dhhs.state.nh.us

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Joseph P. Harding

Signature of CEO or Designee¹: _____

Title: Director and SSA, NH Bureau of Drug & Alcohol Services

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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Fiscal Year 2016

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New Hampshire

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

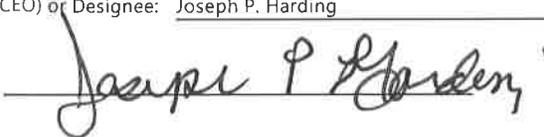
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Joseph P. Harding

Signature of CEO or Designee¹: 

Title: Director and SSA, NH Bureau of Drug & Alcohol Services

Date Signed: 9-16-15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

September 9, 2015

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

RE: Substance Abuse Prevention and Treatment Block Grant

Dear Ms. Simmons:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority through the current Commissioner of the Department of Health and Human Services to the Director of the Single State Authority (SSA), for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

With every good wish,

A handwritten signature in blue ink that reads "Maggie H" with a long horizontal flourish extending to the right.

Margaret Wood Hassan
Governor

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Shannon Quinn"/>
Title	<input type="text" value="Training Coordinator"/>
Organization	<input type="text" value="NH Bureau of Drug & Alcohol Services"/>

Signature: _____ Date: _____

Footnotes:

The NH Bureau of Drug and Alcohol Services does not use any funding for lobbying.

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

New Hampshire - 2016/17 Behavioral Health Assessment and Plan

Step I: Assess the strengths and needs of the service system to address the specific populations:

Planning for the 21 month period October 1, 2015 to June 30, 2017

OVERVIEW

The Bureau of Drug and Alcohol Services (BDAS) is part of the New Hampshire Department of Health and Human Services (DHHS). Also included in this Department are the Bureaus of Behavioral Health, Developmental Services, and Elderly and Adult Services, as well as the New Hampshire Hospital (acute psychiatric services). These bureaus and programs report directly to the Associate Commissioner of DHHS.

- Of NH residents 12 and older, 106,000 individuals (9.34%) meet the criteria for dependence or abuse of illicit drugs or alcohol.
- The number of heroin related emergency department (ED) visits during the first six months of 2015 is 56% greater than the number of heroin ED visits during the same six months in 2014.
- In 2014, there were 98 heroin related overdose deaths and 145 fentanyl related deaths. 2015 trends suggest that these numbers will be higher for 2015.

The following units structure BDAS internally: Prevention Services; Clinical Services, including Impaired Driver Services; Resources and Development; and Business and Financial Services.

BDAS treatment, intervention and recovery support services include:

- 2422 clinical evaluations
- 4195.5 hours of individual, group, and family outpatient services, including intensive outpatient step down services, to 2460 clients.
- 8900 days of intensive outpatient services to 685 clients.
- Clinically Managed High Intensity Residential Treatment services for 72 women and their children.
- Clinically Managed Medium Intensity Residential Treatment services for 34 adolescents.
- Clinically Managed High Intensity Residential Treatment services for 1020 adults.
- Clinically Managed Low Intensity Residential Treatment services for 295 adults and 6 adolescents.
- 212.75 hours of recovery support services to 174 clients.
- In 2014, more than 50% of all treatment admissions were for Opioids.
- Administrative oversight of 8 Opiate Treatment Programs (not funded by BDAS)
- Oversight of 7 Impaired Driver Care Management Programs at 22 sites and approximately 200 Impaired Driver Services Providers
- The Bureau employs a Master's level LADC eligible clinician for crisis and referral services and initial brief case management of priority populations such as pregnant and parenting women and injection drug users.

New Hampshire - 2016/17 Behavioral Health Assessment and Plan

Step 1: Assess the strengths and needs of the service system to address the specific populations:

Continuum of Care (CoC)

BDAS has developed a vision and description of a Resiliency and Recovery Oriented Continuum of Care that includes health promotion, prevention, early identification and intervention, treatment, and recovery supports. This approach recognizes the importance of developing a coordinated and diverse system of community-based services, strategies and supports that are person-centered and builds on the strengths and resiliencies of individuals, families, and communities. By recognizing substance use disorders (SUDs) as preventable and treatable chronic conditions needing long-term management and support services, communities can begin to work together to ensure effective and integrated services to prevent risky behavior, to deter the progression of SUDs, and to treat and manage recovery from these disorders. BDAS is promoting the development of full continua of care on a regional basis by funding a CoC Facilitator in each of the 13 Regional Public Health Networks who are charged with assessing the gaps and engaging community partners to develop and seamlessly connect the necessary supports and services to adequately address substance-related issues in their communities. (<http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm>).

Prevention

BDAS funds 13 Regional Public Health Networks (RPHN) that are geographically designed to cover every community in the state. The RPHN utilize the Strategic Prevention Framework Model (assessment, capacity, planning, implementation and evaluation), a data driven public health approach to address the misuse of alcohol and drugs in their area, including:

- The collection and utilization of quantitative and qualitative data to understand the impact that the misuse of alcohol and drugs has on each of the sectors outlined above and the community as a whole
- Assist the CoC in identifying existing and potential capacity/resources as well as gaps for each of element of the service continuum (prevention, early intervention, treatment, recovery, etc.) needed to implement a comprehensive approach to address the misuse of alcohol and drugs within each region.
- Develop a Community Health Improvement Plan (CHIP), that ties to and is consistent with the objectives outlined in the State Health Improvement Plan (SHIP) <http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>, effectively taking a state down/community up approach to address the misuse of alcohol and drugs that are tailored to the particular characteristics and circumstances of each region. The CHIP plan identifies evidence based strategies and practices to address the misuse of alcohol and drugs in their area.
- Mobilizing the community across the six sectors (local government, business, healthcare, education, safety, and community support agencies) to implement the CHIP
- Evaluation / Continuous Quality Improvement
- Ongoing evaluation of the effectiveness of the substance misuse related objectives of the Community Health Improvement Plans (CHIP)
- Implement quality improvement objectives to address deficiencies and to improve upon the plan.

The regional structure is an initiative of the Department of Public Health Services (DPHS) and BDAS in alignment of their respective regional initiatives to create efficiencies, eliminate duplication, and build upon the strengths of the two systems; increasing the range of Ten Essential Public Health Services and Substance Misuse Prevention and Related Health Promotion

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activities within defined geographic regions that include all communities in New Hampshire. One primary scope of work for each RPHN is the development of a broad Regional Public Health Advisory Committee(s) comprised of leaders from key community sectors to serve in an advisory role. Regional leadership serves in an advisory capacity while also building additional capacity among regional partners to protect and promote the overall health of their communities.

Each region's organizational structure consists of: a fiscal sponsor, a contract administrator, one full time Certified Prevention Specialist, one full time Continuum of Care Facilitator, one full time Emergency Preparedness Coordinator, and a Public Health Advisory Committee. As of September 30, 2015 RPHN will have a CHIP with five target indicators (one indicator substance misuse prevention and health promotion). RPHN plans align with state level plans: Governor's Commission Collective Action Collect Impact 5-year plan for the state (<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.PDF>) and the SHIP.

As a result of the NH Substance Abuse Prevention and Synar technical review conducted May 12–14, 2015 by the Center for Substance Abuse Prevention, BDAS will be receiving technical assistance to review our programmatic alignment with a public health approach; this will include state and sub-state levels. The TA will assist BDAS to operationalize a public health approach that includes:

- A systemic collection and review of information and data to define the magnitude, scope, characteristics, and consequences of substance abuse and pinpoint the key factors (intervening variables) that contribute to the problem in each region;
- A targeted assessment of the degree to which capacity for prevention exists and the ability of partners to strategically mobilize partners to impact the problem;
- the implementation of approaches, including those that target populations, that have evidence of effectively addressing the most salient factors that are contributing to the problem;
- The collection and review of data and information to determine the effects of the interventions on those factors that contribute to the problem and the target populations.

NH's prevention structures and efforts are supported by public and private partnership that provides additional funds toward prevention. The New Hampshire Charitable Foundation invests approximately \$3 million per year to "reduce the burden caused to the citizens of New Hampshire by alcohol, tobacco and other drugs". Core to the strategy is policy and advocacy to improve public financing, research and evaluation of best practices in substance use disorder services, as well as funding for proven strategies. In 2012, the foundation approved 10-year strategy dedicated to the prevention of substance use disorders. Approximately \$1.2 million dollars per year will be allocated from the portfolio in furtherance of this strategy. This strategy is implemented in close partnership with the Department of Health and Human Services. This includes strategic co-funding, integrated planning and reporting systems for grantees.

Intervention:

a) Screening, Brief Intervention and Referral to Treatment (SBIRT)

DHSS has utilized Federal Block Grant Funds for implementing SBIRT (screening, brief intervention, referral to treatment) in all 15 Community Health Centers.

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b) Naloxone

Recent legislation has allowed the possession and administration of naloxone by first responders, such as police and fire; individuals with opioid use disorders as well as their friends and family members; and organizations having contact with individuals with opioid use disorders. This legislation also protects individuals who administer naloxone in good faith from civil or criminal prosecution related to administration. The Governor's Office, the Governor's Commission, and state agencies are working together to implement a plan for distribution and training.

As a result of the recent passage of this legislation the Department of Health and Human Services, in coordination with the Bureau of Emergency Services at the New Hampshire Department of Safety and in communication with the Governor's Office, is utilizing Federal Block Grant funding to purchase Naloxone and related trainings. The Department of Health and Human Services has set up an Incident Command Structure to implement a statewide Naloxone distribution and training initiative. This program is being implemented during the fall of 2015 and has identified the following targets:

- Police Departments that as a result of the recent legislation that are in the process of becoming certified to administer Naloxone by the Bureau of Emergency Services
- CHC and FQHCs (first priority) and other health and social services agencies that come in frequent contact with individuals at risk for opioid overdose
- Individuals at risk for opioid overdose, their families and friends

c) Impaired Driver Services

The Impaired Driver Services system changed significantly as of January 1, 2013. These changes include:

- Greater emphasis on clinical services for individuals convicted of impaired driving offenses
- An approval process for clinicians providing services to impaired drivers
- Increased monitoring of both clinicians and clients

BDAS has oversight of the Impaired Driver Care Management Programs as well as the Impaired Driver Education Programs and Impaired Driver Services Providers. This change will increase both the availability and quality of services for individuals convicted of impaired driving offenses. BDAS continues to work with the programs listed above, courts, and the Department of Safety to refine and improve this system.

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Treatment Services

On August 15, 2014 the New Hampshire Health Protection Program (NHHPP) rolled out, including a robust SUD benefit, which has been phased in over the intervening year. This benefit includes a full array of SUD treatment and recovery support services. In order to maximize the benefits of available treatment funding, NHHPP funding and block grant funding are carefully coordinated.

Most NH citizens aged 19 – 64 who are at or below 138% of FPL are eligible for services under NHHPP and our providers work with clients to enroll them in NHHPP. This frees up block grant dollars to serve clients who are not NHHPP eligible and who are below 400% of FPL based on a sliding fee scale. This coordination of funding streams ensures that Federal funding is being utilized as efficiently as possible.

NH continues to help providers move toward integrating medication assisted treatment (MAT) with existing services. In the current contract, providers were given the opportunity to access both planning and implementation dollars for MAT. The RFP that will be released soon for the next contract period (effective 1/1/16) will require providers to offer either integrated or collaborative medication assisted treatment services to all appropriate clients. In addition, we are working with the Center for Excellence (our technical assistance contractor) to engage more primary care providers in medication assisted treatment. A respected physician is assisting us to design an engagement strategy. We have also applied for a SAMHSA grant to implement MAT in 5 community health centers around the state.

In concert with the New Hampshire Charitable Foundation, the Department developed a treatment locator (nhtreatment.org) to help professionals and lay people more readily identify treatment resources in NH, regardless of payor. We continue to work with our partners to refine and improve the locator.

Regardless of the level of care or payor source, the Department continues to require providers to utilize American Society of Addiction Medicine (ASAM, October 2013) criteria to determine the initial level of care for an individual as well as to make decisions about continuing care, transferring, or discharging.

The Bureau will continue to fund services for pregnant women and women with dependent children. These services currently include:

- A partnership between a treatment program with a comprehensive service array (Southeastern NH Services in Dover NH) and a Federally Qualified Health Center (Goodwin Health Center in Rochester NH) to offer an Intensive Outpatient Program for pregnant women and women with dependent children.
- The Cynthia Day Family Center (CDFC), a residential treatment program for pregnant substance abusing women and women with dependent children. The program accommodates up to 16 women and 16 children.

In addition, the Department is working with the Governor's Commission Neonatal Abstinence Syndrome Taskforce to bring physicians and the opiate treatment programs together to more effectively coordinate care for pregnant and post-partum women and their infants.

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The Bureau will continue to mandate priority admission for injection drug using individuals as required by the SAPT Block Grant. NH takes a broad perspective in defining IDUs as those individuals with current or a past history of injection drug use, preferring this term rather than only intravenous drug use. In addition, we have added individuals who have recently been administered naloxone as a priority population for contracted treatment services.

The Bureau provides on-going technical assistance and quality assurance monitoring relative to the implementation of all of the above practices and initiatives.

Infectious Disease

The Bureau takes a broad approach to infectious disease. In NH, the tuberculosis rate is relatively low. NH is also not an HIV incidence state. However, various strains of hepatitis, particularly A, B and C, are a concern. BDAS has worked closely with the Viral Hepatitis Unit of the NH Division of Public Health Services and routinely promotes their trainings, approximately two per year. One of BDAS' Clinical Services Unit staff, the Women's Services Network (WSN) Coordinator, is a trained Viral Hepatitis Educator.

Infectious disease is addressed in Administrative Rule He-A 302.06 Clinical Manual. Providers are also referred to Treatment Improvement Protocol (TIP) #6, *Screening for Infectious Diseases Among Substance Abusers* and #11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*, in developing their policies. These are submitted during applications in response to BDAS treatment services' biannual Request for Proposals and are then included in treatment contracts that are then monitored as part of provider site visits.

