New Hampshire

UNIFORM APPLICATION
FY 2024/2025 SUPTRS BG Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 06/14/2024 10.36.04 AM)

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	2024
End Year	2025

State Unique Entity Identification

Unique Entity ID	6B08T1084659

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	Jill
Last Name	Burke
Agency Name	NHDHHS, DBH, Bureau of Drug & Alcohol Services
Mailing Address	105 Pleasant St Main Bldg., 3rd Floor North
City	Concord
Zip Code	03301
Telephone	(603) 271-6112
Fax	(603) 271-6105
Email Address	jill.burke@dhhs.nh.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	10/2/2023 1:34:05 PM
Revision Date	5/8/2024 10:36:30 AM

V. Contact Person Responsible for Application Submission

First Name	Olivia
Last Name	Afshar
Telephone	603-271-6822
Fax	603-271-6105
Email Address	Olivia.Afshar@dhhs.nh.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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
Tile 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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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 19 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, as applicable, with 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

07.18.2023

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Federal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.govemor.nh.gov/ • Email: govemorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

State Information

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

Fiscal Year 2024

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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.
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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.
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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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).

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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: NEW Hampshire

Name of Chief Executive Officer (CEO) or Designee: Jill A. Burke

Signature of CEO or Designee[1]: Jill a Burke

Title: Bureau Chief
NH DHHS - Div of Behavioral Health
Bureau of Drug & Alcohol Services

Date Signed: 02/22/2022 mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

07.18.2023

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Federal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.governor.nh.gov/ • Email: governorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

State Information

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

Fiscal Year 2024

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 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, as applicable, with 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.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: NEW Hampshire

Name of Chief Executive Officer (CEO) or Designee: Jill A. Burke

Signature of CEO or Designee[1]: Jill a Burke

Title: Bureau Chief
NH DHHS - Div of Behavioral Health
Bureau of Drug & Alcohol Services

Date Signed: 02/22/2022 mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

07.18.2023

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Federal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.governor.nh.gov/ • Email: governorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

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

Jill A. Burke

Title

Bureau Chief

Organization

NH DHHS Bureau of Drug and Alcohol Services

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NH DHHS is prohibited from Lobbying

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

The striking escalation of opiate use and opioid misuse over the last five years is affecting individuals, families, and communities throughout the state. In 2022, there were 463 confirmed drug overdose deaths, of which 395 deaths were caused by opiates/opioids. (Source: Office of the NH Chief Medical Examiner report 3/10/23). Reducing substance use disorders and related problems is critical to the physical and mental health, safety, and overall quality of life of New Hampshire residents, as well as the state's economy. Substance use disorders are preventable, treatable, and people do recover.

Recognizing that substance use disorders (SUD) are complex, chronic, and life-threatening diseases, New Hampshire is striving to implement a comprehensive approach toward a continuum of care that includes prevention, early intervention, treatment, and recovery services as an integral part of every region of the state's public health and healthcare system. The State's collective response to date, as well as the continued coordinated response, moves New Hampshire further toward that goal.

The Bureau of Drug and Alcohol Services (BDAS) is responsible for managing the federal substance use prevention and treatment and recovery block grant (SUPTR-BG), as well as the administration of a full continuum of substance misuse services under contract with the NH DHHS that are supported by resources from SAMHSA and the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery (Governor's Commission). BDAS sits within the New Hampshire Department of Health and Human Services (DHHS), Division for Behavioral Health (DBH). Also included under the DBH umbrella are the Bureau of Children's Behavioral Health, Bureau of Mental Health Services, Bureau of Housing and Homelessness, and the Policy Section.

BDAS provides administrative / regulatory oversight, on behalf of NH DHHS, over the opioid treatment programs and all impaired driving programs in the state. BDAS also serves as the NH DHHS' subject matter resource for alcohol and drugs, for managing alcohol and drug-related public awareness efforts and training and technical assistance resources for prevention, treatment and recovery services.

BDAS has a primary role in representing NH DHHS, in concert with numerous stakeholders from the public and private sector at both the state and local level, that are working together to implement the Governor's Commission plan for the state. This plan utilizes a comprehensive public health approach to address the misuse of alcohol and drugs in New Hampshire. The Governor's Commission is comprised of representatives from all state agencies which is critical to ensuring collaboration and partnership for addressing

The following four units structure BDAS internally and work to carry out the mission of the Bureau; to join individuals, families and communities in reducing alcohol and other drug problems thereby increasing opportunities for citizens to achieve health and independence:

- Prevention Services
- Clinical Services, including Impaired Driver Services

- Resources and Development, including Recovery Support Services
- Business and Financial Services

NH- DHHS has been authorized by the Governor and Executive Council to enter into agreements with multiple vendors to provide prevention and early intervention services, substance use disorder treatment, and recovery support services statewide.

NH Substance Use Services Landscape

The Governor's Commission on Alcohol and other Drugs which includes representatives from all State Agencies helps to set the strategic direction for the Department of Health and Human Service's approach and resourcing of substance use services in New Hampshire. The mission of the Governor's Commission on Alcohol and Other Drugs is to prevent and reduce alcohol and drug problems and their behavioral and physical health and social consequences for the citizens of New Hampshire by advising the Governor regarding the delivery of effective and coordinated alcohol and drug abuse prevention, treatment and recovery services throughout the state. BDAS works closely with the Commission and external stakeholders to consider, within the context of a full continuum of strategies and services, what resources can support which elements of the continuum of care for particular populations. The Commission was created by the NH Legislature in the year 2000 and revised in 2014. Its duties include:

- Developing and revising, as necessary, a statewide plan for the effective prevention of alcohol and drug misuse, particularly among youth; and a comprehensive system of treatment and recovery services for individuals and families affected by alcohol and drug misuse;
- Promoting collaboration between and among state agencies and communities to foster the development of effective community-based alcohol and drug misuse prevention programs;
- Promoting the development of treatment services to meet the needs of citizens with substance use disorders;
- Identifying unmet needs the resources required to reduce the incidence of alcohol and drug misuse in NH and to make recommendations to the Governor regarding legislation and funding to address such needs; and
- Authorizing the disbursement of moneys from the alcohol abuse and prevention and treatment fund, pursuant to RSA 176-A:1, III.

The Commission released its 2023-2025 Strategic Plan, which highlights progress, challenges, and opportunities for the Commission and its collective efforts to address the misuse of alcohol and other drugs, particularly opioids, and to promote treatment and recovery. The Director of BDAS serves as the Executive Director of the Commission and ensures that directives of the Commission and initiatives of the Bureau align efforts to mitigate substance use disorders for the citizens of NH.

For more information, please visit the Commission's webpage https://nhcenterforexcellence.org/governors-commission/.

Prevention Services

NH has a robust prevention system impacting individuals across the life span and is comprised of population level prevention delivered by NH's Regional Public Health Network (RPHN) and a range of prevention direct services. NH's prevention structures and efforts are supported by public and private partnership that provides additional funds toward prevention. In the past, 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"; however, there is some question as to whether or not this vital support will continue. 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 DHHS. This includes strategic co-funding, integrated planning, and reporting systems for grantees.

The SUPTR-BG funds are used to advance population prevention through the Regional Public Health Network system consisting of 13 regions across the state. Each region utilizes 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 by convening and collaborating with the core sectors (local government, education, community organizations, safety, businesses, and health/medical) to increase service capacity and to reduce "factors that put people, families and communities at risk" and increase "factors that protect people, families and communities" in the prevention of misuse of alcohol and drugs.

Other BDAS funded Prevention activities include:

- Public Awareness Campaigns – through various contracts and collaborations , we are developing evidence informed public awareness messaging targeting children, adolescents, adults and families for use in public awareness / social marketing campaigns utilizing a variety of media, including television, radio, newspapers, printed materials, social media. https://drugfreenh.org/. Block Grant funds do not support this campaign
- Life of an Athlete - a comprehensive multicomponent prevention program which empowers and motivates youth participating in athletics and leadership programs to make healthy choices and decisions by educating them on the impact alcohol and other drugs have on performance and development. Block Grant funds do not support this program
- Student Assistance Programs (SAP) - a school based program for middle and high schools as well as colleges and universities using trained SAP counselors to deliver the services. SAP services administered by the BDAS are based on the "Project Success" evidence based practice. The program is designed to prevent and reduce substance misuse among students 12 to 25 years of age. The school-based program combines school wide alcohol and other drug prevention awareness activities, classroom based prevention education, individual and group sessions for students, parent education and referral to community resources. Block Grant funds are used to support these programs.
- Prevention Direct Services – These interventions used braided funding including Block Grant to target youth and parents/caregivers within selective and indicated categories to reduce risk factors and increase protective factors to prevention or diminish the onset of substance using behaviors and progression of a SUD. Programming includes a variety of components including screening for substance misuse and/or mental health issues,

prevention education, positive alternative activities, prevention counseling, and parent education.

- Young Adult Strategies-Based on an innovative assessment process which identified young adults as a population at high risk and high need and that involved gathering qualitative data from NH's young adults (The Voices of NH Young Adults), an investment was made using the Partnership for Success 2015 grant to fund a diverse range of strategies including college based, home visiting and community based programs. Since the sunset of the Partnership for Success 2015 grant, BDAS has utilized Block Grant funds to support this program.

Early Intervention

- Juvenile Diversion Services – although not funded through the Block Grant, the NH Juvenile Diversion programs are critical partners in the early intervention and identification of juveniles at risk of substance use disorders due to criminal behavior. The programs use restorative justice principals that divert juveniles otherwise headed to the NH court system by utilizing prevention and early intervention services that reduce the harm to the victim, decrease the impact and cost to the community, and restore the pathway of success for the juveniles participating in the program
- Referral, Education, Assistance Program (REAP) for Older Adults - a community based statewide prevention education and early intervention program for individuals 60 years of age or older and their caregivers. The program is designed to provide brief screening to identify areas of concern related to mental well-being and substance misuse, brief counseling, prevention education and supportive referral to community based services. The goal is to provide the services, supports, and skill-building needed to help an older adult maintain their independent lifestyle and regain health and emotional wellbeing.