The clinical services unit administrator meets regularly with a group of colleagues working on a broad range of infectious diseases issues under the DPHS. The goal of these meetings is to identify areas where the departments can support each other and more effectively leverage resources in the prevention and treatment of both substance use disorders and infectious disease.

Neo-Natal Taskforce

The Perinatal Substance Exposure Task Force conducted a forum 1/14/2015 for stakeholders who participate in the care of pregnant and newly parenting women who are receiving medication assisted treatment with an opportunity to improve care for these women. The Task Force has identified 3 priority areas; 1) Poster Campaign to be launched during NOFAS NH Awareness Day 2015, 2) Methadone Workgroup regarding prescribing practices, 3) Patient Support Workgroup to create an informational document on medication assisted treatment for pregnant and postpartum women.

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Recovery Supports

BDAS has convened stakeholders from the addiction recovery and mental health peer support communities to form a team to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). The NH BRSS TACS team has established a mission and value statement for increasing the capacity to provide peer recovery support services (PRSS), across the state by:

- Educating all community sectors on what PRSS is and its value.
- Increasing the involvement of peers in promoting health in all sectors of the state,
- Ensuring good communication and coordination between addiction recovery and mental health peer support systems.
- Researching standards on training, certification and supervision for PRSS.
- Identifying potential public and private funding sources to pay for PRSS.
- Supporting the development of sustainable peer recovery support services.

BDAS supports the work of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, and its Recovery Task Force, as it seeks to increase the quality and quantity of recovery support services across the state (as detailed in "Collective Action – Collective Impact, New Hampshire's strategy to prevent and reduce alcohol and other drug misuse and promote recovery"

<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf>). The Recovery Task Force is primarily comprised of people in long-term recovery so that they can be the drivers of recommendations on recovery support services development.

Currently, non-peer recovery support services are covered under SAPT Block Grant funded contracts and the intent is to continue this funding. In addition, NHHPP will cover both peer and non-peer recovery support services as of September 1, 2015 and there are plans to release an RFP utilizing block grant funds to develop capacity for and implement these peer recovery support services.

PERFORMANCE MONITORING

Substance Misuse Prevention and Related Health Promotion

Outcome and evaluation measure instruments will be administered in cooperation with the NH Center for Excellence and monthly submission of process data via the web-based performance monitoring system (P-WITS) and other surveys and reports as required by BDAS (e.g. PARTNER survey, Regional Network Evaluation, Regional Network Annual Report).

As a result of the CSAP review NH will be receiving technical assistance and re-examining how we measure prevention effectiveness.

The bullets below indicated what BDAS measures now and the source data comes from and how

- Percentage of increase of evidence-based programs, practices and policies adopted by sector as recorded in P-WITS data collection system.

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- Increase in the amount of funds and resources leveraged in the implementation of prevention strategies as recorded in P-WITS data collection system.
- Number of persons served or reached by IOM classification as recorded in P-WITS data collection system.
- Number of Strategic Prevention Framework key products produced and milestones reached and reported annually in the Regional Network Annual Report.
- Long term Population level change are measured by the National Outcomes Measures:
 - 30 day prevalence rate,
 - perception of harm and risk,
 - age of onset,
 - perception of disapproval,
 - DUI, traffic fatalities
 - number of evidence based interventions,
 - number of persons served by age, gender, race and ethnicity

Substance Abuse Treatment and Recovery Support Services

BDAS Program managers monitor performance through in-person site visits and record reviews conducted via the Web Information Technology System (WITS) electronic health record. Reviews include, but are not limited to, appropriate use of ASAM criteria in admission, continuing care, transfer, and discharge decisions; comprehensiveness, readability and organization of client files; client demographic and collateral contact information; health and medical information; client treatment history; screenings and assessments; treatment plan and updates; program activities and progress notes; Notice of Client Rights; discharge planning; and releases of information. Providers also utilize a standardized checklist to report compliance with SAPT Block Grant requirements.

Contracted providers are encouraged to increase their performance in key areas through incentives:

- **Access to Services:** For each client who screens eligible for services and starts receiving services, whether for the identified level of care or interim services, within 10 business days following the eligibility screening, the treatment contractor receives an incentive payment of \$75.00.
- **Completion:** For each client who is discharged from the program because they have completed treatment or transferred to another treatment provider, the treatment contractor receives an incentive payment of \$75.00.
- **Client Outcomes:** If a client who was discharged from the program meets at least 3 of the outcome criteria below in the 3rd and/or 6th month post-discharge, the treatment contractor receives an incentive payment in the amount of \$50.
 - **Abstinence:** The client reports reduced or no substance use in the past 30 days.
 - **Employment/Education:** The client reports increased or retained employment or the client reports returning to or staying in school.
 - **Crime and Criminal Justice:** The client reports no arrests in the past 30 days.
 - **Stability in Housing:** The client reports being in stable housing.
 - **Social Connectedness:** The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days.

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Workforce and Best Practices

BDAS, working with external partners has developed, released and is promoting utilization of a document that outlines clinical core competencies required for effectively addressing substance use disorders (SUD) and co-occurring disorders (COD) and making low cost training and no cost technical assistance available to providers in adopting these practices.

BDAS contracts with three state level agencies that provide quality improvement toward best practices, evidence-based interventions, workforce and professional training for alcohol and other drug service professionals, and certification standards.

- The New Hampshire Center for Excellence (CFEx) is a state level contract that provides technical assistance and fosters systems change and related professional development to support community level practitioners in implementing evidence-based interventions and improving their practices to address substance use issues through prevention, intervention, treatment, and recovery support services. Technical assistance is provided through various formats, including webinars, learning collaboratives, on-site consultation, and group meetings, as well as by posting tools, relevant data and resources on a professional provider web site: www.nhcenterforexcellence.org. Additionally, CFEx provides data analysis and data products to support BDAS and the State Epidemiological Outcomes Workgroup. The department is currently working with CFEx to develop a community of practice around medication assisted treatment, which will have “neighborhoods” for different providers and stakeholders and serve as a clearing house for training, technical assistance, information sharing and networking. The initial focus will be on the neighborhood for physicians.
- The NH Training Institute on Addictive Disorders provides high quality training and workforce development activities to enhance the skills of the prevention, intervention, treatment and recovery supports services workforce through training opportunities that meet requirements for licensure and certification; increasing provider knowledge and skills in applying outcome-supported policies, programs and practices; and cross-training opportunities that increase effective integration of services. They are also providing specific trainings for behavioral health professionals to meet core competencies for treating SUD. Their training events are affordable and accessible to people across the state and meet different adult learning styles and levels through the integration of face-to-face, distance and blended learning opportunities.
- The NH Certification Board’s primary purpose is to ensure high quality standards for NH's substance abuse prevention specialists by aligning with the International Certification & Reciprocity Consortium (IC&RC) standards. The NH Certification Board and IC&RC principles call for prevention practitioners to stay abreast of the latest research findings, employ best practices, apply innovations in prevention methods, and follow industry trends in order to ensure the competency of the services they provide. The NH Certification Board provides management and oversight at the state level to ensure NH prevention practitioners are prevention specialists certified. The state requires that all contracted prevention services have lead staff who are prevention specialist certified, and maintains this certification through the two year renewal process by obtaining the necessary certification hours.

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The Resources and Development Unit of BDAS develops and provides introductory training and consultation to professionals in related service systems, e.g. health, education, corrections and social services, on addiction, recovery and practices to address substance use issues with clients in their systems.

In an effort to recruit and retain staff in SUD treatment agencies, BDAS has partnered with the Division of Public Health Services to include Licensed Drug and Alcohol Counselors (LADCs) and Master Licensed Drug and Alcohol Counselors (MLADCs) in the NH State Loan Repayment Program as of October 1, 2015. This will allow LADCs and MLADCs who work in approved agencies to be eligible for up to 5 years of educational loan repayment. BDAS funded treatment contractors have been deemed approved agencies.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Unmet Service Needs; State Specific Priority Populations

Sources of data used are: NSDUH, YRBS, and BRFSS and other health data sources as displayed by NH WISDOM. This data indicates that the populations listed below are identified as experiencing the highest rates of use and experiencing the greatest consequence (impact to these individuals, their families and communities, as well as the cost to the state) from substance abuse and are therefore identified among the groups with the greatest need for services:

Youth, address high prevalence rates for:

- Underage drinking (30 day use)
- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)
- Opioid
- Illicit Drug Use other than marijuana

Young Adults:

- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)
- Opioid
- Illicit Drug Use other than marijuana

Adults:

- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)
- Opioid
- Illicit Drug Use other than marijuana

State Specific Priority Populations

- Pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame.
- Individuals who have been administered Narcan to reverse the effects of an opioid overdose either in the 14 days prior to screening or in the period between screening and admission to the program.
- Individuals with a history of injection drug use including the provision of interim services within 14 days.
- Individuals with substance use co-occurring mental health disorders.
- Individuals with Opioid Use Disorders.
- Veterans with substance use disorders
- Criminal justice involved individuals, including individuals convicted of an impaired driving offense

Critical Gaps in Services

Limited Selective and Indicated Prevention Services

A full range of comprehensive selective and indicated prevention services across the state's behavioral health system of care is limited. This includes a wide range of evidenced based strategies targeted to high risk youth and families, and other high risk populations such as, substance using women of child bearing age and Lesbian, Gay, Bi-Sexual, and Transgendered (LGBT). The primary challenges are lack of data, limited funding and capacity. NH does not collect data that is specific to LGBT populations therefore targeting this high risk population is difficult. NH was awarded the five-year Partnership for Success Federal Grant which targets the high risk areas and populations. NH is implementing student assistance targeting several high risk schools and colleges. However, more data is needed to impact young adults. NH will be conducting a young adult qualitative and quantitative assessment over the next year to determine in-depth root cause analysis and the intervening variables to better determine the best strategies and practices to improve outcomes for this population.

Limited Universal Prevention Services

As of July 1, 2014 the Bureau's Prevention Services Unit, within the scope of work of substance misuse prevention health promotion services, integrated with Division of Public Health Services in the third year of the redesign of the 13 Public Health Networks that include every community in NH. BDAS works collaboratively within many state committees under the larger umbrella of DHHS Behavioral Health Services to improve

overall integration of mental, emotional and behavioral (MEB) services including suicide prevention across the state. Although progress has been made, we are lacking sufficient capacity for data collection and analysis across systems, identification of best practices and funding for a full array of services.

Gaps in the treatment system

There are a number of gaps in the current treatment system, including:

- Lack of medical detoxification and medication assisted treatment services...
- It is necessary to continue with the development and implementation of standards for treatment services which are based on the principles outlined in SAMHSA's National Behavioral Health Quality Framework and Description of a Good and Modern Addictions and Mental Health Service System as well as the Center for Substance Abuse Treatment's Treatment Improvement Protocols in the state as well as for technical assistance and quality assurance monitoring for providers as they implement these practices within their agencies.
- Lack of care coordination services.
- There is currently a lack of coordination between substance use treatment and primary care and providers of other medical and behavioral health services. Facilitating communication and coordination between these treatment systems would allow clients to engage in didactic therapies with medication and other support from the primary care provider.
- The Bureau has significantly increased funding for transitional housing programs; however, there is a need for further expansion of these services. The need for additional services is evidenced by monthly utilization figures for currently contracted transitional living providers, which are consistently, well above 100%.
- Currently, there are only limited peer and non-peer Recovery Support Services available in New Hampshire. A significant barrier to the development of these services is lack of provider buy-in which must be overcome in order to continue expanding the service array.
- Lack of specialty treatment for pregnant and parenting individuals and their dependent children.
- Lack of a process for certifying treatment programs and facilities due to the certification rule being expired, which creates a barrier to providers enrolling in Medicaid and private insurance.

Developing Service Delivery System for Individuals Convicted of Driving While Impaired (DWI) offenses

Developmental issues continue to impact this system including concerns that service capacity in some regions of the state is not sufficient to meet the needs of individuals living in those regions; the need to refine the system and partnerships within the system based on lessons learned; and identification of additional resources to support these services.

Limited prevalence, consequence and outcome data collection and analysis capacity

Although there have been some resources available to the Bureau for the collection, analysis and utilization of state and regional data made available through the original State Epidemiological Outcomes Workgroup (SEOW) established under the Strategic Prevention Framework Grant (SPF-SIG) that ended in 2010, this capacity was primarily focused on meeting the objectives of that grant. The Bureau recognizes the need to expand this capacity across the array of the service delivery system to meet the objectives of data driven decision making and performance contracting. For this reason the work of the newly established SEOW under the Partnership for Success II grant, in addition to meeting the objectives of that grant will be expanded to meet these broader objectives that will include certain mental health data (suicide prevention, Neonatal abstinence Syndrome). Over the last year BDAS worked in partnership with representative of the SEOW and Division of Public Health Services in establishing phase one substance misuse data indicators for Web-Based Interactive for Direction and Outcomes (WISDOM). WISDOM provides free on-demand information to the public, public health partners, and to state staff to instantly access summaries of data related to determinants of health, health risks, and health outcomes in an easy to understand graphical format. WISDOM contains interactive “dashboards” and “report cards” which allow users to customize, organize, and manage graphs, tables, and maps using an intuitive graphical user interface. More development is planned over the next year for phase two and three data indicators to be added to WISDOM. WISDOM access: <http://wisdom.dhhs.nh.gov/wisdom/>

Limited Capacity for Program Management and Contract Performance Data Collection and Analysis

The Bureau has implemented the WITS (Web Information Technology System) electronic health record for all contracted treatment, prevention, opiate treatment program and Impaired Driver Services providers and this system includes tools that increase capacity for program management and contract performance data collection; however, many of these are still in development. This developmental process has interfered with the ability to tie performance to payment and for providers and the Bureau of Drug and Alcohol Services to use the system to monitor performance data.

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Step 2 (Table 2): Identify the unmet service needs and critical gaps within the current system

The Bureau is moving forward with a number of initiatives to enhance our contract performance monitoring capacity, including:

- Addressing problems with the features currently available in WITS.
- Expanding features available in the WITS electronic health record system to contractors, potentially including the billing component of this system.
- Prevention Services Unit is now using WITS Prevention Module for performance monitoring of the RPHNs
- Collaborating with the Division of Public Health to collaborate and coordinate on epi work on the collection, analysis and sharing of data and the possible interoperability of IT systems.

BDAS is placing greater emphasis on the integration and collaboration with other systems on the provision services and health promotion in consideration of potential opportunities made available under the Affordable Care Act (ACA). This includes partnering with the Division of Public Health Services in integrating our Regional Prevention Networks (RPHN) with the Regional, as well as BDAS supporting and utilizing New Hampshire Wisdom, the new public health IT system.

This work will include the substance prevention coordinators expanding their scope of work to include, behavior health promotion, with an emphasis on suicide prevention. This work will also include expanding clinical practices for substance use disorders broadly across health and social service systems, with an emphasis on the mental health and primary care systems in New Hampshire. The idea is to implement a modified SBIRT (Screening, Brief Intervention and Referral to Treatment) model in the state. This would include primary care setting screening for substance use disorders, applying early interventions, conducting full SUD (substance use disorders) evaluation when indicated, addressing lower levels of acuity address by substance abuse counselors on sight and referring high levels of acuity to specialty substance use disorders treatment.

Program management and contract performance data collection are impeded in the areas of specialty treatment and impaired driving services due to a lack of staff. Once staff positions are filled the unit's goal is to create an overall program management and quality assurance framework.

New Hampshire State Epidemiological Outcome Workgroup (SEOW)

Context and Purpose:

The NH State Epidemiological Workgroup is a multidisciplinary advisory group that works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance use and behavioral health issues in order to inform prevention and treatment policy, programs and services in the state.

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Step 2 (Table 2): Identify the unmet service needs and critical gaps within the current system

The SEOW meets quarterly and is administered through as contract with Community Health Institute under the direction of BDAS. September 2014 the SEOW adopted the following six objectives:

- Objective 1: Facilitate assembly, analysis and interpretation of data and reports to determine the scope and extent of substance use and behavioral health risk and related problems at the state and regional level.
- Objective 2: Facilitate assembly, analysis, and interpretation of data and reports to characterize protective factors for mental, emotional, and behavioral health, and assets vital to the delivery of prevention, treatment, and recovery services.
- Objective 3: Guide the development and sustainability of a web-accessible database of substance use and substance use-related mental health indicators to enable analysis of prevalence, trends and impacts at the state and regional levels.
- Objective 4: Guide the development and dissemination of data products to targeted audiences in the education, health, government, business and safety sectors to address questions of policy, increase awareness, and foster a sense of shared responsibility.
- Objective 5: Provide technical assistance and recommendations for improving data sharing and use across state level systems to assess prevalence rates and financial impacts of alcohol and drug misuse, as well as outcomes of strategies being implemented to address alcohol or other drug misuse among populations served by state systems including evaluation results of the Partnership for Success Initiative.
- Objective 6: Provide technical assistance and recommendations for developing a sustainable approach to data monitoring and reporting to assess progress on the 2013 State Strategic Plan to reduce substance misuse prepared by the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

BDAS may request technical assistance in the future regarding program and client evaluation to determine how they might enhance prevention, intervention, treatment and recovery support services in the State of New Hampshire.

Footnotes:

SABG Planning Step: Quality and Data Collection Readiness

Plan covering 2 year period: 7/1/15 – 6/30/17

- 1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**
 - *NH uses the Web Information Technology System (WITS) for program management and evaluation and for data collection and reporting purposes. WITS is an open-source, web-based clinical and administrative system for behavioral health providers. With this system, NH is able to collect and report on data at the client, program, and provider levels.*
 - *Although some BDAS providers do not currently use the full WITS system because they are already using another proprietary system embedded in the larger organization (Community Mental Health Centers, Community Health Centers and hospital based BDAS funded programs, in particular), they are still contractually obligated to report the full NOMS/TEDS data through WITS which is a requirement of the federal block grant that the State of NH is a recipient of. In addition, BDAS has the capacity to store all financial data in WITS for each facility. Thus all reporting requirements are met for all SAPT funded treatment facilities and their clients.*

- 2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**
 - *The Web Information Technology System (WITS) is an Electronic Health Record with Meaningful Use Certification, which is focused on Behavioral Health and related safety net programs. WITS in the State of NH is used for:*
 - *Substance Abuse Treatment for all levels of care, with Treatment episode data set (TEDS) and National Outcomes Measurement (NOMs) reporting*
 - *Management of data sharing through a 42 CFR compliant consent and referral module*
 - *Impaired Driver Care Management Programs (IDCMP), Opiate Treatment Providers (OTP)*
 - *Prevention Programs*
 - *Federal Grant Management, including full integration with GPRA reporting systems and support of Block Grant reporting requirements*
 - *Voucher Management System Contract Management of providers, including accreditation*
 - *Reporting via canned reports as well as user-defined ad-hoc reporting*

SABG Planning Step: Quality and Data Collection Readiness

Plan covering 2 year period: 7/1/15 – 6/30/17

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

- *Yes*

4. If not, what changes will the state need to make to be able to collect and report on these measures?

- *NA*

Please indicate areas of technical assistance needed related to this section.

- BDAS may request technical assistance in the future regarding program and client evaluation to determine how they might enhance prevention, intervention, treatment and recovery support services in the State of New Hampshire.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Pregnant Women and Women with Dependant Children
 Priority Type: SAT
 Population(s): PWWDC

Goal of the priority area:

Increase the number of pregnant and parenting women (PPW) served.

Objective:

- 1 - Increase the number of PPW admitted to treatment.
- 2 - Increase referrals of PPW from medical providers.

Strategies to attain the objective:

- 1 - Continue to fund specialty treatment for PPW.
- 2 - Continue to prioritize admission for pregnant women into contracted treatment services.
- 3 - Outreach to medical providers regarding treatment services for PPW.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Number of pregnant and parenting women served
 Baseline Measurement: 115 admissions for PPW in SFY15
 First-year target/outcome measurement: 121 admissions for PPW in SFY16
 Second-year target/outcome measurement: 127 admissions for PPW in SFY17

Data Source:

WITS "Admission Data" report

Description of Data:

Number of women who reported being pregnant per the WITS admission module.

Data issues/caveats that affect outcome measures::

none

Indicator #: 2
 Indicator: Referral of PPW to contracted treatment providers from medical providers.
 Baseline Measurement: 24 pregnant women reported being referred by a medical professional at the time of screening in SFY15
 First-year target/outcome measurement: 25 pregnant women reported being referred by a medical professional at the time of screening in SFY16
 Second-year target/outcome measurement: 26 pregnant women reported being referred by a medical professional at the time of screening in SFY17

Data Source:

New Hampshire - WITS SSRS 2008: Home > My Reports > PPW Screening Data

Description of Data:

Number of women who reported being pregnant on the WITS Social Detox Screener

Data issues/caveats that affect outcome measures::

Providers may not choose the appropriate referral source for clients. On-going provider training is being done to address this.

Priority #: 2
Priority Area: IVDUs
Priority Type: SAT
Population(s): IVDUs

Goal of the priority area:

Increase collaboration with Division of Public Health Services (DPHS) regarding various public health risk factors for injection drug users.

Objective:

- 1 - Provide testing for HIV/HCV through treatment providers.
- 2- Provide training in collaboration with DPHS around the infectious diseases associated with IVDU.

Strategies to attain the objective:

- 1 - Include HIV/HCV testing in SUD treatment and recovery support services RFP in collaboration with DPHS.
- 2 - Offer trainings in collaboration with DPHS around the infectious diseases associated with IVDU.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Contracted treatment providers regularly test clients for HIV/HCV
 Baseline Measurement: HIV/HCV testing is not currently available to contracted treatment providers.
 First-year target/outcome measurement: 25% of contracted treatment providers will request HIV/HCV testing from DPHS
 Second-year target/outcome measurement: 50% of contracted treatment providers will request HIV/HCV testing from DPHS

Data Source:

DPHS data on contracted treatment providers who request HIV/HCV testing services for clients

Description of Data:

Number of contracted treatment providers who request HIV/HCV testing from DPHS

Data issues/caveats that affect outcome measures::

Both goals will require coordination and collaboration with DPHS and this work is in the early stages; however, both BDAS and DPHS staff are committed to working together.

Indicator #: 2
 Indicator: Trainings for SUD providers are available
 Baseline Measurement: Collaborative trainings are not currently available to contracted treatment providers
 First-year target/outcome measurement: 2 collaborative trainings will be made available to contracted treatment providers
 Second-year target/outcome measurement: 4 collaborative trainings will be made available to contracted treatment providers

Data Source:

Number of collaborative trainings available to contracted treatment providers

Description of Data:

Number of collaborative trainings available to contracted treatment providers

Data issues/caveats that affect outcome measures::

Both goals will require coordination and collaboration with DPHS and this work is in the early stages; however, both BDAS and DPHS staff are committed to working together.

Priority #: 3
Priority Area: TB
Priority Type: SAT
Population(s): TB

Goal of the priority area:

All contracted provider staff will participate in TB training available through the NH Department of Public Health Services (DPHS), Public Health Emergency Preparedness Education and Training unit

Objective:

Training treatment provider staff on TB.

Strategies to attain the objective:

Providers will be notified of available and appropriate trainings that staff may complete.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Provider reporting of staff who have successfully completed DPHS TB training.
Baseline Measurement: Not currently in contract
First-year target/outcome measurement: 50% of provider staff will have successfully completed DPHS TB training.
Second-year target/outcome measurement: 100% of provider staff will have successfully completed DPHS TB training.

Data Source:

Provider reporting

Description of Data:

List of staff who have and have not completed DPHS TB training.

Data issues/caveats that affect outcome measures::

Possibility that providers will not be accurate in their reporting. Possibility (although unlikely) that trainings will become unavailable.

Priority #: 4
Priority Area: Youth Misuse of Alcohol, Marijuana, Prescription Drugs
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Reduce Alcohol, Marijuana, Prescription Drugs among Youth

Objective:

Changes in 3 risk factors: reduce access to substances, increase perception of risk / harm, increase peer and parental disapproval as measured by YRBS through increase participation in substance misuse activities as measured by the alternative yearly stakeholder survey.

Strategies to attain the objective:

Regional Public Health Networks (RPHN) as of January 2016 will have a data driven 3 year strategic primary prevention plan. Each region convenes local stakeholders and employs an array of comprehensive approaches across the IOM. Strategies include policy changes that impact behavior per core sector (business, government, safety, education, health care, and community).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Alcohol 30 day use
Baseline Measurement: 31.5% (2015 data)
First-year target/outcome measurement: 30%
Second-year target/outcome measurement: 29%

Data Source:

National Survey for Drug Use and Health (NSDUH)

Description of Data:

NSDUH - New Hampshire State Estimates is annual nationwide survey based on interviews of about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Indicator #: 2
Indicator: Marijuana 30 day use
Baseline Measurement: 24.0% (2015 data)
First-year target/outcome measurement: 23.7%
Second-year target/outcome measurement: 23.5%

Data Source:

National Survey for Drug Use and Health

Description of Data:

National Survey on Drug Use and Health (NSDUH) – New Hampshire State Estimates is annual nationwide survey based on interviews of about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Indicator #: 3
Indicator: Prescription Drugs past year use
Baseline Measurement: 5.60% (2015 data)
First-year target/outcome measurement: 5.0%
Second-year target/outcome measurement: 4.8%

Data Source:

National Survey for Drug Use and Health

Description of Data:

National Survey on Drug Use and Health (NSDUH) – New Hampshire State Estimates is annual nationwide survey based on interviews of

about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Priority #: 5
Priority Area: Young Adult Misuse of Alcohol, Marijuana, Heroin
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Reduce misuse of Alcohol, Marijuana, and Heroin among young adults

Objective:

Changes in 3 risk factors: reduce access to substances, increase perception of risk / harm, increase peer and parental disapproval as measured by YRBS through increase participation in substance misuse activities as measured by the alternative yearly stakeholder survey.

Strategies to attain the objective:

Regional Public Health Networks (RPHN) as of January 2016 will have a data driven 3 year strategic primary prevention plan. Each region convenes local stakeholders and employs an array of comprehensive approaches across the IOM. Strategies include policy changes that impact behavior per core sector (business, government, safety, education, health care, and community).

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Alcohol 30 day use
Baseline Measurement: 71.8% (2015 data)
First-year target/outcome measurement: 71.2%
Second-year target/outcome measurement: 70.8%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

National Survey on Drug Use and Health (NSDUH) – New Hampshire State Estimates is annual nationwide survey based on interviews of about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Indicator #: 2
Indicator: Marijuana 30 day use
Baseline Measurement: 25.4% (2015 data)
First-year target/outcome measurement: 25%
Second-year target/outcome measurement: 24.6%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

National Survey on Drug Use and Health (NSDUH) – New Hampshire State Estimates is annual nationwide survey based on interviews of about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Indicator #: 3
Indicator: Heroin - Lifetime use
Baseline Measurement: 4.1% (2015 data)
First-year target/outcome measurement: 4.0%
Second-year target/outcome measurement: 3.8%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

National Survey on Drug Use and Health (NSDUH) – New Hampshire State Estimates is annual nationwide survey based on interviews of about 300 individuals of each population group identified through random sampling process.

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period overlap from one year to another.

Priority #: 6
Priority Area: Facilitating Coordination between SUD Treatment and Primary Care, including BH
Priority Type: SAT
Population(s): Other

Goal of the priority area:

All contracted providers will coordinate with client's physical health, behavioral health, and medication assisted treatment providers as applicable.

Objective:

Increase coordination between treatment providers and physical health, behavioral health, and medication assisted treatment providers.

Strategies to attain the objective:

Provider contracts will include a requirement for coordination with these providers and the state will monitor client progress notes to ensure that this coordination is taking place.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Progress notes indicate referral to (where appropriate) and coordination with the client's physical health provider.
Baseline Measurement: Coordination requirements for providers is new to contracts, baseline is 0.
First-year target/outcome measurement: 50% of files reviewed during annual site visits indicate referral to (where appropriate) and coordination with the client's physical health provider.
Second-year target/outcome measurement: 75% of files reviewed during annual site visits indicate referral to (where appropriate) and coordination with the client's physical health provider.