- Impaired Driver Care Management Program-BDAS has oversight of the Impaired Driver Care Management Programs as well as the Impaired Driver Education Programs and Impaired Driver Services Providers. Work between BDAS, Department of Safety, Division of Motor Vehicles, and state police continues to refine and improve systems and update Impaired Driving State Policy.

Crisis Intervention

Since 2012, approximately 2,500 NH residents have died as a result of opioid-related overdoses. As a response to this epidemic, the following services were initiated and continue to develop:

- The Doorways (https://www.thedoorway.nh.gov/) – The new hub and spoke system went live on January 1, 2019. The hubs, known as Doorways, serve as a comprehensive, 24/7 statewide access and referral hub with a minimum of nine physical locations situated to ensure that no one in NH has to travel more than sixty minutes to begin the process towards recovery. Doorways are responsible for providing screening, evaluation, closed loop referrals, and care coordination for the client throughout their experience along the continuum of care. In addition to the core services, some Doorways are also able to provide medication assisted treatment (MAT), peer recovery support services, and other supportive services.

- Integration of Substance Use Services in Hospital Systems – Through our work with Emergency Departments, it was identified that a more holistic approach was needed. As result, we will be expanding the existing contract to include hospital systems as a whole, not only Emergency Departments.
- Naloxone Administration / Department of Safety (DOS) EMS First Responder Training - The New Hampshire Statewide Naloxone Distribution and Training initiative is jointly administered by a number of program areas within the New Hampshire Department of Health and Human Services, including BDAS, the Division of Public Health Services (DPHS) and the Emergency Services Unit, that coordinate with the Bureau of Emergency Medical Services (BEMS) at the Department of Safety (DOS). This initiative makes Naloxone (Narcan) Kits and related instructions available free of charge to individuals at risk for opioid overdose, their families and friends that do not have insurance to cover the cost of a kit and that otherwise cannot afford to purchase one. DHHS makes Naloxone kits available to substance use disorder treatment providers, community health centers and other health and social services agencies that serve individuals at risk for opioid overdose, their families and friends through the Doorways system. These kits are also available to agencies through the 13 RPHNs. Each of these networks have also held numerous public events in their area, where Naloxone Kits and related instructions are likewise made available to individuals at risk for opioid overdose, their families and friends that otherwise cannot afford one. BEMS has developed a training of trainers program made available at a number of locations across the state for the administration of Naloxone and has made these and related First Aid/CPR training available to Law Enforcement personnel from agencies across the state, many of which become certified by BEMS to administer Naloxone. This initiative is particularly import for areas that don't have rapid response emergency medical services (EMS).

SUD Treatment Services

BDAS provides treatment and recovery support services to individuals with a substance use disorder who are residents of or homeless in NH; are under 400% of Federal Poverty level; and who do not have public or private insurance that will pay for the required services. Contracted services include Outpatient, Intensive Outpatient, Partial Hospitalization, Transitional Living, Low and High Intensity Residential Treatment Services, Medically Monitored Intensive Inpatient Services, withdrawal management and medication assisted treatment. These contracts also fund specialty outpatient, intensive outpatient, and residential services for pregnant and parenting women and their children. All treatment providers are strongly encouraged to enroll and credential with public and private insurers in an effort to better support patients and their ability to access available services.

New Hampshire boasts a very robust Medicaid benefit for substance use disorders treatment and recovery support services. Previously, NH utilized a premium assistance program model that limited the access of some beneficiaries to these benefits; however, as of January 1, 2019 all

beneficiaries either are in Medicaid managed care or fee for service models with access to the full range of SUD benefits. Furthermore, amendments to the managed care contract continue to make significant improvements to the requirements for all behavioral health services, including SUD treatment, services for substance exposed infants and their caregivers, and social determinants of health. BDAS coordinates closely with the Division of Medicaid Services in the design and administration of the SUD benefit.

Regardless of the payor source, NH law requires all providers of SUD services to utilize American Society of Addiction Medicine (ASAM) criteria to determine the initial level of care for an individual as well as to make decisions about continuing care, transferring care, or discharging from care. When the identified level of care is not immediately available, contracted treatment providers are required to offer interim services to support the individual while they wait for the appropriate level of care. These services include group counseling, individual counseling, recovery support services and community based services. To assist providers with meeting these requirements as well as to improve overall client care, BDAS sponsors a community of practice for treatment providers to connect clinicians and other providers with the opportunity to gain knowledge and information and share experiences related to improving services for individuals with a substance use disorder.

Neo-Natal Taskforce

The Department worked with the Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery to bring physicians and the opiate treatment programs together to more effectively coordinate care for pregnant and post-partum women and their infants. Members of the Task Force to include BDAS staff held a summit Optimizing Care for Mothers and Babies Affected by Prenatal Substance Exposure to address Plan of Safe Care in January 2019. Representatives from local birthing hospitals, NH DCYF, SUD treatment providers and other stakeholders partners were provided the opportunity to learn about and discuss the Plan of Safe Care for infants who are born with substance exposure with the collective goal of ensuring women with a substance use disorder feel safe enough to access quality prenatal care (and treatment) and ensuring the safety of their infant. The Task Force completed the 2019-2022 Governor's Commission Plan/State Plan Recommendations in March 2018 for presentation at the Governor's Commission monthly meeting. The taskforce continues to work with hospitals and families on the development of Plans of Safe Care and integrated care implementation.

Individuals who Inject Drugs

BDAS will continue to mandate priority admission for pregnant and parenting women and injection drug using individuals. NH takes a broad perspective in defining individuals who inject drugs as those individuals with current or 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.

Per NH law, RSA 318:52:C, persons over 18 years of age may legally purchase a hypodermic syringe or needle at a pharmacy without a prescription from a physician. Through the NH Division of Public Health Services, Bureau of Infection Disease Control, Syringe Service Programs in NH are community-based programs that provide access to sterile needles and

syringes and facilitate safe disposal of used needles and syringes. As of July 8, 2021, 8 organizations are registered with the NH DHHS as Syringe Services Programs. These programs are an effective component of a comprehensive, integrated approach to preventing infectious diseases among people who inject drugs.

Infectious Disease

BDAS takes a broad approach to infectious disease. In NH, the tuberculosis rate is relatively low and NH is not an HIV incidence state. However, various strains of hepatitis, particularly A, B, and C, are a concern. BDAS works closely with the Viral Hepatitis Unit of the NH Division of Public Health Services (DPHS) and routinely promotes their trainings as well as the NH Training Institute offers trainings though out the year.

Infectious disease is addressed in our substance use disorder treatment contracts. 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. Infectious disease policies are reviewed as part of provider site visits.

Medication-Assisted Treatment (MAT)

NH continues to help providers move toward integrating MAT with existing services. NH recently updated our Guidance Document on Best Practices for Delivering Community-Based MAT Services for Opioid Use Disorders in NH (https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf) based on advances in knowledge and understanding since the original publication.

BDAS is building infrastructure in Community Health Centers and Hospital-Based Primary Care Networks to develop their capacity to provide MAT fully integrated with primary care to their patients identified with a substance use disorder. These Health Centers and Hospitals are developing MAT services that meet the recommendations in the guidance document mentioned above, inclusive of retaining and training staff, modifying EHRs, developing and implementing policies, practices and workflow. As of 9/20/21, 31 practices associated with 12 hospitals are providing MAT to patients. BDAS funds MAT efforts and works in partnership with the New Hampshire Medical Society, the Foundation for Healthy Communities (FHC), Growth Partners and Bi-State Primary Care Association (BSPCA) to support training and learning opportunities for medical practices engaged in developing MAT services. This includes multiple free waiver trainings at which the NH Guidance Document is distributed to all participants.

Integration of Care & Addressing Social Determinants of Health

NH recognizes that outcomes for clients are improved when behavioral (mental health and SUD) and physical health services are coordinated and integrated and social determinants of health are addressed. To this end, contracted service providers are required to obtain consent from all willing clients to coordinate care with clients primary care providers; behavioral healthcare providers; medication assisted treatment providers; peer recovery programs; and other agencies involved in the client's care, including but not limited to Managed Care Organizations, Integrated Delivery Networks, private insurers, Doorways, DCYF and criminal justice agencies. In order to ensure that social determinants of health are being actively addressed clinical

evaluations and treatment plans are required to address all ASAM domains either directly through the treatment provider or through referral to and coordination with community-based providers.

Recovery

Recovery

BDAS continues to develop capacity for Peer Recovery Support Services (PRSS) provided by peer-led Recovery Community Organizations (RCOs) utilizing a facilitating organization model. NH has a Medicaid benefit for certain Recovery Support Services and established a Certified Recovery Support Worker credential which meets, but is not limited to the requirement of IC&RC's Peer Recovery Support Specialist.

The state has funded the development of 12 RCOs with a total of 19 Recovery Centers. All funded RCOs are required to work toward meeting the newly developed standards, New Hampshire's Recovery Community Organization Standards of Excellence (NHRCOSE), help staff achieve Certified Recovery Support Worker status, open at least 1 Recovery Center, provide recovery coaching and telephone recovery support services, and develop the capacity to bill Medicaid for these services. RCOs are peer-led and peer-run and support all paths to recovery.

In addition to providing the specified PRSS, Recovery Centers also provide a variety of workshops and activities to enhance recovery and host multiple mutual support groups. Some of them also contract with medical providers, hospital EDs, law enforcement, drug courts, correctional facilities and/or businesses to provide outreach and support.

BDAS and our vendor has completed the 2021 comprehensive evaluation of the peer recovery system in NH to identify the factors associated with increasing recovery capital, leading to greater success in recovery. A second evaluation is currently underway to monitor the RCOs' effectiveness in addressing those factors.