Data Source:

Client progress notes

Description of Data:

Review of progress notes during annual site visits

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical.

Indicator #:

2

Indicator:

For clients with a co-occurring mental health disorder, progress notes indicate referral to (where appropriate) and coordination with the client's behavioral health provider.

Baseline Measurement:

Coordination requirements for providers is new to contracts, baseline is 0.

First-year target/outcome measurement:

50% of files reviewed during annual site visits where the file indicates that the client has a co-occurring mental health disorder indicate referral to (where appropriate) and coordination with the client's behavioral health provider.

Second-year target/outcome measurement:

75% of files reviewed during annual site visits where the file indicates that the client has a co-occurring mental health disorder indicate referral to (where appropriate) and coordination with the client's behavioral health provider.

Data Source:

Client progress notes

Description of Data:

Review of progress notes during annual site visits

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical.

Indicator #:

3

Indicator:

For clients receiving medication assisted treatment outside of the treatment program, progress notes indicate coordination with the client's medication assisted treatment provider.

Baseline Measurement:

Coordination requirements for providers is new to contracts, baseline is 0.

First-year target/outcome measurement:

50% of files reviewed during annual site visits where the file indicates that the client is receiving medication assisted treatment outside of the treatment program indicate coordination with the client's medication assisted treatment provider.

Second-year target/outcome measurement:

75% of files reviewed during annual site visits where the file indicates that the client is receiving medication assisted treatment outside of the treatment program indicate coordination with the client's medication assisted treatment provider.

Data Source:

Client progress notes.

Description of Data:

Review of progress notes during annual site visits.

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical.

Priority Area: Peer Recovery Support Services (PRSS)

Priority Type: SAT

Population(s): Other (People in Recovery)

Goal of the priority area:

More people with Substance Use Disorders will have access to affordable PRSS.

Objective:

Increase the number of state-funded organizations providing PRSS across the state.

Strategies to attain the objective:

State standards for PRSS will be established; funding streams to pay for PRSS will be identified; and funding and Technical Assistance will be provided to Recovery Organizations and contracted treatment providers to initiate PRSS according to standards.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of state-funded organizations providing PRSS
Baseline Measurement:	0 state-funded organizations providing PRSS
First-year target/outcome measurement:	0 state-funded organizations providing PRSS
Second-year target/outcome measurement:	3 state-funded organizations providing PRSS

Data Source:

Scope of service in BDAS contracts as reported by BDAS Business Office

Description of Data:

BDAS contracts delineate the various activities for which the provider is accountable in the Scope of Service section.

Data issues/caveats that affect outcome measures::

The first year will be a time of development during which state standards will be established, funding streams identified and TA provided so that organizations can meet standards for contracts for PRSS. PRSS will be included in contracts in the second year.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$4,895,317		\$0	\$0	\$8,000,000	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$687,500		\$0	\$0	\$0	\$0	\$0
b. All Other	\$4,207,817		\$0	\$0	\$8,000,000	\$0	\$0
2. Substance Abuse Primary Prevention	\$1,587,940		\$0	\$4,800,000	\$600,000	\$0	\$100,000
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$341,200		\$0	\$0	\$2,300,000	\$0	\$0
13. Total	\$6,824,457	\$0	\$0	\$4,800,000	\$10,900,000	\$0	\$100,000

* Prevention other than primary prevention

Footnotes:

We have estimated numbers for the entire planning period 7/1/15 through 6/30/17.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$4,236,342
2 . Substance Abuse Primary Prevention	\$2,246,915
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$341,200
6. Total	\$6,824,457

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$121,673
	Selective	
	Indicated	
	Unspecified	
	Total	\$121,673
Education	Universal	\$39,401
	Selective	\$18,700
	Indicated	
	Unspecified	
	Total	\$58,101
Alternatives	Universal	\$12,821
	Selective	\$189
	Indicated	
	Unspecified	
	Total	\$13,010
Problem Identification and Referral	Universal	\$150,000
	Selective	\$100,000
	Indicated	\$33,000
	Unspecified	
	Total	\$283,000

Community-Based Process	Universal	\$318,468
	Selective	\$3,464
	Indicated	\$716
	Unspecified	
	Total	\$322,648
Environmental	Universal	\$83,060
	Selective	\$0
	Indicated	\$3,423
	Unspecified	
	Total	\$86,483
Section 1926 Tobacco	Universal	\$25,000
	Selective	
	Indicated	
	Unspecified	
	Total	\$25,000
Other	Universal	\$28,000
	Selective	
	Indicated	
	Unspecified	\$1,309,000
	Total	\$1,337,000
Total Prevention Expenditures		\$2,246,915
Total SABG Award*		\$6,824,457
Planned Primary Prevention Percentage		32.92 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

These numbers were pulled from 2015 BG tables from PWITS - this informed us where money was being spent for the current plan.

The amount for "other" "unspecified" correlates to table 6a Prevention Resource and Development Activities (which includes 50% of CoC)
25000 in the Tobacco section is for Synar

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$0	
Universal Indirect	\$0	
Selective	\$0	
Indicated	\$0	
Column Total	\$0	
Total SABG Award*	\$6,824,457	
Planned Primary Prevention Percentage	0.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
NH has completed table 5a

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	b
LGBT	e
American Indians/Alaska Natives	e
African American	e
Hispanic	e
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	e
Underserved Racial and Ethnic Minorities	e

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$325,000	\$325,000	\$0	\$650,000
2. Quality Assurance	\$485,000	\$230,000	\$60,000	\$775,000
3. Training (Post-Employment)	\$104,000	\$28,000	\$0	\$132,000
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$335,000	\$327,500	\$0	\$662,500
6. Research and Evaluation	\$10,000	\$0	\$0	\$10,000
7. Information Systems	\$50,000	\$0	\$0	\$50,000
8. Total	\$1,309,000	\$910,500	\$60,000	\$2,279,500

Footnotes:

Continuum of Care (CoC) monies (1,300,000) were distributed as follows:

325,000 for Px planning, coord, and needs assess
325,000 for Tx planning, coord, and needs assess
325,000 for Px program dev
325,000 for Tx program dev

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Section IV: Environmental Factors and Plan
NH 2016/17 SABG

The Health Care System and Integration

As a result of the functional "redesign" taking place within the NH Department of Health and Human Services, the Bureau of Drug and Alcohol Services (BDAS), which serves as the SSA for New Hampshire, is now under the umbrella of Health Strategies at the Department. Health Strategies is overseen by Associate Commissioner Kathleen Dunn and includes the BDAS, Developmental Services, Behavioral Health and a number of other programs and program support units. The Bureau has developed a close working relationship with the Division of Public Health Services (DPHS), including co-funding the 13 regional public health networks, which are responsible for emergency preparedness and for implementing the 10 essential health services. The BDAS has included funding for one FTE substance misuse prevention coordinator (SMPC) and starting July 1, 2015, a full time continuum of care facilitator within each of these regional networks.

BDAS serves as the subject matter expert for the Department including playing a leading role with the Office of Medicaid Business and Policy (OMBP) that also included other program areas within the Department in designing the substance use disorder (SUD) benefit for the New Hampshire Health Protection Program (Medicaid Expansion). It is anticipated that the same SUD benefits will be extended to the regular Medicaid program starting in state fiscal year 2017. BDAS continues to work closely with the Medicaid Office in other units within the Department and the Managed Care Organizations as these benefits are being implemented, including managing related quality and capacity issues.

Externally, the director at the BDAS serves as the executive director of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. This Commission includes members of the legislature, high level representation (Commissioners or their designees) from most of the state agencies, the courts, and a number of stakeholder groups and is responsible for the coordination and integration of alcohol and drug policies and services at the state and regional level. This Commission is also responsible for managing the alcohol prevention and treatment (state general) fund and for submitting a report each year to the Governor and legislature about the impact of alcohol and drugs has on the state plan (<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf>) including any gaps in service capacity and or resources needed to address these issues. The SSA director works closely with the Chair of the Governor's Commission, the Senior Policy Advisor on Mental Health and Substance Misuse at the Governor's Office and a Design Team to frame out some of the more salient alcohol and drug misuse issues that are then addressed within the Commission and its task forces (prevention, treatment, opioid, prenatal exposure and recovery) to develop, coordinate and implement strategies and services and related resources (including public and private health benefits and other resources) needed to effectively address the misuse of alcohol and drugs in New Hampshire . The following section provides an overview of some of the key *Healthcare System and Integration* initiatives currently underway.

Section IV: Environmental Factors and Plan
NH 2016/17 SABG

Bureau of Drug and Alcohol Services Integration Initiatives:

Facilitation the Continuum of Care for Substance Misuse Strategies and Services within the 13 Regional Public Health Networks

Increasing Capacity for a Continuum of Strategies and Services to Address the Misuse of Alcohol and Drugs and Optimizing resources

As indicated in the section on “unmet service needs and gaps in services”, although the ACA (Affordable Care Act) parity requirements have done much in the way of making benefits for substance use disorders available in both the private and public sector health insurance programs, there remains very limited capacity for SUD services (especially for medication assisted treatment (MAT) and withdrawal management (WM) that have not historically been included within DHHS contracted services). The Department of Health and Human Services has submitted an 1115 transformation waiver with the Federal Center for Medicare and Medicaid Services. Once approved, this waiver will provide significant resources for mental health and substance use disorder services delivery development and reform. In addition, the Department of Health and Human Services has received approval from SAMHSA to include one full time Continuum of Care Facilitator in addition to the current substance misuse prevention coordinator in each of the 13 regional public health networks. This position will support each of these regions utilizing a public health approach (strategic planning framework model) to identify capacity and gaps in the continuum of substance misuse prevention, early identification and intervention, treatment (including MAT and WM services) and recovery support services. Following this model these networks will identify and consider all available resources (public, private, Federal, state, county, local) resources that can be utilized to support a coordinated continuum of strategies and services in each of these regions. SAMHSA has also approved the Department’s utilizing significant block grant funds to contribute to this effort to develop additional capacity for the continuum of services within each of these regions.

The following sections outline key initiatives underway to develop integrated service capacity in New Hampshire

SBIRT

In keeping with our efforts to implement a comprehensive approach to address the misuse of alcohol and drugs, which includes a full continuum of services, the BDAS has worked closely with the DPHS within the Department, to develop capacity within Community Health Centers (CHCs & FQHCs) for the SBIRT (Screening, Brief Intervention, Referral to Treatment) model. Utilizing block grant funds, BDAS released an RFP, exclusive to the Community Health Centers, for the first cohort of CHCs in SFY-2015 and included funding for the remaining CHCs in cohort two directly in the DPHS services contracts. The Bureau also partnered with the New Hampshire Charitable Foundation (NHCF), which concurrently implemented an adolescent SBIRT program utilizing Hilton Foundation resources to provide training and technical assistance through our mutually supported New Hampshire Center for Excellence (CFEx) for these new SBIRT programs. DHSS has utilized Federal Block Grant Funds for implementing SBIRT (screening, brief intervention, referral to treatment) in all 15 Community Health Centers and all are

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currently under contract to develop/implement/provide SBIRT services. The Bureau has been in communication with the New Hampshire Hospital Association about making SBIRT services available in hospital base primary care networks.

MAT

New Hampshire is among states with the highest rates of non-medical use of pain medication and heroin in the country. Although medication assisted treatment (MAT) is a critical type of service needed to effectively address opioid use disorders, the state's capacity for MAT services is very limited (8 OTP sites and only 62 DATA waived physicians).

The Department of Health and Human Services is actively working to increase capacity for MAT services. BDAS is awaiting notice about a SAMHSA MAT grant application submitted in the spring of 2015. In the interim, BDAS has convened a work group of subject matter experts (SME) for a time limited series of sessions to develop a high level strategy for recruiting and engaging medical practitioners that can prescribe buprenorphine and other medications to provide community based (including primary care and hospital based) medication assisted substance use disorder treatment and withdrawal management services. The goal of this effort is to expand the availability MAT and WM services in New Hampshire as quickly and effectively as possible. Like the Department's SBIRT initiative, the Bureau's MAT initiative will initially focus on engaging the 15 Community Health Centers (CHCs) around the state to initiate office based opioid treatment (OBOT) services and will then focus on hospital based primary care networks. Key tenets of this initiative include:

- Engaging high level management and primary care staff
- Offering a model that addresses some of the challenges that primary care organizations face in providing MAT services
- Providing training and technical assistance and other resources supported by the block grant to facilitate additional physicians obtaining their DATA 2000 waiver and more primary care and specialty care organizations providing MAT services
- The state is also interested in expanding Opioid Treatment Program Capacity OTP within the state and via Secretary Burwell's 50-State Meeting on Opioids, is continuing the dialogue with other Northeast states to expand capacity in this area.

SAMHSA Grants

Youth Treatment Planning Grant:

The New Hampshire Department of Health and Human Services was recently awarded a SAMHSA Youth Treatment Planning Grant. Senior management at the Department are leading this effort with the participation of a number of program areas within the Department, including BDAS, the Bureau of Behavioral Health, and the Division of Children Youth and Families among others. Participants will be developing a 3-year Strategic Plan on increasing access throughout the state to evidence-based screening assessment, treatment and recovery services supports for 12-17 year olds and transition age youth ages 18-25 with substance use and/or co-occurring mental disorders.

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SAMHSA Drug Court Grant

The New Hampshire Department of Health and Human was recently awarded a SAMHSA Drug Court Grant. Senior management at the Department, in collaboration with the New Hampshire Superior Court, are leading this effort with the participation of a number of program areas within the Department including the BDAS. The Hillsborough County Drug Court Program (HCDC) is proposing to expand and further develop the HCDC which was initiated with a US Department of Justice (DOJ) grant. The goals of the HCDC are to reduce recidivism and substance abuse among high risk/high need non-violent offenders and increase the likelihood of successful rehabilitation by breaking the criminogenic patterns of behavior related to addiction and substance abuse. This is achieved through early, continuous, and intense treatment; mandatory random drug testing; community supervision; appropriate sanctions and incentives; and other rehabilitation services, all of which are supervised by the HCDC. To meet the goals and objectives of the program, the HCDC will continue to utilize a range of evidence-based practices during screening, assessment, and treatment.

New Hampshire Children's Behavioral Health Collaborative (CHBC)

The director of BDAS, the SSA, serves on the Advisory Council of the New Hampshire Children's Behavioral Health Collaborative. The mission of the Collaborative is to transform New Hampshire's current children's behavioral health care services and supports into an integrated, comprehensive system of care. The system of care is family driven and youth guided, community based, and culturally and linguistically competent

High level goals of the Collaborative include:

- To provide centralized, individualized community-based services and supports that involve the youth and family in service planning for youth with serious behavioral health needs
- To create a permanent way of increasing the capacity of the behavioral health workforce, recruiting and training new professionals as well as supporting current professionals and promoting best practices
- To identify and address behavioral health problems earlier in a range of settings including schools, primary care, and child care
- To integrate mental illness and substance abuse prevention, intervention, and treatment with primary care

Workforce Development:

The BDAS is currently engaged in a number of workforce development initiatives, including:

- Securing contracts that support community and state level training and technical assistance needs. The technical assistance contract will include data, analysis and reporting capacity for community and state level planning and implementation of strategies and services
- BDAS participates with the Division of Public Health Service in a tuition reimbursement program
- The Bureau, working with external partners has developed, released and is promoting utilization of a document that outlines clinical core competencies required for effectively addressing substance use

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disorders (SUD) and co-occurring disorders (COD) and per the 1st bullet above, making low cost training and no cost technical assistance available to providers in adopting these practices.

- BDAS is participating with other program areas within the Department in the Region One SAMHSA Workforce Development Initiative being coordinated by Katheryn Power. This effort is particularly helpful in addressing larger cross systems workforce and systems integration issues and includes the advantage of considering the experiences of other states in the area that may be further ahead in certain areas.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2: The Health Disparities

The New Hampshire Bureau of Drug and Alcohol Services – BDAS (SSA) does not have the capacity to report on this narrative at this time.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3: Use of Evidence in Purchasing

The healthcare landscape is changing dramatically in NH, resulting in the Bureau needing to urgently respond to those changes. It is the Bureau's intent to pursue the use of evidence in purchasing decisions; however the current circumstances are posing challenges for us at this time.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7: Participant Directed Care

New Hampshire has experience utilizing a voucher system through our participation in the Access to Recovery Program. We are evaluating moving to this type of system for SAPT Block Grant funded programs in the future.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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7: Program Integrity

Due to a dramatic redesign of the NH Department of Health and Human Services, all units within the Department are working closely together; making progress in connecting and utilizing resources that are already in place relative to integrity and program quality and are looking to standardize those requirements across the department including those services supported by the Block Grant.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

NH Does not have any federally recognized tribes.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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9: Primary Prevention

- 1) NH SABG prevention set-aside is 33% of the overall Block Grant budget. There is a total amount of \$937,915 that supports the 13 Regional Public Health Networks (RPHN) and Referral, Education and Assistance & Prevention Program (REAP)
- 2) The NH State Epidemiological Outcomes Workgroup (SEOW) meets quarterly.

PURPOSE Statement for The NH SEOW is a multidisciplinary advisory group that works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance use and behavioral health issues in order to inform prevention and treatment policy, programs and services in the state. The SEOW has six objectives that guide the work. The SEOW surveyed the RPHN for input to identify Priority Indicators of Substance Misuse and Related Mental Health Conditions with Surveillance and Data Considerations. During February and March 2015 the RPHN convened their regional data work groups for a total number of 242 individuals and organizations participated in determining what data would be used to define priorities and track outcomes. The SEOW provided phase-one of the substance misuse indicators that are include in the Web-based Interactive System for Direction, Outcome Measures (WISDOM) on line data resource site. WISDOM provides access to the most current available data, determinants of health data, health risks, and health outcomes in an easy to understand graphical format. WISDON phase-one data indicator sources are retrieved from:

- Youth Risk Behavior Survey (YRBS) – NH Local Aggregate Sample
- National Survey on Drug Use and Health (NSDUH)
- NH Hospital Discharge Data Set (UHFDDS)
- NH Division of Vital Records Administration Death Certificate Data
- NH County Health Rankings: <http://www.countyhealthrankings.org>

Over the next year the NH SEOW will begin to work on identifying phase-two and phase –three data indicators to be added to WISDOM.

Data used to inform allocation of funds:

Data was gathered using both the Youth Risk Behavior Surveillance System (YRBSS) and the Nation Survey on Drug Use and Health (NSDUH). All available data is displayed with projection data used in the High School And Young Adult Metrics. Most recent data available from both the YRBSS and NSDUH was used to create all metrics. 2017 projection is based on a formula informed by previous data changes.

YOUTH

Metric	2003	2005	2007	2009	2011	2013	2015	2016	2017
% of 18-25 Year Old Lifetime Use of Heroin	2.4%	2.2%	2.4%	3.1%	3.6%	3.7%	4.1%*	4.3%*	4.4%*
% of 18-25 Year Old Who Reported Past 30 Day Use of Alcohol	n/a	n/a	n/a	75.0%	73.2%	72.8%	71.8%*	71.2%*	70.8%*
% of 18-25 Year Old Who Reported Past 30 Day Use of Marijuana	n/a	n/a	n/a	27.3%	27.0%	26.2%	25.4%*	25.0%*	24.6%*
% of 18-25 Year Old Who Reported Misuse of Pain Medication in the Past Year	n/a	n/a	n/a	16.8%	12.3%	9.6%	5.9%*	3.9%*	2.0%*
Data Sources: 1, National Survey on Drug Use and Health									
* Projection Data									

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YOUNG ADULT

Metric	2003	2005	2007	2009	2011	2013	2015	2016	2017
% of 18-25 Year Old Lifetime Use of Heroin	2.4%	2.2%	2.4%	3.1%	3.6%	3.7%	4.1%*	4.3%*	4.4%*
% of 18-25 Year Old Who Reported Past 30 Day Use of Alcohol	n/a	n/a	n/a	75.0%	73.2%	72.8%	71.8%*	71.2%*	70.8%*
% of 18-25 Year Old Who Reported Past 30 Day Use of Marijuana	n/a	n/a	n/a	27.3%	27.0%	26.2%	25.4%*	25.0%*	24.6%*
% of 18-25 Year Old Who Reported Misuse of Pain Medication in the Past Year	n/a	n/a	n/a	16.8%	12.3%	9.6%	5.9%*	3.9%*	2.0%*
Data Sources: 1, National Survey on Drug Use and Health * Projection Data									

Adult Age 26 and Over						
Metric	2003	2005	2007	2009	2011	2013
% of Age 26 and Over Lifetime Use of Heroin	2.5%	1.1%	2.6%	3.3%	3.7%	4.0%
% of Age 26 and over Who Reported Misuse of Pain Medication in the Past Year	3.4%	3.0%	3.6%	3.8%	3.2%	n/a
% of Age 26 and over Who Reported Past 30 Day Use of Marijuana	6.0%	4.9%	6.3%	6.9%	5.4%	n/a
% of Age 26 and Over Who Reported Alcohol Use in Past 30 Days	63.3%	71.0%	74.8%	67.5%	66.8%	n/a
Data Sources: 1, National Survey on Drug Use and Health * Projection Data						

* Due to the epidemic of prescription drug abuse over the past decade and reemergence of heroin and drug overdose deaths in New Hampshire, escalating to a 700% increase from 2003 to present. The highest risk population is young adults. Over the next year BDAS will conduct a root cause analyst among young adults (college, non-college, working and non-working). The assessment will include binge drinking, prescription drug misuse and illicit opioid use. The results of this assessment and the recommendations for best practices are expected to impact prevention planning in 2016 and 2017.

- 3) BDAS will continue to fund the thirteen (13) RPHNs in utilizing a data-driven public health approach to address the misuse of alcohol and drugs in their area and Referral, Education and Assistance & Prevention Programs:
 - a. The RPHN geographically designed to include every community in NH and are funded the same amount. This is based on NH substance misuse indicators are similar across the state and some regions have a few “hot spots” of highest need areas. The regions are designed to support population health utilizing a public health approach to reduce substance misuse.
 - b. Block Grant funds support an older adult program that addresses high need older adults. The Referral, Education and Assistance & Prevention Programs (REAP) is housed across the state in 10 Community Mental Health Centers. Each Center have trained REAP counselors that provide a statewide community-based education and brief intervention-counseling program specific for persons age 60 and older, their families or other informal caregivers. The first priority of the program is prevention of substance misuse, i.e. alcohol, medications or other drugs, and secondarily issues relative to depression, isolation, interpersonal relationships, grief and loss, and other life changes.
- 4) Discretionary federal grant, Partnership for Success is distributed to regions and communities based on the highest needs. Calculated by the following:
 - a. In identifying the highest needs highest need communities for young adult BDAS used the 2012-2013 NSDUH data. According to the data, 10% of young adults reported illicit drug use other than marijuana, the highest rate in the country. For pain reliever abuse, 10.5% of NH young adults reported this behavior in the past year. In addition 49% of NH’s 18-25 year olds reported binge drinking in the past 30 days. This rate is the third highest in the country and much higher than the national average of 38.7%. BDAS identified 14 municipalities with heroin issues among 18-25 year olds based on the number of naloxone administrations in 2014, and based on illicit (non-marijuana) drug use and opioid misuse (2010-2012 NSDUH) data, at least one opioid-related death among 18-25 year olds in 2013. And at least one opioid-related death among all age groups in 2013, and located in a high-need county as identified by the 2014 county health rankings.

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- b. In identifying the highest need communities for youth BDAS used local sample NH YRBS data: past 30-day alcohol use, past 30-day binge drinking, perception of peer wrongness, and perception of risk. For prescription drug abuse, composite scores were developed for each school using three data points: past 30-day use of prescription drugs, perception of peer wrongness, and perception of risk. These data points were chosen because they indicate use or risk factors related to use and were determined to be significantly correlated with each other. The composite scores for alcohol and prescription drugs were added together to create a total severity score. The communities with a composite risk score or “severity score” above the state average are presented on the following table from highest to lowest.

5) 13 Regional Public Health Networks (RPHN)

The 13 Regional Public Health Networks (as of July 1, 2013) are combined contracts with Division of Public Health Services and the Bureau of Drug and Alcohol Services that provides infrastructure to conduct a variety of population health initiatives which includes promotion of substance misuse prevention programs, practices and policies. The role substance misuse prevention within each region is to implement primary prevention services that include assessment, capacity development, planning, implementation and evaluation and to build, maintain and sustain a regional network of professionals and community members who are concerned about substance misuse in the region and to leverage additional resources. As of January 2016 each region will have a revised 3-year strategic plan that is align with the goals of the state plan and the New Hampshire State Health Improvement Plan (SHIP). Regions’ provide technical assistance to promote best practices within six core sectors (Safety and Law Enforcement, Health & Medical, Education, Government, Business, and Community and Family Supports) as it aligns with the 3-year strategic plan as driven by regional data. Each Regional Public Health Network has one full-time equivalent substance misuse preventions certified specialist coordinator to carry out the regions substance misuse prevention activities. The Regional Public Health Networks contract shared objective and function is to engage and convene community stakeholders, representative of the geographical area, and to serve on the region’s Public Health Advisory Council (PHAC). The PHAC advises the Regional Public Health Network in the identification of regional public health priorities based on regional health assessments; assure the implementation of programs, practices and policies that are aligned with the data and are evidence-based to meet improved health outcomes; and advance the coordination of services among partners. Primary prevention initiatives are conducted within the six CSAP categories and target populations across the IOM, indicated, selective and universal. This is reported in the WITS on-line data system to meet the reporting needs of the Substance Abuse Block Grant.

***It is anticipated both Partnership for Success target goals and allocation of resources and RPHN 3-year strategic plans will be revised based on the findings of the young adult assessment.**

6) Capacity

- a. Regions are encouraged to secure additional sources of funding or in-kind resources in the implementation of their strategies, and report out on how block grant and other resources were used to support these efforts and the implementation of the planned strategies. Overall prevention capacity is supported and advanced by the following:
- b. NH substance misuse prevention efforts are supported by a public-private partnership with the New Hampshire Charitable Foundation (NHCF) and BDAS. NHCF has made a ten-year commitment and investment approximately \$1.2 million dollars per year in prevention. BDAS and NHCF meet regular (at minimum once a month) to ensure we are meeting our shared goals and objectives.
- c. The system is built upon the six-sector model; business, health/medical, safety/enforcement, government, education, family & community supports. Each sector has stake in the health and wellness of the community in which they work, live, play and learn. The NH Governor’s Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment published five-year plan utilizes the six sector model, thereby encouraging community sectors to engage and adopt best practices to complement state-level efforts to achieve the goals of reducing alcohol and other drug misuse.

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- d. The regional network(s) conducted regional assessment, capacity assessment, and planning with their regional work groups and leadership team that will produced a three-year strategic plan for each of the 13 regions. Within each plan strategies are identified and aligned with the data and risk and protective factors.
- e. NH Center for Excellence, the state’s technical assistance quality improvement contractor, provided technical assistance for each region to ensure strategies chosen addressed contributing factor(s) that demonstrated strength of evidence and overall fit and feasible of the intervention. NH follows SAMHSA evidence-based determination chart. Primary prevention programs, practices, and strategies or interventions are approved once they meet the above rigor of evidence determined by the NH Center for Excellence.