The Family Support Services program provides guidance and training for the retention and expansion of the capacity to provide family and community support groups. These groups are for families and individuals with substance use and co occurring mental health issues. They currently have 7 active groups with a majority of meetings being in-person.

The New Hampshire Coalition of Recovery Residences (NHCORR) certifies an increasing number of certified residences that assure quality by meeting the National Alliance for Recovery Residence (NARR) standards. The current number of recovery residences is 91, with a total capacity of 1,177 beds. Of the 91 residences, 59 are male only, 30 are female only, one is mixed, and the remaining residence is LGBTQ+. In SFY23, NHCORR awarded over $360,000 of housing assistance to 729 individuals.

BDAS recently launched the first public-facing peer recovery support services dashboard, hosted on the NH DHHS Data Portal. The aggregate data is updated on a quarterly basis and provides demographic information of participants engaged, sessions and activities, and distribution of supplies as well as locations of all of the RCOs.

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Workforce Development

BDAS contracts with agencies to provide quality improvement toward best practices, evidence-based interventions and professional training for alcohol and other drug service professionals; certification standards; and recruitment and retention activities.

- Growth Partners provides technical assistance to the provider community across the continuum of care as well as to the Bureau directly. This TA 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. (https://nhtac.org)
    - Growth Partners facilitates four Communities of Practice which include; Prevention, Substance Use Disorder Providers, Peer Recovery Support Services, and Hospital System Addiction Care.
- The Arkansas Foundation for Medical Care (AFMC) provides program evaluation and data analysis and interpretation and support.
- The NH Alcohol and Drug Counselors Association's (NHADACA) Training Institute on Addictive Disorders (NHTIAD)provides high quality, low cost training and workforce development activities to enhance the knowledge, skills, and abilities of the prevention, intervention, treatment and recovery supports services workforce. Training opportunities that meet requirements for licensure and certification are offered throughout the year and assist providers in applying outcome-supported policies, programs and practices. NHTIAD also offers cross-training opportunities that increase effective integration of services across the CoC. A list of upcoming trainings is available at https://www.nhadaca.org/Training-Events.
- The NH Prevention Certification Board's primary purpose is to ensure high quality standards for NH's substance misuse prevention specialists by aligning with the International Certification & Reciprocity Consortium (IC&RC) credentialing. The Board also has the responsibility of reviewing and approving Continuing Education (CEUs) for

Certified Prevention Specialists for various types of training events (workshops, webinars, trainings, conferences, etc). (http://nhpreventcert.org/) The Department requires that all contracted prevention services have lead staff who are prevention specialist certified.

In further efforts to recruit and retain staff in SUD treatment agencies, BDAS has collaborated with the Division of Public Health Services to include Licensed Drug and Alcohol Counselors (LADCs), Master Licensed Drug and Alcohol Counselors (MLADCs) in the NH State Loan Repayment Program. This allows LADCs and MLADCs who work in approved agencies to be eligible for up to 5 years of educational loan repayment. All BDAS funded treatment contractors have been deemed as approved agencies.
(https://www.dhhs.nh.gov/dphs/bchs/rhpc/repayment.htm)

Although not funded through SUPTR-BG funding, statewide efforts are in place, working to build the behavioral health workforce capacity.

- Recovery Friendly Workplace Initiative: Led by Governor Chris Sununu, New Hampshire's ”Recovery Friendly Workplace Initiative" (https://www.recoveryfriendlyworkplace.com/) promotes individual wellness for Granite Staters by empowering workplaces to provide support for people recovering from substance use disorders. The Recovery Friendly Workplace Initiative gives business owners the resources and support they need to foster a supportive environment that encourages the success of their employees in recovery. To assist companies in developing and sustaining the Recovery Friendly Workforce initiative in their organizations, Recovery Friendly Advisors (RFAs) support interested companies, at no cost, to find evidence-based practices to meet their individualized needs. In SFY20 and 21, 115 businesses received designations as Recovery Friendly Workplaces.

Addressing Diverse Needs

Targeted Services to Diverse Racial, Ethnic, and Gender Minority Populations

New Hampshire has historically been composed of a homogeneous population. According to the U.S. Census Bureau, 15.8 % of New Hampshire’s population are racial minorities or of Hispanic or Latino descent. 7.2% of the New Hampshire population are persons in poverty.

Substance Use Services to Minorities

The data system used by BDAS include the Web Infrastructure Information Technology System (WITS) and RED CAP both have the capacity to report race, ethnicity, gender, sexual orientation, and age. BDAS works closely with its provider system to ensure this data is mapped correctly in their system and an emphasis on the importance of accurate data was placed. The quality of that data submitted to has improved and is continued to be watch for errors and unknowns with active feedback occurring at the agency level.

The Office of Health Equity

The Office of Health Equity has a strategic plan to provide culturally competent mental health screening services to refugees and minorities in the state of New Hampshire. The Office of Health

Equity partners with BDAS as well as with contracted agencies to also provide a wide array of supportive services such as language interpreters, language teaching services, and case management to assist people with resettlement.

All BDAS providers have language interpreters either onsite or available through outside agencies such as Certified Languages International and the Language Bank. All providers are also contractually required to provide meaningful and effective treatment for those consumers who are deaf or hard of hearing. The Deaf Service Program ensures that provider staff who are fluent in American Sign Language (ASL) are available for these consumers.

CLAS Standards in New Hampshire
The National CLAS (Culturally and Linguistically Appropriate Services) Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

In 1999, DHHS created the Office of Minority Health to help ensure that all residents of New Hampshire have access to DHHS services and to improve the health of minorities. Renamed the Office of Health Equity, this bureau has assisted in meeting the needs of minorities by instituting processes to respect the National CLAS Standards:

Since 2014, all NH-DHHS Requests for Proposals (RFPs) have include a CLAS Section with an explicit statement of contractors' obligation to comply with all applicable Federal Civil Rights laws, and a list of the laws. The RFP template provides the four-factor analysis bidders should use to determine the mix of language assistance services they need to provide to Limited English Proficient (LEP) clients to comply with Title VI of the Civil Rights Act of 1964.

Ensuring Equity for Diverse Minorities
Under-served/historically marginalized populations in NH (with penetration rates per 1000 population served), as shown in the most recent 2021 SAMHSA Uniform Reporting System (URS) report on New Hampshire located at NH 2021 Mental Health National Outcome Measures (NOMS) include: Black (33.1), Latino/Hispanic (36.6), Indigenous and Native American persons (36.5); Asian Americans (6.8) and Pacific Islanders (155.5) and other persons of color (11.2); members of religious minorities; Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The state average penetration rate served per 1000 population was 35.9.

NH participates in a robust refugee resettlement program. BDAS recognizes the increasing diversity of the NH population overall and the corresponding diversity in clients. Wh felt compelled to measure equality of access and other outcomes. For the 2016 Community Mental Health Consumer Survey, administered by BMHS through application of MHBG BHSIS funds, the BMHS invited one hundred percent of minority adult clients to participate in the survey to enable comparison of satisfaction scores and behavioral outcomes by race and ethnicity. The adult

survey was also translated into 10 additional languages. A total of 254 minority adult clients or 46% completed the survey.

New Hampshire's demand for mental health and substance use services is increasing among all demographics. Several factors make behavioral health transformation a priority of the State, including enacting the New Hampshire Health Protection Program (NHHPP) to cover a new adult group, in which an estimated one in six have extensive mental health or substance use care needs. New Hampshire now covers substance use disorder (SUD) services to the NHHPP population.

New Hampshire seeks to transform its behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of the qualified population's needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Additional efforts to advance parity include:

- Implemented outreach efforts using community health workers who were representative of under-served/historically marginalized communities
- Supported behavioral health (BH) and physical health integration through the use of the University of Washington AIMS Center integration model
- Implemented an on-site BH clinician at high-volume primary care practice (PCP) sites
- Supported Peer-to-Peer Psychiatric and Substance Use Disorcer consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs
- Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care. The platform went live in February 2020
- Provided training and education to all providers with a focus on a whole person approach, reducing the stigma associated with mental health issues and suicide prevention
- Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our twenty-four hour, seven days a week (24/7) nurse advice line to their entire provider network
- Passage of legislation to authorize the provision of many Medicaid-covered services to be delivered through telehealth, inclusive of pay parity, for behavioral health services with patient consent and as long as it is clinically appropriate for the service to be conducted via telehealth
- Ongoing review and updating of Medicaid rates associated with behavioral health services to support beneficiary access to services and providers (e.g., a 2022 increase to ASAM 3.7 Medically-Monitored Detoxification Treatment, a 2021 increase of residential treatment beds for individuals with a serious mental illness(es)

Planning Steps

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

Narrative Question:

This step should identify the unmet service 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 required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

STEP 2 Revision:

The SUPTS block grant allows for individuals in NH, without insurance, to receive treatment for an SUD. The NH PRAMS Data Summary notes that 4% of individuals in NH lacked health insurance in the month preceding pregnancy (prams-datasummary-2021.pdf (nh.gov)). Although specific data on the percentage of these uninsured individuals who have a SUD was unavailable, the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) 2013-2017 report for NH (PowerPoint Presentation (nh.gov)), revealed that an average of 11.2% of surveyed individuals reported alcohol consumption in the last three months of pregnancy. Additionally, according to the 2021 NH PRAMS Data Summary, (prams-datasummary-2021.pdf (nh.gov)) indicated that an average of 5.4% of individuals used marijuana or hash during their most recent pregnancy, and nationally, cannabis use among pregnant individuals has risen to 8.14% (Young-Wolff et al., 2021).

Data on illicit opioid use among pregnant individuals in NH is not currently available, and NH will seek Technical Assistance (TA) to address this gap. However, it's worth noting that overdose deaths among pregnant and postpartum individuals in the US surged by 81% between 2017 and 202, according to Columbia University researchers (US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020 | Emergency Medicine | JAMA | JAMA Network).