7) Data collection and evaluation

- a. Process data is collected through our contract with FEI, P-WITS. All prevention plans: goals, objectives and strategies are recorded and approved prior to implementation. Once plans are approved within P-WITS providers can begin reporting their prevention activities and outcomes. Aggregated monthly and annually reports are generated from P-WITS. Process data will be compared to recorded short, intermediate and long term outcomes; as follows:
- b. **Short-term:** increase of collaboration across the engagement – integration continuum, improve trust among stakeholders, increase prevention activities support by other leveraged resources, increase implementation of evidenced based programs & practices (EBPP), increase number of people reached by EBPP.
- c. **Intermediate:** increase perception of risk of harm, increase perception of wrongness, decrease accessibility/availability of substances, increase parental monitoring, decrease community norm favorable toward substance use, increase age of onset of first use, increase exposure to prevention messaging.
- d. **Long term:** is to change overall prevalence rates of substance misuse and consequence data
 - i. **Decreased past 30-day use of alcohol**
 - 1. high school aged youth from 31.5% in 2015 to 29.0 in 2017
 - 2. 18-25 year olds from 71.8% in 2015 to 70.8% 2017
 - ii. **Decreased past 30-day use of marijuana**
 - 1. high school aged youth from 24.0% in 2015 to 23.5% in 2017
 - 2. 18-25 year olds from 25.4% in 2015 to 24.6% 2017
 - iii. **Decreased past year use of Prescription drugs**
 - 1. high school aged youth from 5.60% in 2015 to 4.8% in 2017
 - iv. **Decease Heroin Use Past Year**
 - 1. 18-25 year olds from 4.1% in 2015 to 3.8% 2017

All levels of outcome, process and outcome data will help to inform NH if our prevention strategies are working. The short and intermediate measures are early indicators, which will allow NH to assess and determine if we are meeting improved outcomes. If these earlier outcomes are not favorable then we will revise our prevention plan.

As a result of the CSAP system review conducted April 2015, NH measures may change as a result of the pending technical assistance that will provide by CSAP. CSAP has proposed technical assistance to increase the skills of BDAS staff, T/TA contractors, funding partners, and RPHN and local committees in applying strategic planning using a logic model, a management information system based on local data, and a dashboard in support of ongoing community management of effective environmental prevention

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8) Workforce development

- a. NH NPN works very closely with NH Certification Board in support of the advancement and expansion of the NH prevention work force. BDAS amended the NH Certification Board’s contract to conduct an assessment of the prevention workforce and the alignment IC&RC core competencies and to expand the fields’ knowledge and integration of behavioral health. This assessment will determine strengths and gaps within the NH workforce then a plan will be developed and implemented to improve NH workforce. Starting late fall of 2015 NH Certification Board will develop a professional mentoring program, pairing newer professionals with more seasoned professionals to enhance the overall prevention work force and to transfer knowledge and skills to the newer professionals. The mentoring program will be based on other evidenced based professional mentoring programs.
- b. NH adopted the national Substance Abuse Prevention Skills Training (SAPST) curriculum and training, 5 NH professionals are trained as SAPST trainers. BDAS in conjunction with Training Institute conducts SAPST in alternate years. The next training is planned for first week of October 2015.
- c. Through a contract with the NH Alcohol and Drug Abuse Counselors Association (NHADACA), the NH Training Institute on Addictive Disorders (NHTIAD) provides monthly training events. Licensed Alcohol and Drug Counselor, Certified Prevention Specialist, Social Worker and Mental Health CEUs are available for the trainings.
- d. NH contracts with The New Hampshire Center for Excellence. This is a resource that provides technical assistance, disseminates data and information, and promotes knowledge transfer in support of communities, practitioners, policymakers, and other stakeholders working to address alcohol and other drug misuse and related consequences throughout New Hampshire. Center for Excellence facilitates NH Service to Science process that allows locally developed programs and practices to be reviewed by an expert panel for endorsement as evidence-based or best practice based upon current research. The Center maintains a professional website <http://www.nhcenterforexcellence.org>.

9) 13 Regional Public Health Networks mainly conduct universal and selective prevention approaches that support and impact environmental change and adoption of best practices. Here is a list of strategies posed in RPHN 3-year plan.

Strategy
Regional Network Facilitation – convening stakeholders and workgroups
Strategic Prevention Framework (Implement ACPIE steps)
Support for Local Community Prevention Coalitions alignment of goals
Community Education and Training - prescribing workshops, SUD First Aid, sector-specific education, parent education, etc.
Social Marketing & Media Campaign
Life of an Athlete
Promotion of Student Assistance Programs
Rx Drug Drop Boxes/Take Back Events
Best practices promotion (enforcement , Targeted patrols, community policing, School Resource Officer)
Promotion of Prescription Drug Monitoring Program
Youth Leadership
Promotion of Universal Screening, Brief Intervention
Education and TA Policy Change per sector

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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10: QI Plan

Due to a dramatic redesign of the NH Department of Health and Human Services, all units within the Department are working closely together; making progress in connecting and utilizing resources that are already in place relative to integrity and program quality and are looking to standardize those requirements across the department including those services supported by the Block Grant.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11: Trauma

NH does not have the capacity to report on Trauma at this time.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

Involvement with the criminal and juvenile justice systems does not preclude an individual from accessing Medicaid as a part of coverage expansion and several of these systems are working actively with clients and other supports to ensure that criminal/juvenile justice involved individuals are also accessing available services. For those clients not able to access services through coverage expansion, block grant and other funds are available to them through department contracts with treatment providers.

Screening and services prior to adjudication and/or sentencing is inconsistent across the state with some counties having vital specialty court programming and other counties not yet able to provide these services. A committee chaired by the Chief Justice of the New Hampshire Supreme Court is actively developing specialty courts in New Hampshire and the NH SSA is supportive of their efforts.

The SSA works to coordinate with both state and county criminal and juvenile justice systems around screening, treatment, diversion, and reentry. While this process has been somewhat slowed by the loss of ATR funding, this continues to be an area of importance for the department.

Trainings are provided to a wide range of provider groups through the NH Training Institute for Addictive Disorders (NHTIAD) and the department regularly requests trainings that will meet the needs of those serving the criminal and juvenile justice systems as well as behavioral health providers.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

NH does not have the capacity to report on Parity Education at this time.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

14. MAT

New Hampshire is pursuing a number of initiatives relative to medication assisted treatment:

- Funding has been added to the current contracts to assist providers to develop integrated or coordinated MAT and it is anticipated that these funds will be available in the next round of contracts as well. Whether or not a contracted provider is funded for medication assisted treatment, they are required under current contracts to work with clients on MAT. It is anticipated that future contracts will require providers to offer integrated or coordinated MAT to all appropriate clients.
- NH is working with our technical assistance contractor and a small group of physicians and behavioral health professionals to develop a strategic plan and community of practice for medication assisted treatment. Initially, this effort will focus on physicians; however, the intent is to expand to behavioral health professionals as well.
- NH is working with our training contractor to offer training to behavioral health professionals around medication assisted treatment. The initial focus is on breaking down myths and stigma associated with medication assisted treatment and promoting skills necessary for behavioral health professionals to work in an integrated environment with primary care.
- NH has applied for SAMHSA funding to expand medication assisted treatment in community health centers.
- The NH Health Protection Program (NH's Medicaid Expansion) funds a wide range of medication assisted treatment services, including office based with prescribers and withdrawal management.

In all efforts described above, there is a heavy focus on the importance of integrating medication with behavioral health treatment to ensure the best outcomes for providers. In addition, the use of evidence based practices is required for all service delivery.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

NH Bureau of Drug and Alcohol Services (BDAS) is taking a multi-dimensional approach to the development of recovery support services and instilling recovery values in communities:

- BDAS is working with the NH Department of Health and Human and NH Medicaid Managed Care organizations on the development of rules and standards for recovery services.
- BDAS provides basic training on addiction and recovery for professionals in the health, education, corrections and human service fields which includes SAMHSA's definition and guiding principles of recovery, recovery orientation and the importance of peer recovery support services.
- BDAS has convened stakeholders from the addiction recovery and mental health peer support communities to form a team to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). The NH BRSS TACS team has established a mission and value statement for increasing the capacity to provide peer recovery support services (PRSS), across the state by:
 - Educating all community sectors on what PRSS is and its value
 - Increasing the involvement of peers in promoting health in all sectors of the state,
 - Ensuring good communication and coordination between addiction recovery and mental health peer support systems
 - Researching standards on training, certification and supervision for PRSS.
 - Identifying potential public and private funding sources to pay for PRSS.
 - Supporting the development of sustainable peer recovery support services.
- BDAS supports the work of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, and its Recovery Task Force, as it seeks to increase the quality and quantity of recovery support services across the state. (as detailed in "Collective Action – Collective Impact, New Hampshire's strategy to prevent and reduce alcohol and other drug misuse and promote recovery"
<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf>) The Recovery Task Force is primarily comprised of people in long-term recovery so that they can be the drivers of recommendations on recovery support services development.
- Family peer support and advocacy services have been institutionalized within the NH Children's Behavioral Health Collaborative. BDAS promotes the existing organizations and the expansion of new support groups and engages representatives of these groups in planning groups.
- BDAS has contracted with thirteen (13) regional public health networks to identify assets in gaps in building regional substance misuse systems of care, including recovery support services and the involvement of those in recovery in the development of the continuum of care.
- BDAS is promoting and providing guidance on coordination with primary health and behavioral health in all continuum of care development work.
- BDAS is promoting and providing guidance on including assets beyond substance abuse services (housing, nutrition, substance free social events, etc.) as part of recovery support services.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

The Children's Behavioral Health Collaborative

The director of BDAS, the SSA, serves on the Advisory Council of the New Hampshire Children's Behavioral Health Collaborative. The mission of the Collaborative is to transform New Hampshire's current children's behavioral health care services and supports into an integrated, comprehensive system of care. The system of care is family driven and youth guided, community based, and culturally and linguistically competent

High level goals of the Collaborative include:

- To provide centralized, individualized community-based services and supports that involve the youth and family in service planning for youth with serious behavioral health needs
- To create a permanent way of increasing the capacity of the behavioral health workforce, recruiting and training new professionals as well as supporting current professionals and promoting best practices
- To identify and address behavioral health problems earlier in a range of settings including schools, primary care, and child care
- To integrate mental illness and substance abuse prevention, intervention, and treatment with primary care

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

19. Pregnant Women & Women with Dependent Children

1. All department funded providers were notified in State Fiscal Year 2015 that all staff with any client contact must review Exhibits A & B of the contracts, which include the SAPT Block Grant requirements for availability of treatment and priority admission preference for pregnant & parenting women. All providers have complied with this request. In addition, providers applying for funding in future fiscal years will be required to report their strategies for meeting this requirement and will be monitored on adherence to these strategies.
2. The department is able to track both screening dates and admission dates of all clients, including pregnant women specifically, through the Web Information Technology System (WITS).
3. The department is able to track services provided to all clients, including interim services for pregnant women specifically, through the WITS system.
4. Oversight of the requirements above is provided by the Bureau of Drug and Alcohol Services Clinical Services Unit.
5. The department funds the Greater Nashua Council on Alcoholism, Cynthia Day Family Center (GNCA-CDFC) in Nashua which is a long-term residential program for pregnant and parenting women and their infants.
 - a. This program does provide medication assisted treatment to clients. In addition, the department is working with several other contracted providers who have expressed interest in working with the medical community to provide medication assisted treatment (MAT) as well as with the medical community to expand MAT availability.
 - b. The North County is particularly challenged by the rural geography; however, Tri-County Community Action Program, a department funded provider in this region, is currently working with an MAT provider.
6. Three programs serve pregnant women and their children, Southeastern New Hampshire Services (SENHS) offers an IOP with childcare arranged while women are in treatment, Families in Transition (FIT) offers OP & IOP for pregnant and parenting women and their children and have childcare on-site and Families First of the Greater Seacoast offers OP with childcare on site. All 15 department funded programs have the ability to serve pregnant & parenting women, however, only GNCA-CDFC can accommodate infants & children on-site in the residential program.
 - a. See 5a.
 - b. See 5 b.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The 2013 NH State Suicide Prevention Plan is NH's most recent plan. The Plan has been developed to focus and coordinate suicide prevention efforts in New Hampshire. The Suicide Prevention Council (SPC) and its partners will guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as the strengths and constraints of the current political and economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC will provide an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

Joseph Harding, Director of BDAS, serves on the SPC as well as the Council's Leadership Committee. Ann Crawford, BDAS Prevention Services Regional Coordinator, serves on the Youth Suicide Prevention Assembly (YSPA).

New Hampshire

Suicide Prevention Plan

January 2013



Suicide Prevention Council

The mission of the State Suicide Prevention Council is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:

- * Raise public and professional awareness of suicide prevention;*
- * Address the mental health and substance abuse needs of all residents;*
- * Address the needs of those affected by suicide; and*
- * Promote policy change*



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

July 2, 2013

I want to thank the New Hampshire Suicide Prevention Council for its work on the 2013 State Suicide Prevention Plan. Since the Plan's last revision in 2010, New Hampshire has accomplished a great deal, and the Suicide Prevention Council has been instrumental in helping to guide these efforts.

Legislatively established in 2008, this Council is responsible for the oversight of the implementation of the State Suicide Prevention Plan, and has developed a strong public and private partnership throughout the State to accomplish this goal. As citizens of New Hampshire, we can all be proud that our Connect Program is a National Best Practice Program that has trained hundreds of professionals and community members to prevent and respond effectively to suicide across the lifespan. Additionally, New Hampshire is a national model for our work recognizing the training and prevention efforts needed to support our veterans and military families. Due to the efforts of the Council, New Hampshire is now recognized as a Leadership State and was awarded one of the first Garrett Lee Smith grants through the Substance Abuse and Mental Health Services Administration.

Suicide, however, remains the second-leading cause of death for New Hampshire young people, and is a major concern for all ages. We must continue our efforts to reduce the number of suicides and suicide attempts statewide. Prevention must be a collaborative effort. The entire community must share the responsibility of identifying at-risk individuals and ensuring that these individuals receive essential, life-saving services. Broad awareness of the warning signs of suicide can only increase appropriate referrals and interventions.

This 2013 State Suicide Prevention Plan has been a true collaboration among many stakeholders, and I look forward to working together to address this issue that affects all of our citizens.

With every good wish,

A handwritten signature in blue ink that reads "Margie H" with a long horizontal line extending to the right.

Margaret Wood Hassan
Governor



From the State Suicide Prevention Council

Child and Family Services
of NH

Disabilities Rights Center

Elliot Hospital

Faith Based Community

Genesis Behavioral Health

Injury Prevention Center

Lakes Region Partnership
for Public Health

NAMI NH

New Futures

NH Association of Counties

NH Community Behavioral
Health Association

NH Dept. of Corrections

NH Dept. of Education

NH Dept. of Health and
Human Services

NH Dept. of Safety

NH General Court

NH Hospital Association

NH Medical Society

NH Mental Health Council

NH National Guard

NH State Senate

Office of the Chief Medical
Examiner

Survivors of Suicide Loss

VA Medical Center

Youth Suicide Prevention
Assembly

As the member organizations of the State Suicide Prevention Council (SPC), we are pleased to present the 2013 State Suicide Prevention Plan. Our hope is that this Plan will help to guide and focus our efforts in addressing the tragedy and burden of suicide across New Hampshire.

The Plan was developed through the wisdom, expertise and collaboration of the SPC, as well as many groups, committees and organizations who have dedicated time and resources to study the issue of suicide and to look at prevention and postvention across the lifespan.

Community collaboration is at the heart of SPC and is included throughout the Plan. The partnerships that have developed at all levels - public and private, local, state and federal, and military and civilian – continue to guide our efforts.

The planning process also included input from the 2012 National Strategy for Suicide Prevention, recognizing our nation's new approach in enlisting all individuals in the fight to prevent suicide.

The State Suicide Prevention Plan was last revised in 2010 and since that time, the SPC has accomplished much to address suicide prevention across the State. The Leadership Team spearheaded several strategic planning sessions, including a 50-person retreat at New Hampshire Hospital and a 100-person summit at the Concord Holiday Inn. Both events addressed state plan development, community collaboration and sustainability.

In 2012, the SPC partnered with the National Alliance on Mental Illness NH and the Youth Suicide Prevention Assembly on the Annual Suicide Prevention Conference. With close to 300 individuals attending, this conference continues to grow every year, reaching the largest and most diverse gathering of individuals in the nine-year history of this Conference.

The SPC will continue to build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability to reduce the risk of suicide for all New Hampshire citizens and promote healing for all those affected by suicide. Despite significant challenges with a struggling economic environment including budget cuts and reduced access to mental health and substance abuse treatment, our State will continue to make progress in suicide prevention work in many diverse and systemic ways.

Knowing that it takes all of us working together with common passion and goals, we would like to thank everyone who has been involved in suicide prevention efforts in our State.



2013 Revised

New Hampshire Suicide Prevention Plan

*Presented by the
New Hampshire Suicide Prevention Council
(SPC)*

INTRODUCTION

Suicide – a Major Issue in New Hampshire

Suicide is a significant public health problem in NH:

- Between 2004 and 2008 suicides outnumbered homicides by more than 8 to 1.
- Suicide is the second leading cause of death for those from age 15 to 34.
- Between 2002 and 2011, firearms were the leading method used, representing 42% of all suicide deaths.
- Three times more males than females ages 10-24 died by suicide between 2005 and 2009.
- Suicidal behaviors, which include attempts as well as completed deaths, are a significant cause of inpatient hospitalization, emergency and outpatient treatment.
- In an average year, between 2004 and 2008, 156 people died; nearly 185 were hospitalized and close to 945 were treated in emergency departments for self-inflicted injuries.
- These attempts and suicides represented an estimated \$16.8 million in acute health care costs alone in 2008.
- For each suicide death, family and close friends are at higher risk for suicide themselves.
- Many others are affected in a variety of ways, including those providing emergency care to the victims and those who may feel they failed to prevent the death.

The data above is from *New Hampshire's 2011 Suicide Prevention Annual Report: Suicide Across the Lifespan*. Annual NH Suicide Data reports can be found here: <http://www.theconnectprogram.org/annual-reports-suicide-prevention-data-nh>

Underlying Principles for the State Suicide Prevention Plan

- **Suicide is generally preventable.** The vast majority of people who die by suicide have mental illness and/or substance use disorders which research demonstrates can be successfully treated. Early identification and access to care are essential.
- **Prevention must be a collaborative effort.** The entire community must share the responsibility of identifying and getting those at risk into needed services. Most people who die by suicide give some indication they are contemplating suicide before they die. Broad awareness of warning signs of suicide will increase appropriate referrals and interventions.
- **Risk factors** occur at the community as well as the individual level. Identifying and addressing community risk factors as well as individual risk factors is an important suicide prevention strategy. Likewise, communities that build and support protective factors will benefit not just in preventing suicide but also in improving public health and public safety.
- **Promoting healing and reducing risk following a suicide** (postvention) for both individuals and communities is an important component of suicide prevention efforts.
- **Significant investments** of time and other resources are required to prevent suicide. Focusing on recognized Best Practices will ensure that these efforts lead to positive outcomes across the lifespan, across the state and across cultures.
- **Suicide prevention must become a part of all of our ongoing work** and become embedded throughout our communities including our schools, health care systems, corrections at all levels. **The NH Suicide Prevention State Plan will be most effective when it is implemented from an ecological perspective that encourages working across individuals, families, communities, workplaces, the military, organizations and systems.**

State Suicide Prevention Plan Process

This Plan has been developed to focus and coordinate suicide prevention efforts in New Hampshire. The SPC and its partners will guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as the strengths and constraints of the current political and economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC will provide an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

COMMUNICATIONS & PUBLIC EDUCATION SUBCOMMITTEE

Goal 1: Promote Awareness that Suicide in NH is a Public Health Problem that is Generally Preventable

Objective 1.1: Promote recognition of suicide as a generally preventable public health problem and promote active involvement in prevention activities.

1. Partner with key stakeholders, including public health regions, throughout the State on planning and convening an annual conference in order to build awareness of suicide prevention, increase knowledge of best practices for prevention, intervention and response to suicide, and increase collaboration, networking and support.

Objective 1.2: Promote education that includes hopeful messaging to NH residents on risk factors, suicide-warning signs, help seeking behaviors, and resources.

1. Create audience specific messaging that encourages individuals to take steps towards preventing suicide, and coordinate with other national, state and local media efforts.
2. Maintain a central repository website updated regularly for press releases, presentations, and fact sheets that include data, risk and protective factors, warning signs, and resources.
3. Periodically repeat surveys to measure attitudes towards suicide prevention and media reporting.
4. Design and sponsor wide dissemination of public health messages and education on suicide prevention, using traditional and new/social media.
5. Encourage communities to effectively implement protocols listed in the Suicide Prevention Resource Center's Best Practice Registry.
6. Continue to educate the general public as well as health care providers and other key stakeholders (e.g. law enforcement/first responders) on risk factors and the efficacy of reducing access to lethal means for those at risk of suicide, particularly regarding firearms and medications.
7. Disseminate and promote information regarding the National Suicide Prevention Lifeline (1-800-273-8255).

Objective 1.3: Encourage new and diverse stakeholders, including policy makers, who work on preventing suicide in all communication subcommittee activities.

1. Review progress and update the State Suicide Prevention Plan.
2. Increase venues where the work of the SPC can be highlighted, e.g. newsletters, etc.

Goal 2: Reduce the Stigma Associated With Obtaining Mental Health, Substance Misuse and Suicide Prevention Services

Objective 2.1: Increase the proportion of the public that views mental disorders as real illnesses, equal and inseparable components of overall health, that respond to specific treatments and consumers of these services as persons taking responsibility for their overall health.

1. Disseminate information to legislators, policy makers, providers and the public demonstrating that there are effective treatments for mental illness and substance use disorders.
2. Educate the public and key gatekeepers that their acceptance of persons with mental illness and substance use disorders and their addressing suicide openly can reduce suicide risk and prevent suicidal behaviors.

3. Provide opportunities for the public to hear from those in recovery from mental illness, survivors of suicide loss, and survivors of suicide attempts, making use of existing speakers bureaus in NH such as *In Our Own Voice*, *Life Interrupted* and *Survivor Voices*.
4. Support initiatives which increase insurance coverage and reimbursement and access to treatment for mental illness and substance use disorders.

Goal 3: Promote Safe Messaging, Media Reporting and Portrayal of Suicidal Behavior

Objective 3.1: Increase the proportion of media professionals who have received training in appropriate reporting of suicidal events, identifying allies who will educate the media and journalism teachers on the national Reporting on Suicide: Recommendations for the Media.

1. Continue and expand efforts to participate in the education of journalism students in New Hampshire on the importance of sensitive reporting of suicide and suicide behavior.

Objective 3.2: Increase the number of sources (public health officials, school personnel, medical examiners, etc.) who have received contact from suicide prevention representatives around media recommendations and training/consultation in appropriate responses to inquiries from media professionals concerning suicide and suicidal events.

1. Incorporate orientation to the *Reporting on Suicide: Recommendations for the Media* and safe messaging in general into all suicide prevention training.

Objective 3.3: Promote news reports and portrayals in NH that observe appropriate reporting of suicidal events, present prevention messages and offer positive adaptations and non-stigmatizing views of mental illness.

1. Continue to respond to positive and negative media stories on an ongoing basis.
2. Cultivate relationships with media personnel for proactive dialogue around media reporting on suicides and encourage media contact with identified SPC spokespersons when suicide incidents occur.
3. Encourage all media reports to encourage hope and help seeking and include information on local supports and treatment resources as well as the National Suicide Prevention Lifeline (1-800-273-8255).

Goal 4: Support survivors of suicide attempts and survivors of suicide loss through the implementation of support and education programs for family, friends, and associates of people who completed or attempted suicide.

Objective 4.1: Support survivors of suicide loss (SOSL) services.

1. Continue distribution of Medical Examiner's Suicide Survivors Bereavement packet and maintain the list of resources for support.
2. Promote American Foundation for Suicide Prevention's (AFSP) annual teleconference for SOSL.
3. Support the continued development of a NH SOSL Network.
4. Encourage use of funds raised by SOSL in NH to promote SOSL resources, information and events.
5. Explore the establishment of a statewide SOSL Committee as part of the SPC to provide oversight and coordination of resources and a voice to planning at the state level.
6. Explore opportunities and strategies for engaging and offering supports and education to suicide attempt survivors and their families/loved ones.

DATA COLLECTION AND ANALYSIS SUBCOMMITTEE

Goal 1: Improve and Expand Suicide Surveillance Systems

Objective 1.1: Produce and disseminate periodic reports on suicide and suicide attempts to policy makers and stakeholders.

1. Produce annual report on suicide to include suicide deaths, attempts, hospitalizations and Emergency Department (ED) visits and ideation utilizing available data sources.
 - a. On a yearly basis, review available data sources to identify other relevant information to include in the annual report.
 - b. Expand and improve methods and templates for reporting on suicide data.
 - c. Coordinate with the Suicide Fatality Review Committee to include recommendations resulting from their case reviews in the annual report.
 - d. Include in annual document progress reports from statewide and local efforts such as suicide prevention grantees (campus and state), coalitions, and other coordinated suicide prevention efforts.
2. Provide interim reports on data related to attempts, deaths, and other related factors to the SPC as requested.
3. On an annual basis, review the guidelines for appropriate release of data (including suppression of smaller numbers) to ensure that current best practices are being followed.
4. On an annual basis, review the summary of pertinent epidemiology terms included within the annual report and update as needed.

Objective 1.2: Increase the proportion of organizations and institutions that routinely collect and analyze reports on suicide attempts, deaths, and related factors.

1. Improve data collection on suicidal behavior.
 - a. On a yearly basis, review the data extraction tools used with compiling data from the Medical Examiner's Office. Refine the extraction tool as needed.
 - b. Track current trends in NH and national data related to suicide deaths and make recommendations to the Medical Examiner's Office on additional and/or alternative data to collect following a suicide death.
2. Investigate data sources related to help-seeking behavior.
 - a. Inventory current data sources and questions used.
 - b. Recommend integration of questions on help-seeking behavior in other surveys when appropriate.
3. Increase and maintain representation by organizations and institutions that would benefit from collecting, analyzing, reporting and utilizing data related to suicide attempts and deaths.
4. Continue assessing needs around the collection and analysis of data.
5. Revisit and update the 2010 review of professional literature on best practices around suicide data collection and analysis every two years.
6. Support New Hampshire's proposal submission for the National Violent Death Reporting System.

Objective 1.3: Increase the proportion of organizations and institutions that utilize data to develop and/or evaluate interventions.

1. Collaborate with other sub-committees of the NH Suicide Prevention Council to increase the number of suicide prevention initiatives in the state that utilize relevant data in an appropriate manner.
2. Include evaluations of current initiatives.

3. Encourage the dissemination of evaluation results.

Objective 1.4: Conduct ongoing epidemiological analyses of current and historical suicide-related and substance misuse data.

1. Increase analysis capacity for all suicide-related data.
 - a. Identify key data sources, tools and personnel.
 - i. Explore nontraditional data sources.
 - ii. Explore emerging technologies and analysis (e.g., small area analysis, GIS).
 - b. Collaborate with key personnel on coordinated analysis.
 - c. Explore how integrating different data sets may identify high-risk populations, regions or other trends, which would inform suicide prevention efforts.

MILITARY AND VETERANS SUBCOMMITTEE

Goal 1: Educate the Public to Improve Recognition of At Risk Behaviors and the Use of Effective Interventions.

Objective 1.1: Promote effective educational programs to the general public to increase awareness, comfort, and knowledge of resources on potentially suicidal veterans, service members and/or their families.

Goal 2: Promote training to personnel that are directly involved with veterans, service members and/or their families who exhibit high risk, concerning behaviors.

Objective 2.1: Promote effective educational programs for community providers who serve veterans, service members, and/or their families to promote collaboration with the Veterans Administration and the involved military unit (NH National Guard, Reserves).

Goal 3: Coordinate delivery of informational material to the community and treatment sites on resources on potentially suicidal veterans, service members and/or their families.

Objective 3.1: Regular delivery of informational outreach materials to local hospitals, Veteran Service Organizations (VSO), military units, law enforcement, family programs, and community resource locations.

Goal 4: Ensure that the Military and Veterans Subcommittee collaborates with all other SPC Subcommittees.