These figures suggest a number of uninsured, pregnant individuals in NH may have a SUD. When the above figures are combined with census figures, this picture becomes clearer. The number of live births in the United States in 2019 was 3.75 million (Pregnancy - Statistics & Facts | Statista), which had population of 328 million at that time (US census, Population Estimates Continue to Show the Nation's Growth Is Slowing (census.gov). This equals out to be a birth rate of 1.14%. According to the 2020 US Census, the population for NH is 1,377,519. 1.14% of that numbers is 15,703 live births. It is estimated by NIDA that 5% of pregnant individuals (Substance Use While Pregnant and Breastfeeding | National Institute on Drug Abuse (NIDA) (nih.gov)) are using one or more substances. This does not necessarily mean that these individuals are in need of SUD treatment; however, it gives the best estimate at this time for pregnant individuals who may be in need of services. 15,703 x 5%= 785 pregnant individuals in New Hampshire who may be in need of SUD services in a given year.

Pregnant individuals are defined by EQ 13985 as an underserved community, and the absence of insurance acts as a barrier to treatment for this community. That being said, the majority of uninsured pregnant individuals in NH are able to enroll in Medicaid, which shrinks this gap. NH requires agencies receiving block grant funding enroll all eligible individuals in Medicaid while in treatment, but it is unknown at what rate this is being done.

NH was unable to located any date regarding treatment gaps for individuals with Tuberculosis (TB) in NH. The prevalence of TB in NH is one of the lowest in the country, despite a nationwide increase in cases of 5.9% between 2021 to 2022, according to the CDC (National Data | Reported TB in the US 2022 | Data & Statistics | TB | CDC).

NH was unable to find any data related to treatment gaps in NH for individuals who use injection drugs.

According to the 2023 NH STI/HIV Summary Report, which covers 2017-2021, the number of individuals newly diagnosed with HIV in NH has remained stable (FINAL_STI HIV 5 Year_2017-2021_01 20 23.xlsx (nh.gov)). Despite the overall rate of diagnosis remaining unchanged, the rate of disease in Strafford County, NH has increased substantially, according to the same report. There are no treatment facilities in NH that are specifically for individuals with HIV/AIDS, but otherwise gaps in services for individuals with HIV/AIDS were not located.

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

New Hampshire had a disproportionately higher rate of substance use disorders (SUD) than other states for many years. Plagued by limitations in funding, inadequate coverage by public and private insurance coverage, high rates of use among the population, and persistent social and structural stigma surrounding SUD. The emergence of the opioid epidemic in the early 2000's ushered in a period of even more challenges, with New Hampshire facing some of the highest per capita overdose death rates in the United States.

However, the epidemic served as a tipping point for collective action, strategic investments, and accelerated policy work to advance the delivery of prevention, treatment and recovery support services in New Hampshire. Strong, cross-sector leadership, coupled with increased funding such as the State Opioid Response (SOR) Grant and expanded insurance coverage for SUD treatment and recovery services expanded care access.

Although NH has continued to invest in a robust continuum of care resulting in steadily improving outcomes, including reduction in overdose fatalities, regional differences still exist in service capacity and resources to address the epidemic. NH has an additional need to invest in prevention, treatment and recovery services in resource limited areas and to expand outreach efforts to increase awareness of NH's SUD access system known statewide as the Doorways. Housing continues to be a critical gap, with the majority of Doorway participants reporting unstable housing or homelessness.

Despite early gains in fatal drug overdoses, New Hampshire is on a trajectory to have fatal drug overdoses faster than the rest of the country. The state medical examiner's office final report for 2022 showed that 486 people died of a drug overdose in New Hampshire. That's the highest number of overdose deaths since 2017.Official numbers for the entire country haven't been released yet, but preliminary data shows that last year, the United States as a whole experienced a 0.5% increase in overdose deaths. New Hampshire experienced a 14% increase in deaths from 2021 to 2022.

Though opioids have been the main cause of the rapid rise in overdose fatalities in NH, in more recent years, drug deaths involving methamphetamines have increased dramatically. Between 2012 and 2015, NH saw less than 6 deaths per year involving methamphetamines, by 2019 that number was more than eight times higher at 50 fatalities. The total number of deaths involving cocaine has seen a similar rise, increasing from 20 fatalities in 2012 to 74 in 2019. The majority of stimulant deaths also involve opioids, further substantiating the complexity of poly-substance use in NH. [1]

In addition to the high rates of opioid use among the adult population, NH consistently ranks among the top in the nation for young adult binge drinking. Regular (past month) illicit drug use rates are significantly higher in NH than the nation (11.5 US, 15.5 NH) and in the18-25 year old age group, rates of illicit use follow the same pattern (24 in US, 31.8 in NH). NH also

[1] NH Office of the Chief Medical Examiner, Drug Deaths as of 03/10/2020 (23 cases from 2019 are still pending toxicology)

experiences higher than national rates of cocaine use in the past year for the 18-25 year old age group (6.0 in the US, 10.7 in NH).[2]

Addressing substance misuse other than opioids has also been an ongoing challenge for existing BDAS contracts with data showing that nearly 1/3 of clients coming to a Doorway for assistance have a problem with a substance other than opioids. The opioid epidemic continues to be one of the worst public health crises in NH's history and this is layered on top of a long history of very high rates of alcohol and binge drinking in the state. While referrals to MOUD has increased, MAUD remains underutilized and many clients being unaware this is an option, despite its efficacy.

Compounding the rise in substance misuse in New Hampshire has been increased mental health issues in New Hampshire's youth. The Centers for Disease Control and Prevention's (CDCs) Youth Risk Behavior Survey (YRBS) collects information about youth behaviors and influences that impact behaviors. Although survey results show that vaping, alcohol and marijuana use among New Hampshire youth decreased in 2021, feelings of hopelessness and being unsafe, suicidality, dating violence and cyber bullying all increased. For example, in 2021, 44.2 percent of all New Hampshire students who participated in the YRBS reported experiencing depression-like symptoms,[i] 24.7 percent reported seriously considering suicide in the past year, 19.3 percent reported making a suicide plan, and 9.8 percent reported attempting suicide. These numbers have steadily increased over the last decade, and research indicates that the isolation of the COVID-19 pandemic exacerbated mental health challenges for many adolescents.[ii] Feeling unsafe is another stressor that impacts many adolescents. In 2021, 21.8 percent of New Hampshire high school students reported being electronically bullied and 20 percent reported being bullied at school in the past year, while 9.6 percent reported missing school on one or more days in the past month because they felt unsafe at—or on their way to—school.

As striking as these data are, the scope of the behavioral health crisis has wide ranging impacts on NH's children and families, public resources (law enforcement, judicial, corrections), public and private healthcare costs, and economic productivity.

To address the escalation in substance misuse and mental health concerns, BDAS recognizes the need renew its commitment to collective active and collective impact. BDAS cannot operate in isolation to solve the complex, large scale impact of substance misuse. A common understanding of the problem and a joint commitment to work together towards a shared vision for change is at the heart of combating the societal and personal impacts of social misuse.

To that end, BDAS in concert with the Division of Behavioral Health, the Governor's Commission on Alcohol and other Drugs and the Opioid Abatement Commission coupled with the input of those with lived experience are joining forces to address the following:

- Integration of behavioral and physical health-No Wrong Door Models;
- Financial Stability of the Behavioral Health System;
- Increased awareness and access to care for all residents including increased mobile crisis teams and harm reduction models;

[2] National Survey on Drug Use and Health, 2018

- Addressing stigma and shame;
- Workforce Development;
- Increased Trauma Informed Care; and
- Advocacy for rate parity between commercial plans and Medicaid
- Increase number of referrals to MAUD for willing, eligible individuals.
- Increase Medicaid enrollment for pregnant and parenting women.

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[i] The question asked was: Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey)

[ii] *CDC. Youth Risk Behavior Survey Data Summary & Trends Report, 2011–2021. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm?s_cid=hy-DSTR1-2023*

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Access and perception of harm for tobacco/nicotine products among underage youth

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Decrease the percentage of underage youth who report ease in access to tobacco/ nicotine products including electronic nicotine delivery system (ENDS) products as well as increase the percentage of underage youth who report greater perception of harm to tobacco/nicotine products including ENDS products.

Strategies to attain the goal:

SSA will fund the Regional Public Health Networks (RPHNs) to identify ongoing information dissemination and education opportunities, as well as increase community-based processes and environmental strategies to advance evidenced informed policies, programs, and practices within communities as well as restorative juvenile justice approaches to decrease access, perception of harm and/or use of tobacco/nicotine products including ENDS among underage youth to attain the goal in Priority #1

Collaboration with the RPHNs, local coalitions, school districts, family resource centers, healthcare providers, direct prevention partners, businesses/retailers, law enforcement, the NH Tobacco Prevention & Cessation, NH Liquor Commission Division of Enforcement & Licensing and any other stakeholders to attain the objective in Priority #1

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage High-School Aged Students who report purchasing on their own tobacco/ nicotine products including ENDS products

Baseline Measurement: 15.9% of High-School Aged Students in the 2021 NH YRBS indicated that they had accessed/obtained tobacco/nicotine products including ENDS products during the past 30 days (84.1% of High-School Aged Students indicated that they did not use EVP in the 2021 NH YRBS).

First-year target/outcome measurement: Reviewing the results from the 2023 NH YRBS (projected availability is for April/May of 2024) to learn if the baseline measurement of 15.9% has fluctuated since 2021, with the goal that the percentage has been lowered and the state will then focus on further decreasing the most current percentage by another 2% as will be anticipated/reflected in the 2025 NH YRBS results. Additionally, the state shall participate and utilize the statewide Tobacco Free Network that has newly been re-established with subject matter experts from throughout the state meeting quarterly to devise solutions and strategies for addressing youth tobacco/nicotine usage within the state. Lastly, the state will continue to work with state level colleagues, retail establishments, and community partners to further reduce the Synar RVR rate, currently at 9.2%, for New Hampshire.

Second-year target/outcome measurement: Working with state partners, increased awareness and perception of harm for tobacco/nicotine products among underage youth will be achieved through the efforts of prevention coalitions, restorative juvenile justice, student assistance network, regional public health networks, and other stakeholders to educate and inform youth, caregivers, and communities in an ongoing basis. This will be evident with lowered numbers of students in school settings being detected of having tobacco/nicotine products including ENDS products in their possession while in school. Additionally, the state will continue working with state level colleagues, retail establishments, and community partners on maintaining and diminishing the Synar RVR rate for New Hampshire.

Data Source:

YRBSS Results for High-School Aged Students in New Hampshire for 2021, 2023

Description of Data:

The Youth Risk Behavior Surveillance System (YRBSS) is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12. The surveys are administered every other year. Some of the health-related behaviors and experiences monitored are:
Student demographics: sex, sexual identity, race and ethnicity, and grade
Youth health behaviors and conditions: sexual, injury and violence, bullying, diet and physical activity, obesity, and mental health, including suicide
Substance use behaviors: electronic vapor product and tobacco product use, alcohol use, and other drug use
Student experiences: parental monitoring, school connectedness, unstable housing, and exposure to community violence

Data issues/caveats that affect outcome measures:

YRBSS Results for High-School Aged Students in New Hampshire is utilized for the baseline measurement as well as demonstrating/notating outcome measurements for the first-year target and the second-year target. Data collection is impacted by the number of schools/students that participate in the survey, and thus will have a bearing on the precision and attainment of targeted outcome measurements for both years.

Priority #: 2

Priority Area: Access and perception of harm for alcohol use among underage youth

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Decrease the percentage of underage youth who report ease in access to alcohol as well as increase the percentage of underage youth who report greater perception of harm for use of alcohol, especially within populations identified as rural, LGBTQIA+, homeless, and underserved racial and ethnic minorities.

Strategies to attain the goal:

SSA will leverage the Regional Public Health Networks (RPHNs) to utilize and apply all six of the Center for Substance Abuse Prevention (CSAP) categories (Information Dissemination, Education, Alternative, Problem Identification and Referral, Community-Based Process, and Environmental) throughout the state to ensure the successful accomplishment and attainment of the goal in Priority #2

Collaboration with the RPHNs, local coalitions, school districts, family resource centers, healthcare providers, direct prevention partners, businesses/retailers, law enforcement, the NH Tobacco Prevention & Cessation, NH Liquor Commission Division of Enforcement & Licensing and any other stakeholders for attainment of the objective in Priority #2

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage High-School Aged Students who had their first drink of alcohol before the age of 13 years old

Baseline Measurement: High-School Aged Students in the 2021 NH YRBS indicated that they felt it was “Not at all wrong” at 9.3% and were “Not sure” at 12.2% when asked “How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage (beer, wine, or liquor) nearly every day” which means that collectively 21.5% of High-School Aged Students do not possess a perception of harm for use of alcohol for themselves among their friends. Additionally, High-School Aged Students in the 2021 NH YRBS indicated that they “Strongly approve” at 2.3%, “Approve” at 2.7%, and “Neither approve nor disapprove” at 25.3% when asked “How do you feel about someone your age having one or two drinks of alcohol (beer, wine, or liquor) nearly every day” which means that collectively 30.3% of High-School Aged Students do not possess a perception of harm for use of alcohol for their peers.

First-year target/outcome measurement: Reviewing the results from the 2023 NH YRBS (projected availability is for April/May of 2024) to learn if the baseline measurement of 21.5% for the first question and 30.3% for the second question has fluctuated since 2021, with the goal that the percentage has been lowered and the state will then focus on further decreasing the most current percentage by 3% and 5% respectively, and as will be anticipated/reflected in the 2025 NH YRBS results.

Second-year target/outcome measurement: Working with state partners, increased the percentage of underage youth who report

greater perception of harm for use of alcohol will be achieved through the efforts of prevention coalitions, restorative juvenile justice, student assistance network, regional public health networks, and other stakeholders to educate and inform youth, caregivers, and communities in an ongoing basis. Specifically focusing on education around deceptive alcohol marketing towards youth as well as alternative activities for underage youth to participate/partake in shaping affirmative social norms. Additionally, the state will collaborate with youth groups/programs on peer-to-peer outreach to New Hampshire young people.

Data Source:

YRBSS Results for High-School Aged Students in New Hampshire for 2021, 2023

Description of Data:

The Youth Risk Behavior Surveillance System (YRBSS) is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12. The surveys are administered every other year. Some of the health-related behaviors and experiences monitored are:
Student demographics: sex, sexual identity, race and ethnicity, and grade
Youth health behaviors and conditions: sexual, injury and violence, bullying, diet and physical activity, obesity, and mental health, including suicide
Substance use behaviors: electronic vapor product and tobacco product use, alcohol use, and other drug use
Student experiences: parental monitoring, school connectedness, unstable housing, and exposure to community violence

Data issues/caveats that affect outcome measures:

YRBSS Results for High-School Aged Students in New Hampshire is utilized for the baseline measurement as well as demonstrating/notating outcome measurements for the first-year target and the second-year target. Data collection is impacted by the number of schools/students that participate in the survey, and thus will have a bearing on the precision and attainment of targeted outcome measurements for both years.

Priority #: 3

Priority Area: Treatment plan updates for all levels of care, include a justification for continued treatment at the current level of care, based on ASAM's Continuing Service Criteria.

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

For clients to receive individualized care.

Strategies to attain the goal:

SSA will conduct audits of provider treatment plans and provide TA and training to providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number records where all treatment plan updates include a level of care contain a justification for continued treatment in the current level of care.

Baseline Measurement: 0% of records contain a justification for the current level of care in each treatment plan update. (Note: only one provider's records were looked at during this time period.)

First-year target/outcome measurement: 50% of all contracted providers' client records contain a justification for the current level of care in each treatment plan update.

Second-year target/outcome measurement: 75% of all contracted providers' client records contain a justification for the current level of care in each treatment plan update.

Data Source:

Client records.

Description of Data:

Monitoring process will include record reviews and site visits

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Increase rate of Medicaid enrollment for pregnant and parenting women, while receiving SUD treatment, after an exploration of baseline data.

Baseline Measurement: Unknown

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures:

Unknown

Priority #: 4

Priority Area: Ensuring willing, eligible individuals are offered referrals for MAUD

Priority Type: SUT

Population(s):

Goal of the priority area:

All contracted providers will refer clients, who are not already receiving MAT services, to MAT, when appropriate.

Strategies to attain the goal:

Provider contracts 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: Number of clients being referred to MAUD.

Baseline Measurement: 80% of appropriate clients were referred to MAUD.

First-year target/outcome measurement: 85% of appropriate clients will be referred to MAUD.

Second-year target/outcome measurement: 95% of appropriate clients will be referred to MAUD.

Data Source:

Client records.

Description of Data:

Monitoring process will include record reviews and site visits.

Data issues/caveats that affect outcome measures:

The majority of clients being served under the block grant are assisted by the treatment facilities with obtaining insurance. It is possible that referrals to MAUD would occur after the client had obtained insurance, and therefor would not be included in this measure.

Priority #: 5

Priority Area: Peer Recovery Support Services

Priority Type: SUR

Population(s): BHCS, PWWDC, PWID

Goal of the priority area:

Assure high quality of peer recovery support services (PRSS) provided by Recovery Community Organizations (RCO)

Strategies to attain the goal:

Assure that TA is provided to RCOs to document adherence to NH SOE. SSA will review documents; solicit input from RCO staff, administrators, Board of Directors and community partners; and administer a site visit to ascertain level of compliance with standards. Additional TA will be provided for any identified quality improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of RCOs meeting NH SOE for PRSS

Baseline Measurement: 2 of 12 RCO currently meet NH SOE

First-year target/outcome measurement: 3 additional RCO meet NH SOE (5 total)

Second-year target/outcome measurement: 3 additional RCO meet NH SOE (8 total)

Data Source:

Description of Data:

Monitoring process will include policies and procedures; surveys of staff and members; interviews with administration, Board of Directors and community partners; and site visit observation.

Data issues/caveats that affect outcome measures:

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$9,094,016.00		$92,193,373.00	$54,635,409.00	$4,779,160.00	$0.00	$15,939,936.00		$1,280,392.00	$2,557,004.00
a. Pregnant Women and Women with Dependent Children[c]	$825,780.00									
b. Recovery Support Services	$1,320,000.00			$4,810,000.00	$680,000.00		$5,876,679.00			
c. All Other	$6,948,236.00		$92,193,373.00	$49,825,409.00	$4,099,160.00		$10,063,257.00		$1,280,392.00	$2,557,004.00
2. Primary Prevention[d]	$5,213,546.00		$69,176,463.00	$0.00	$1,885,616.00	$0.00	$19,471,808.00		$341,438.00	$730,572.00
a. Substance Use Primary Prevention	$5,213,546.00		$69,176,463.00		$1,885,616.00		$19,471,808.00		$341,438.00	$730,572.00
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$753,030.00			$892,354.00	$877,677.00				$85,359.00	$365,286.00
11. Crisis Services (5 percent set-aside)										
12. Total	**$15,060,592.00**	**$0.00**	**$161,369,836.00**	**$55,527,763.00**	**$7,542,453.00**	**$0.00**	**$35,411,744.00**	**$0.00**	**$1,707,189.00**	**$3,652,862.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	785	5
2. Women with Dependent Children	6,698	106
3. Individuals with a co-occurring M/SUD	38,157	224
4. Persons who inject drugs	13,522	99
5. Persons experiencing homelessness	1,779	72

Please provide an explanation for any data cells for which the state does not have a data source.

Sources for Table: #1 Pregnant Women The number of live births in the United States in 2019 was 3.75 million (Pregnancy - Statistics & Facts | Statista), which had population of 328 million at that time (US census, Population Estimates Continue to Show the Nation's Growth Is Slowing (census.gov). This equals out to be a birth rate of 1.14%. According to the 2020 US Census, the population for NH is 1,377,519. 1.14% of that numbers is 15,703 live births. It is estimated by NIDA that 5% of pregnant individuals (Substance Use While Pregnant and Breastfeeding | National Institute on Drug Abuse (NIDA) (nih.gov)) are using one or more substances. This does not necessarily mean that these individuals are in need of SUD treatment; however, it gives the best estimate at this time for pregnant individuals who may be in need of services. 15,703 x 5%= 785 pregnant individuals in New Hampshire who may be in need of SUD services. U.S. Census Bureau QuickFacts: New Hampshire #2 Women with Dependent Children According to the 2020 U.S Census, the number of women in New Hampshire is 697,616. Of those 697,616 women, 50.54% of them are women who have dependent children. (U.S. family households with children, by family type 1970-2021). This makes the number of women with dependent children 352,575 in NH. It is estimated that 1.9%

of these women use illicit drugs, making the number of women with dependent children who use illicit drugs, in NH, 6,698. 697,616*.5054=352,575.1264*.019=6698.93 U.S. Census Bureau QuickFacts: New Hampshire Share of U.S. family households with children, by type 1970-2021 | Statista Illicit Drug Use among Women with Children in the United States: 2002–2003 - PMC (nih.gov) #3 Individuals with a co-occurring M/SUD According to SAMSHA, the number of individuals with a co-occurring mental health/SUD in the USA is 9.2 million individuals. There are 331.89 million people in the US; 9.2 million is 2.77% of the total population. According to the US census, there are 1,377,519 individuals in New Hampshire; 2.77% of the NH population is 38,157 individuals with co-occurring mental health/SUD. 1,377,519*.0277=38,157.2763 U.S. Census Bureau QuickFacts: New Hampshire Co-Occurring Disorders and Other Health Conditions | SAMHSA, #4 Person who inject drugs According to the NIH, there are an estimated 3,694,500 people who inject drugs in the United States, representing 1.46% of the adult population. According to New Hampshire population statistics, there are 926,224 adults in NH; therefore, there is an estimated 13,522 adults who inject drug in NH. Adults included in this number are 18 and older. 926,224*.0146=13,522.8704 Estimated Number of People Who Inject Drugs in the United States - PubMed (nih.gov) #5 Person experiencing homelessness According to the NH Coalition to End Homelessness 2022 report, there are 4,682 people experiencing homelessness in NH. According to SAMHSA, 38% of homeless people misuse alcohol, and 26% of homeless individuals use other drugs. 38% of 4,682 is 1,779 individuals. This is an approximate number of homeless individuals that may be in need of SUD services. 4682*.38= 1779 Substance Abuse and Homelessness: Statistics and Rehab Treatment (americanaddictioncenters.org) 2022-NHCEH-Full-Report-6.2.2022_compressed.pdf Microsoft Word - Substance Abuse and Homelessness.docx (nationalhomeless.org)

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Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$4,547,008.00	$1,280,392.00	$2,557,004.00
2 . Substance Use Primary Prevention	$2,606,773.00	$341,438.00	$730,572.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$660,000.00		
6 . Administration (SSA Level Only)	$376,515.00	$85,359.00	$365,286.00
7. Total	**$8,190,296.00**	**$1,707,189.00**	**$3,652,862.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

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Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 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 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$50,000		
	Selected			
	Indicated			
	Unspecified			
	Total	**$50,000**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$50,000**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$8,190,296**	**$1,707,189**	**$3,652,862**
Planned Primary Prevention Percentage		**0.61 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$1,042,709	$51,215	$401,815
Universal Indirect	$782,032	$68,289	$328,757
Selected	$521,355	$119,503	$0
Indicated	$260,677	$102,431	$0
Column Total	**$2,606,773**	**$341,438**	**$730,572**
Total SUPTRS BG Award[3]	**$8,190,296**	**$1,707,189**	**$3,652,862**
Planned Primary Prevention Percentage	**31.83 %**	**20.00 %**	**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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FOOTNOTE: the column total for the FFY2024 SUPTRS BG Award includes the amounts listed above the total and does not include the $836,421.30 from Table 6 for our Non-direct services/system development

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☐	☑	☐
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☐	☐
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support	$475,315.50				$915,551.00
3. Partnerships, community outreach, and needs assessment		$836,421.30			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement	$164,962.05			$391,368.00	
6. Research and Evaluation	$75,910.73				
7. Training and Education	$116,019.59				$130,000.00
8. Total	**$832,207.87**	**$836,421.30**	**$0.00**	**$391,368.00**	**$1,045,551.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

Hampshire's 10-Year Mental Health Plan and the Governor's Commission on Alcohol and other Drugs Three Year Strategic Plan resulted from a robust stakeholder engagement process that has included input from hundreds of interested parties statewide through focus groups, workgroups, public sessions, and written comments. It takes a comprehensive and innovative approach to improve access to care for the mental health needs, substance use disorders, and co-occurring disorders of individuals in New Hampshire across their life span.

As a result of the previous Governor's Commission strategic plan the following efforts have been accomplished:
Significant progress has been made to increase access to alcohol and other drug related services and supports in NH, as outlined in the Report on Action Plan Progress 2019 - 2021 including: » Creation of The Doorway system, providing access to screening, assessment, and referral to services throughout the state; » Expansion of the availability of telehealth; » Increased access to and utilization of Medication for Addiction Treatment (MAT); » Expansion of access to Recovery Centers led by Recovery Community Organizations; » Expansion of the Recovery Friendly Workplace initiative; » Increased access to substance use disorder treatment; and » Expansion of prevention programs, policies, and activities in schools and communities.

The 10-Year Mental Health Plan was adopted in 2019. It envisions and lays out a road map to achieve a statewide mental health system that aims to improve behavioral health for all individuals in New Hampshire by providing:
system that aims to improve behavioral health for all individuals in New Hampshire by providing:
• Increased access to a full continuum of care, including community education and engagement,
• Prevention and early intervention services,
• Outpatient, inpatient, and crisis support and services,
• Child-focused strategies and recommendations,
• Integration of mental health and primary health care, and
• Intensified efforts to address suicide prevention
The Plan includes a vision to expand the crisis continuum to include statewide integrated mobile crisis services, incentives to increase psychiatric bed capacity, increased support for those transitioning to and from higher levels of mental health care, and more peer support as people with a mental illness navigate their way through the system of care. The Plan's initial 13 foundational recommendations highlight and reflect stakeholder input and include action steps on how the Department and stakeholders will implement those recommendations, funding benchmarks, and potential legal and regulatory changes.
increase psychiatric bed capacity, increased support for those transitioning to and from higher levels of mental health care, and more peer support as people with a mental illness navigate their way through the system of care. The Plan’s initial 13 foundational recommendations highlight and reflect stakeholder input and include action steps on how the Department and stakeholders will implement those recommendations, funding benchmarks, and potential legal and regulatory changes.
Since the release of the State's 10-Year Mental Health Plan in 2019, significant investments in mental health have been made. In support of the 10-Year Plan's goals, the Division for Behavioral Health (DBH) has been building system capacity, supporting innovation, and building a continuum of care that is responsive to the needs of New Hampshire residents. With strong legislative support and dedicated providers, New Hampshire has made significant gains under each of the core goals outlined in the Plan.
support of the 10-Year Plan’s goals, the Division for Behavioral Health (DBH) has been building system capacity, supporting innovation, and building a continuum of care that is responsive to the needs of New Hampshire residents. With strong legislative support and dedicated providers, New Hampshire has made significant gains under each of the core goals outlined in the Plan.
An annual report of accomplishments is published annually each September. The 2023 accomplishments report still needs to be finalized. Still, the 2022 report identified the below key accomplishments achieved on each of the 13 foundational recommendations:
Key Accomplishments for the Plan's 13 Recommendations through August 2022 include the following:
finalized. Still, the 2022 report identified the below key accomplishments achieved on each of the 13 foundational recommendations:Key Accomplishments for the Plan’s 13 Recommendations through August 2022 include the following:
Recommendation 1: Increase Medicaid Rates for Mental Health Services
• Increased Medicaid rates by 3.1% in January 2020 and another 3.1% in January 2021, increasing total funds for providers by $6M
• Annually, $5M of Directed Mental Health Payments have been made since SFY 2019
• Increased the transitional housing/community residence per diem by 88%
Recommendation 2: Action Steps to Address Emergency Department Waits
Recommendation 2: Action Steps to Address Emergency Department Waits
• Transformed crisis services; integrated Mobile Crisis Teams and Supports; Rapid Response services available statewide
• Access Point/988 Public Outreach and Education
• Mobile Crisis Rural Implementation
• Crisis Stabilization Model Expansion
• Increased Designated Receiving Facility rates and added 34 beds since 2019, with plans to increase inpatient beds by 150 through 2025
through 2025
• Established 40 new transitional housing beds
• Reallocated capacity at New Hampshire Hospital - children's unit transitioned to Hampstead
• The state acquired Hampstead Hospital and established the contract to develop the first-ever Psychiatric Residential Treatment Facility in New Hampshire.
Facility in New Hampshire.
• Amended New Hampshire's substance use disorder Institutions for Mental Disease (IMD) Medicaid waiver to include severe mental illness
Recommendation 3: Renewed & Intensified Efforts to Address Suicide Prevention
mental illnessRecommendation 3: Renewed & Intensified Efforts to Address Suicide Prevention

• Allocated $450K of new State funds to support suicide prevention per year since 2020
• Established New Hampshire's first suicide prevention specialist position
• New Hampshire Suicide Prevention Council revised the statewide suicide prevention plan
• Established school suicide prevention planning and training standards; CALM training provided to 33 individuals statewide
• Developed a standardized suicide screening and risk assessment tool for use in emergency departments
• Collaborative 9-8-8 planning and launch
Recommendation 4: Enhanced Regional Delivery of Mental Health Services
• Expanded services for children's system of care through Senate Bill 14
• Developed a centralized mental health Access Point
Recommendation 5: Community Services and Housing Supports
PointRecommendation 5: Community Services and Housing Supports
• Increased Housing Bridge subsidies by over 100 vouchers
• Established Integrated Housing Program, a housing voucher program for individuals with mental illness and criminal records
• Contracted for 60-bed supported housing expansion
• Expanded partnership with New Hampshire Housing Finance Authority and secured grant funding from the federal Department of Housing and Urban Development (HUD)
of Housing and Urban Development (HUD)
• Launched birth to 5 early childhood enhanced care coordination (EC-ECC)
• Expanded Families and Systems Together (FAST) Forward for children
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Recommendation 6: Step-up/Step-down Options
Recommendation 6: Step-up/Step-down Options
• Launched a Recovery Oriented Step-up/Step-down pilot program (12 beds)
• Launched a Recovery Oriented Step-up/Step-down pilot program (12 beds)
• Expanded the Transitional Residential Enhanced Care Coordination (TR-ECC) program for children
• Expanded the Transitional Residential Enhanced Care Coordination (TR-ECC) program for children
• Launched Critical Time Intervention
Recommendation 7: Integration of Peers and Natural Supports
• Launched Critical Time InterventionRecommendation 7: Integration of Peers and Natural Supports
• Expanded Access to Peer Support Centers
• Expanded Access to Peer Support Centers
• Expanded training for peer leadership and workforce services
• Expanded training for peer leadership and workforce services
• Expanded youth peer support services
• Expanded youth peer support services
• Increased peers throughout the continuum
• Increased peers throughout the continuum
• Incorporate peers into ACT/Mobile Crisis Teams, EDs, and SUSD program
Recommendation 8: Establish a Commission to Address Justice-Involved Individuals
• Incorporate peers into ACT/Mobile Crisis Teams, EDs, and SUSD programRecommendation 8: Establish a Commission to Address Justice-Involved Individuals
• Established the Governor's Advisory Commission on Mental Illness and the Corrections System.
• Established the Governor's Advisory Commission on Mental Illness and the Corrections System.
• Commission partnered with the National Council of State Governments Justice Center on a high-utilizer assessment project.
Recommendation 9: Community Education
• Commission partnered with the National Council of State Governments Justice Center on a high-utilizer assessment project.Recommendation 9: Community Education
• Launched I Care NH and Onward NH, suicide prevention and early intervention campaigns
• Launched I Care NH and Onward NH, suicide prevention and early intervention campaigns
• Entered into a contract with a vendor to create a public awareness campaign encouraging positive help-seeking behavior and the reduction of stigma
Recommendation 10: Prevention & Early Intervention
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• Developed the Early Childhood Prevention and Treatment for Behavioral Health Plan
• Developed the Early Childhood Prevention and Treatment for Behavioral Health Plan
• Increased availability of First Episode Psychosis intervention services
• Increased availability of First Episode Psychosis intervention services
• Deployed Crisis Teams to children and families
• Deployed Crisis Teams to children and families
• Developed the Infant Mental Health Plan
• Developed the Infant Mental Health Plan
• Solicited proposals to study the readiness, capability, and cost-effectiveness of implementing the Certified Community Behavioral Health Clinic (CCBHC) model
Recommendation 11: Workforce Coordination
• Solicited proposals to study the readiness, capability, and cost-effectiveness of implementing the Certified Community Behavioral

Health Clinic (CCBHC) model Recommendation 11: Workforce Coordination
• Established the Governor's Statewide Oversight Commission on Mental Health Workforce Development
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• Invested $5M of ARPA Home and Community Based Services (HCBS) funds to support direct care staff at CMHCs
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• Developed the Peer Workforce Advancement Plan
• Developed the Peer Workforce Advancement Plan
• Conducted cross-department training for criminal justice staff
• Conducted cross-department training for criminal justice staff
• Expanded the State Loan Repayment Program (SLRP)
• Expanded the State Loan Repayment Program (SLRP)
• Enhanced workforce training options
Recommendation 12: Quality Improvement & Monitoring/DHHS Capacity
• Enhanced workforce training optionsRecommendation 12: Quality Improvement & Monitoring/DHHS Capacity
• The DHHS established a Division of Performance Evaluation & Innovation
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• Contracted with an evaluation team that would evaluate and advise on crisis system transformation and implementation
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• Created four new staff positions in the Bureau for Children's Behavioral Health
Recommendation 13: Streamlining Administrative Requirements
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• Streamlined administrative requirements, annual data enhancement projects, and program reviews
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• Informal stakeholder engagement for State rule revisions is underway
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Integration of Substance Use and Mental Health Treatment
Challenges experienced regarding gaps in service for individuals with co-occurring mental health and substance use disorders have been identified and targeted for improvement. Collaborative work is occurring across the New Hampshire Division for Behavioral Health (DBH) on care coordination, access, and program development. The DBH is comprised of the following bureaus: Mental Health Services (SMHA), Drug and Alcohol Services (SSA), Children's Behavioral Health, and Homeless Services.
The New Hampshire DBH has been working to develop financial and programmatic procedures to address the continuum of care for these individuals. Cross-walking of Bureau rules and regulations and outlining service and access standards has begun. The goal is to streamline standards of care to ensure there is "no wrong door" and leverage innovative, sustainable treatment models.
Integration of Substance Use and Mental Health TreatmentChallenges experienced regarding gaps in service for individuals with co-occurring mental health and substance use disorders have been identified and targeted for improvement. Collaborative work is occurring across the New Hampshire Division for Behavioral Health (DBH) on care coordination, access, and program development. The DBH is comprised of the following bureaus: Mental Health Services (SMHA), Drug and Alcohol Services (SSA), Children’s Behavioral Health, and Homeless Services. The New Hampshire DBH has been working to develop financial and programmatic procedures to address the continuum of care for these individuals. Cross-walking of Bureau rules and regulations and outlining service and access standards has begun. The goal is to streamline standards of care to ensure there is “no wrong door” and leverage innovative, sustainable treatment models.
One focus area related to integration for individuals with a substance use disorder and a co-occurring mental health disorder (COD) includes workforce development strategies specific to integration. The DBH has developed the capacity to cross-train those in the behavioral health system to be better equipped to identify, screen for, and respond to individuals with COD. The DBH entered into a contract with a statewide COD trainer to provide COD training, evaluation, and consultation to both SUD and MH treatment providers.
One focus area related to integration for individuals with a substance use disorder and a co-occurring mental health disorder (COD) includes workforce development strategies specific to integration. The DBH has developed the capacity to cross-train those in the behavioral health system to be better equipped to identify, screen for, and respond to individuals with COD. The DBH entered into a contract with a statewide COD trainer to provide COD training, evaluation, and consultation to both SUD and MH treatment providers.
Another program area that has strategically and intentionally been integrated is New Hampshire's crisis response system. New Hampshire is transforming its behavioral health crisis system, which includes implementing a statewide integrated (responding to both mental health and substance use crises across the age continuum) mobile crisis response model to work in tandem with the existing infrastructure, such as the Doorways (https://www.thedoorway.nh.gov/), which provide 24/7 support to individuals seeking treatment for a substance use disorder, and CMHCs.
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At a policy level, all DBH Bureaus actively manage the state's Managed Care Organization (MCO) contracts to ensure effective care coordination and support services for individuals diagnosed with co-occurring disorders. Staff from each Bureau meet regularly to discuss reporting provided by the MCOs to identify policy or practice changes needed to serve individuals with co-occurring needs better. Ongoing management-level work ensures system-wide financial and programmatic discussions occur and are an ongoing focus for the coming year.

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Critical Time Intervention (CTI)

Critical Time Intervention (CTI) is a model of care specially designed to support people through transitions of care. CTI is a cost-effective, evidence-based practice offering highly specialized interventions that bridge the gap and ease transitions from institutional to community-based care. When implemented correctly, CTI facilitates successful transitions during critical times of change. The ongoing services facilitate community reintegration and ensure individuals have established ties and support systems for sustained care continuity.

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In New Hampshire, CTI has been implemented (starting in 2022) to enhance the quality of life of adults with serious mental illness transitioning from inpatient behavioral health settings back to the community. Once enrolled, individuals are assigned a CTI coach who provides up to 9 months of supportive services following a discharge from an inpatient psychiatric hospitalization. The goal is to improve linkages to community supports that enable recovery and help prevent readmissions. All 10 New Hampshire Community Mental Health Centers (CMHCs) have implemented and operationalized CTI to offer statewide program availability. Training, consultation, a community of practice, and technical assistance around fidelity to the model are provided through a state contract with the University of New Hampshire.

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Crisis Respite and Withdrawal Management Services

New Hampshire's network of Doorways has identified the need for non-clinical, safe housing for individuals waiting to access either residential treatment services or safe housing. Currently, three such programs are funded through State Opioid Response (SOR) funds; however, a need remains, especially for individuals who use substances other than opioids or stimulants, such as alcohol. These funds would be utilized to set up respite housing in areas of the State that are currently underserved in this area. A third area of need is Medically Monitored Residential Withdrawal Management (ASAM Level 3.7-WM). These critical services are being explored within New Hampshire. A vital component of this service development would be that the providers must be able to bill Medicaid and private insurance for services beyond the initial startup period for ongoing service sustainability beyond the grant period.

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Suicide Prevention Initiatives

In early 2021, the Division for Behavioral Health (DBH) hired its first statewide suicide prevention coordinator, linking the Bureaus' efforts in this area. This position also leads DBH with the state's legislatively mandated Suicide Prevention Council (SPC). Because of the impact suicide has on the residents of New Hampshire, New Hampshire RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall "oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the Plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the Plan. The council shall also be a proponent for suicide prevention in New Hampshire."

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

Suicide Prevention Initiatives In early 2021, the Division for Behavioral Health (DBH) hired its first statewide suicide prevention coordinator, linking the Bureaus' efforts in this area. This position also leads DBH with the state's legislatively mandated Suicide Prevention Council (SPC). Because of the impact suicide has on the residents of New Hampshire, New Hampshire RSA 126-R established a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall "oversee the implementation of the New Hampshire suicide prevention plan. The council shall ensure the continued effectiveness of the Plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the Plan. The council shall also be a proponent for suicide

prevention in New Hampshire."The mission of the SPC 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;
• Raise public and professional awareness of suicide prevention;
• Address the mental health and substance abuse needs of all residents;
• Address the mental health and substance abuse needs of all residents;
• Address the needs of those affected by suicide and
• Address the needs of those affected by suicide and
• Promote policy change
• Promote policy change
Great strides have been made through the ongoing communication and efforts between the Bureau of Mental Health Services (BMHS), the Bureau for Children's Behavioral Health (BCBH), and the Bureau of Drug and Alcohol Services (BDAS) regarding statewide suicide prevention initiatives.
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A substance use disorder is a known risk factor for suicide, so even when not in a life-threatening crisis, it is prevalent for individuals with a substance use disorder to have a co-occurring mental health disorder (COD). Addressing COD during treatment for a substance use disorder can improve client outcomes. As a step towards more comprehensive treatment of COD and support for individuals in recovery experiencing COD, New Hampshire DBH is providing Mental Health First Aid and Zero Suicide training to all contracted substance use disorder (SUD) treatment providers and to recovery community organizations under the umbrella of the division's contracted facilitating organization. Training may also be made available to other treatment and recovery providers outside of those contracted with the DBH upon review of the implementation design.
Development and Coordination of Prevention Services New Hampshire's prevention efforts are primarily driven by the State's Regional Public Health Networks and Community Coalitions. These groups already provide a robust support network, but more work is underway. BDAS is providing funding to apply the Strategic Prevention Framework at both the state and local levels to support and expand existing initiatives, such as Student Assistance Programming and the I Care NH Initiative (part of the I Care Mental Health & Wellness Initiative) as well as to develop new initiatives made possible by the rollout of 988. The goal of this work is to help regions and communities identify the evidenced-based and/or promising practices that will be the most effective in their localities and assist these communities in standing up programs as well as to coordinate better the efforts of these groups in providing population, targeted, and direct prevention services across New Hampshire.
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2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

New Hampshire's demand for mental health and substance use services is increasing. Several factors make behavioral health transformation a priority of the State, including enacting the New Hampshire Health Protection Program (NHHPP) to cover a new adult group, in which an estimated one in six individuals have extensive mental health or substance use care needs. New
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New Hampshire, through the NHHPP, seeks to transform its behavioral health delivery system through:
· Integrating physical and behavioral health to address better the full range of the qualified population's needs;
· Expanding provider capacity to address behavioral health needs in appropriate settings and
· Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.
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Additional efforts to advance parity include:
· Supported behavioral health (BH) and physical health integration using the University of Washington AIMS Center integration model
· Implemented an on-site BH clinician at high-volume primary care practice (PCP) sites
· Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs
· Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care. The platform went live in February 2020
· Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention
· Provided education about appropriate Emergency Department use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our twenty-four hour, seven days a week (24/7) nurse advice line to their entire provider network
· Passage of legislation to authorize the provision of many Medicaid-covered services to be delivered through telehealth, inclusive of pay parity, for behavioral health services with patient consent and as long as it is clinically appropriate for the service to be conducted via telehealth
· Ongoing review and updating of Medicaid rates associated with behavioral health services to support beneficiary access to services and providers (e.g., a 2022 increase to ASAM 3.7 Medically-Monitored Detoxification Treatment, a 2021 increase of residential treatment beds for individuals with a severe mental illness(es)
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3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Demonstration Project and Integrated Delivery Networks
In 2016, the Centers for Medicare and Medicaid Services (CMS) approved a New Hampshire DHHS five-year Medicaid demonstration project to improve access to and quality behavioral health services by establishing regionally-based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical healthcare delivery system. To achieve the goals of the demonstration waiver, the IDNs were charged with participating in statewide planning efforts and selecting and implementing specific evidence-supported projects. These projects comprised three enabling pathways: mental health and substance use disorder treatment capacity building, physical and behavioral care integration, and improving care transitions across settings.
The central focus of the networks is the integration of care across primary care, behavioral health, and social support services. This includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions to address more comprehensively the current challenges experienced by patients, families, and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.
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Specific achievements include:

· Integration of primary care and behavioral health
· Supported expanded implementation of Medications for Opioid Use Disorders (MOUD) for people with substance use disorders, in conjunction with the Doorways (points of entry for people seeking help for substance use), which have been established in New Hampshire
· Critical Time Intervention (CTI), an evidence-based practice, was used in several regions to improve transitions from emergency departments, inpatient care, residential settings, or incarceration to stable housing and community recovery (individual IDNs targeted different segments of the population)
· Established standardized protocols across multidisciplinary providers for comprehensive assessment, workflows, timely exchange of information, closed-loop referrals, and multidisciplinary care teams.
· Implemented various levels and types of co-located Primary care and Behavioral Health reverse integration clinics for people with serious mental illness/ serious emotional disturbance (SMI/SED)
· Several IDNs have designed and implemented a Collaborative Care Model (CoCM) inclusive of the development of processes and protocols.
· Integrated Care and Enhanced Care Coordination between hospitals, SUD, Federally Qualified Health Centers (FQHCs), and CMHCs
· Improved Health Information Technology (HIT) to enhance integration, improve transitions and promote quality
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· Implementation of a real-time event notification system, electronic shared care plan, and statewide direct and secure messaging
· IDNs supported the expansion of telehealth during the COVID-19 public health state of emergency (funding, training, ongoing technical support)
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ProHealth Program in New Hampshire
In 2018, New Hampshire received a five-year grant from SAMHSA to provide integrated behavioral and physical health care within the services of CMHCs in New Hampshire to improve health and wellness for its young people with SED and SMI.
This project, called the ProHealth NH program, has since delivered integrated medical and behavioral health care, recovery, and wellness services in 3 New Hampshire communities (Greater Manchester, Greater Nashua, and Strafford County). ProHealth NH was implemented utilizing partnerships between FQHCs and CMHCs that serve over one-third of the State. Primary care services are now co-located and integrated at the three CMHCs with this project. The other seven CMHCs in the State have also implemented or are now implementing an integrated care program.
The ProHealth NH program has enrolled over 800 youth and young adults aged 16 and older with SED or SMI, including a substantial proportion of people who identify as a cultural or linguistic minority. Across the State, over 650 individuals are enrolled in integrated care services.
Continuing evaluation, training, and consultation are provided on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through participating CMHCs and FQHC partnerships. Per SAMHSA guidance, evaluations will measure effectiveness in identifying and addressing SED, SMI, SPMI, and physical health indicators earlier and improving health outcomes for youth and young adults with mental illness.
New Hampshire DBH continues to conduct the evaluation and reporting of outcomes consistent with federal project requirements to be able to examine the resulting outcomes of integrated care. The expectation is that integration can increase access to and receipt of recommended outpatient screening and treatment for both physical and mental health conditions. Such treatment will reduce unnecessary emergency room visits and hospital stays. The team also expects that service recipients' physical and mental health will stabilize and improve with treatment and that satisfaction will be high.
CCBHC Introductory Efforts
On 3/15/23, SAMHSA awarded New Hampshire DBH a grant of $1 million to fund planning activities for implementing CCBHCs in New Hampshire.
There are three project goals in this CCBHC Planning grant to help the State build efficiencies and increase the quality of integrated community-based mental health and substance use services through potentially implementing the CCBHC model in New Hampshire:
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1. Develop and implement a certification system for CCBHCs in New Hampshire,

1. Develop and implement a certification system for CCBHCs in New Hampshire,

2. Establish Prospective Payment Systems (PPS) for Medicaid reimbursable services, and

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3. Prepare an application to participate in a four-year CCBHC Demonstration program

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These three goals are vital to the potential establishment of a CCBHC model of service - integrating physical health care with behavioral health care and substance use treatment - across New Hampshire's current Community Mental Health and Substance Use Disorder treatment systems.

Support for integration through MCOs

New Hampshire contracts with three Managed Care Organizations (MCOs) supporting integration with physical health services. The MCOs have worked to promote the values of whole-person care and foster a coordinated continuum of care. To that end, they have focused on building collaborative relationships across providers. Specific MCO accomplishments include:

· Developed provider resource packets distributed in March 2020 to the entire provider network. Included in the resource packet was a PCP toolkit providing tools to screen for the most common behavioral health diagnoses and social determinants. Packets also included referral information and behavioral health resources.

· Supported behavioral health (BH) and physical health integration using the University of Washington AIMS Center integration model

· Implemented an on-site BH clinician at high-volume PCP sites

· Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs

· Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care

· Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention

· Provided IDN partners with comprehensive care gap reports, Healthcare Effectiveness Data and Information Set (HEDIS) rates, and under/over-utilization reports

· Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our 24/7 nurse advice line to their entire provider network

· Supported expanded implementation of Medications for Opioid Use Disorder (MOUD) for people with substance use disorders in conjunction with the Doorways established in New Hampshire. Doorways are points of entry for people seeking help for substance use.

These three goals are vital to the potential establishment of a CCBHC model of service – integrating physical health care with behavioral health care and substance use treatment – across New Hampshire's current Community Mental Health and Substance Use Disorder treatment systems.Support for integration through MCOsNew Hampshire contracts with three Managed Care Organizations (MCOs) supporting integration with physical health services. The MCOs have worked to promote the values of whole-person care and foster a coordinated continuum of care. To that end, they have focused on building collaborative relationships across providers. Specific MCO accomplishments include: · Developed provider resource packets distributed in March 2020 to the entire provider network. Included in the resource packet was a PCP toolkit providing tools to screen for the most common behavioral health diagnoses and social determinants. Packets also included referral information and behavioral health resources. · Supported behavioral health (BH) and physical health integration using the University of Washington AIMS Center integration model· Implemented an on-site BH clinician at high-volume PCP sites· Supported Peer-to-Peer Psychiatric