Objective 4.1: Request and share minutes/agenda of all State Suicide Prevention Council subcommittee meetings.

Objective 4.2: Subcommittee members of the SPC band together as needed to form a Task Force to work on Suicide Prevention Council projects (i.e.; revise the State Plan or create the Strategic Plan for the SPC), which will build and improve our collaboration and cohesiveness as a council.

CROSS TRAINING & PROFESSIONAL EDUCATION SUBCOMMITTEE

Goal 1: Promote Effective Clinical and Professional Practices

Objective 1.1: Promote guidelines for clinical practice and continuity of care for all health care providers who treat persons with suicide risk.

1. Promote routine screening for suicide risk and the documentation of results in the provision of health care.
2. Promote the use of concrete, specific and individualized mental health follow-up plans for patients treated for suicidal ideation or behavior.
3. Encourage post-assessment contact to reinforce plans where appropriate (e.g. Project RED).
4. Promote use of effective protocols for ensuring collaboration and effective communication among professionals.
5. Promote education on laws/RSAs, ethical obligations, and best practices regarding the sharing of information related to the treatment of individuals at risk for suicide.
6. Promote and cultivate relationships with other agencies and individuals so that collaboration and response can occur seamlessly and in a timely manner.
7. Foster sustainability and infrastructure by encouraging exchange of information/learning among providers and systems who are implementing best practices in suicide prevention.
8. Stay abreast of current trends, research and resources in suicide prevention and disseminate as appropriate.
9. Promote the use and availability of research based, age and culturally appropriate screening and assessment tools.

Goal 2: Support sustainability and infrastructure of best practices in NH by promoting training and protocols to community members, schools, organizations and providers on the prevention of suicide and related behaviors.

Objective 2.1: Encourage recertification and continued delivery of training programs through existing NH trainers in Connect, Counseling on Access to Lethal Means (CALM) Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR) and other best practices that are available in NH.

Objective 2.2: Promote culturally informed training to mental health and substance use disorder treatment and prevention providers on the recognition, assessment and management of at-risk behavior.

Objective 2.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors for all health professions including graduate and continuing education.

Objective 2.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 2.5: Promote the implementation of protocols and programs for clinicians and clinical supervisors, first responders, crisis staff and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Goal 3: Promote the integration and coordination of suicide prevention activities across multiple sectors and settings.

Objective 3.1: Promote awareness of local and regional resources for suicide assessment and intervention to Accountable Care Organizations (ACOs).

Objective 3.2: Promote training for primary care Providers, care managers and ambulatory care staff around risk assessment and referral and their relationship to untreated medical conditions (e.g. asthma).

Objective 3.3: Promote integration of suicide prevention and interventions into all relevant health care reform efforts.

Objective 3.4: Strengthen linkages between systems and build on existing infrastructure of suicide prevention efforts such as communities, organizations, systems and trainers that have implemented best practices around suicide prevention.

Objective 3.5: Consider options and resources for a central clearing house (i.e. statewide website) that can provide readily available information to NH citizens about suicide prevention and postvention resources and supports as well as upcoming events, trainings, etc.

Goal 4. Support efforts to reduce risk and promote healing after a suicide by identifying and linking existing programs and resources with needs.

Objective 4.1: Inform key stakeholders who may be in need of or involved in postvention response (i.e. faith leaders, school superintendents) about existing resources, such as Disaster Behavioral Health Response Teams (DBHRTs), National Alliance on Mental Illness NH Chapter (NAMI NH), Community Mental Health Centers (CMHCs), Survivor Network & Resources, Postvention Trainers and Coalitions.

Objective 4.2: Support coalitions in having readily available information about postvention practices and resources in their region such as Victims Inc, Samaritans, survivor of suicide loss support groups, medical examiner and related information packets.

Objective 4.3: Encourage utilization of postvention training and protocols (i.e. After a Suicide Toolkit, Media Recommendations) for first responders, law enforcement, emergency departments, schools and others who may be involved or affected by a suicide to reduce risk of contagion and promote healing.

PUBLIC POLICY SUBCOMMITTEE

Goal 1: Develop and implement public policy initiatives to ensure the sustainability of suicide prevention efforts.

Objective 1.1: Require training in suicide prevention for education, healthcare, mental health and substance misuse professional licensure and certification in New Hampshire.

1. Research licensure and certification requirements for above-mentioned professions.
2. Outreach to Professional Practice Subcommittee for input and partnership on achieving goal.
3. Develop strategic approach for working with above-mentioned licensure and certification boards to encourage training in suicide prevention as part of credentialing requirements.

Objective 1.2: Require schools to include mental wellness/suicide prevention education as part of the health curriculum.

1. Outreach to the State Board of Education and the NH Department of Education for support in achieving goal.
2. Create workgroup to develop strategic approach for achieving goal.

Objective 1.3: Recruit additional subcommittee members and formalize expectations of membership.

1. Review subcommittee charter annually with members of subcommittee.
2. Develop and implement member recruitment plan.

Objective 1.4: Support other subcommittees with policy needs.

1. Outreach to other subcommittees to offer support with policy issues.

Objective 1.5: Track legislation related to suicide prevention and advocate where appropriate.

1. Utilize legislative tracking document to track legislation of interest to the Suicide Prevention Council.
2. Report on legislation of interest at Suicide Prevention Council meetings.
3. With support of SPC leadership, testify on legislation of importance to Suicide Prevention Council.

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20. Suicide Prevention

The 2013 NH State Suicide Prevention Plan is NH's most recent plan (attached). The Plan has been developed to focus and coordinate suicide prevention efforts in New Hampshire. The Suicide Prevention Council (SPC) and its partners will guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as the strengths and constraints of the current political and economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC will provide an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

Joseph Harding, Director of BDAS, serves on the SPC as well as the Council's Leadership Committee. Ann Crawford, BDAS Prevention Services Regional Coordinator, serves on the Youth Suicide Prevention Assembly (YSPA).

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

Governor's Commission

The director at the Bureau of Drug and Alcohol Services (BDAS) services, who serves as the Single State Authority (SSA) director, also serves as the executive director of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. This Commission includes members of the legislature, high level representation (Attorney General, Commissioners or their designees) from most of the state agencies, the courts, and a number of stakeholder groups and is responsible for the coordination and integration of alcohol and drug policies and services at the state and regional level. This Commission is also responsible for managing the alcohol prevention and treatment (state general) fund and for submitting a report each year to the Governor and legislature about the impact of alcohol and drugs has on the state, plan (reference the Collective Action / Collective Impact plan) including any gaps in service capacity and or resources needed to address these issues. The Commission has a number of Task Forces each of which includes broad stakeholder representation, including the:

- Prevention Task Force
- Treatment Task Force
- Pre-Natal Exposure Task Force
- Opioid Misuse Task Force
 - Including a Health and Medical Workgroup that has played a critical role in framing out integrated substance use disorder and primary care services (SBIRT / MAT)
- Recovery Task Force
 - Including a workgroup that includes individuals in recovery and family members that are also participating in BDAS BRSS TAC initiative and are framing out broad funding options to support recovery community organization (RCO) operations and the provision of peer recovery support services (PRSS)
 - BDAS will be involving members of the BRSS TACS initiative and The Recovery Task Force to consider options for RCO certification and PRSS credentialing

The Contracted Center for Excellence plays a key role in providing logistical and administrative support in addition to in-depth technical assistance to the Bureau and each of these task forces.

As the executive director of the Commission, the director at BDAS (SSA), in coordination with the Chair of the Commission, utilizes each of these task forces to inform and further develop and implement elements of the Governor's Commission "Collective Action / Collective Impact" state plan (<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf>) that aligns with planning outlined in our Block Grant application.

The SSA director works closely with the Chair of the Governor's Commission, the Senior Policy Advisor on Mental Health and Substance Misuse at the Governor's Office and a Design Team to frame out some of the more salient alcohol and drug misuse issues that are then addressed within the Commission and its task forces (outlined above) to develop, coordinate and implement strategies and services and related resources (including public and private health

benefits and other resources) needed to effectively address the misuse of alcohol and drugs in New Hampshire .

The Bureau of Drug and Alcohol Services also participates the NHHPP (NH Health Protection Program) SUD (substance use disorder) Implementation Workgroup. This stakeholders workgroup is facilitated by New Futures (Advocacy Organization) with the occasional senior members of the Governor's staff and the following:

- Director of Inter-governmental Affairs at DHHS
- Bureau of Drug and Alcohol Services at DHHS
- Bureau of Behavioral Health at DHHS
- Governor's Commission Treatment Task Force
- Governor's Commission Recovery Task Force
- Medicaid Office at DHHS
- NH AOD Services Providers Association (SUD service providers)
- NH Alcohol and Drug Abuse Counselor's Association
- NH Community Behavioral Health Association (CMHCs)
- Bi-State Association (FQHC/CHCs)
- Hope for Recovery New Hampshire
- National Alliance for Mental Illness (NAMI) – NH
- Other members that are less involved

Naloxone Distribution

Upon the passage of two companion House Bills, HB 271* (relative to possession and administration of an opioid antagonist for opioid-related overdoses) and HB 270* (relative to granting immunity from arrest, prosecution or conviction to a person who requests medical assistance to save the life of an overdose victim), the Director at the Bureau of Drug and Alcohol Services at the Department of Health and Human Services (DHHS) is leading an initiative with a number of areas within DHHS, including the Division of Public Health Services (DPHS), the Emergency Services Unit (ESU), the Bureau of Emergency Services (BEMS) at the Department of Safety (DOS) and our contracted Center for Excellence (CFEx) to make Naloxone readily available at the community and regional levels across the state. This includes DHHS purchasing a large quantity of Naloxone Kits (almost 5,000) to make available to end users within communities and regions throughout the state. As part of this effort the BEMS is providing comprehensive training (first aid, CPR, AED, Naloxone administration) to police departments, that have recently been certified by BEMS, to administer Naloxone and that have not had access to the medication up to this point in time. The BEMS is providing regional trainings (using a training of trainers model) to members of the Medical Reserve Corp (MRC) and the Metro Medical Response System (MMR), who in turn will provide training to the following:

- Staff at agencies that come in frequent contact with individuals at risk for opioid overdose, their families and friends.

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- Individuals at risk for opioid overdose, their families and friends that attend community events that will be scheduled by staff within the 13 Regional Public Health Networks (RPHN) with support from DHHS.

* Go to link for more information about these bills: http://www.gencourt.state.nh.us/bill_status/default.aspx

This effort is complementary to an initiative being put forth by the Governor's Commission Recovery Task Force, the Governor's Senior Policy Advisor for Behavioral Health, the Attorney General's Office, BDAS, the Board of Medicine, the Medical Society and others to make naloxone readily available at pharmacy by prescription or standing order.

Prescription Drug Monitoring Program

In addition, the Director of the Bureau of Drug and Alcohol Services (BDAS) actively participates on the New Hampshire Prescription Drug Monitoring Program (PDMP) Advisory Council, established in 2012. The New Hampshire PDMP Advisory Council has worked over this past year to develop its administrative rules and to establish a scope of work for the program, that will include an array of state and regional population level reports that will be utilized to inform future alcohol and drug policy and services. The New Hampshire PDMP was awarded a Federal Harold Rogers Grant to support the development and implementation of the program in September of 2013, and was award a new SAMHSA grant commencing 10/1/15. Additional information can be obtained at the New Hampshire Board of Pharmacy web site at: <http://www.nh.gov/pharmacy/prescription-monitoring/index.htm>

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. Behavioral Health Planning/Advisory Council and Input on BG Application

BHAC:

The New Hampshire Behavioral Health Advisory Council (BHAC) maintains the required 50:50 ratio of Consumers/Family/Other to State Employees/Providers. All required state agencies are represented. Two parents identify as the parents of children with serious emotional disturbances but one must identify as a provider. Representation of parents of children with SED remains less than optimal but recruiting efforts continue. There is more than adequate professional and advocacy representation at the table for children's issues. Greater representation in the past has dwindled as youth "age out" of children's services. Three members of the BHAC also serve on the Department of Education's State Advisory Council which addresses children with special education needs, including mental health issues.

The Bureau of Drug and Alcohol Services (BDAS) has assigned one staff person to attend the BHAC monthly meetings in an effort to incorporate and align some portion of our goals and objectives. Valerie Morgan, BDAS Prevention Services Unit Administrator, is a member of the BHAC Executive Committee. BDAS is hoping to add representation from our Clinical Services Unit to the BHAC within the next year.

State Plan:

BDAS posts our SAPT Block Grant application, along with the 2 guidance documents for the application on the following web pages

NH DHHS web page - <http://www.dhhs.nh.gov/dcbcs/bdas/SAPTGrant.htm>

NH Center for Excellent - <http://nhcenterforexcellence.org/>

BDAS will also include information on our Block Grant and how to view and/or comment on it, in the NH Center for Excellence's quarterly newsletter.

The following state and federal partners are be alerted by email when our Block Grant Application is ready to be viewed both in draft and final forms:

- BDAS contracted agencies for treatment and recovery support services
- Early intervention (DWI service providers)
- Prevention services
- BDAS contracted services for training and evidence based practices
- Members of the Governor's Commission on Prevention, Intervention, and Treatment (The Governor's Commission includes Department Commissioners from Health and Human Services, Corrections, Education, the Attorney General, and legislative (NH House and Senate) and public members)
- Each of the Governor's Commission Task Force members (Treatment and Recovery Task Force, Prevention Task Force, Public Awareness Task Force)

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- Division of Community Based Care partner Bureaus
- Behavioral Health, Developmental Services, Homeless and Housing Services, Elderly and Adult Services
- NH Behavioral Health Advisory Council (BHAC) will be specifically solicited for comment
- Division of Public Health Services
- Office of Medicaid
- Division for Children, Youth and Families, which now includes Juvenile Justice Services
- Temporary Assistance to Needy Families
- New Futures (a community partner organization)

Subsequent emails will provide notices of specific changes or revisions and highlighted specific sections of the plan to prompt comment from citizens.

BDAS has both telephone and e-mail capacity to receive comments.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: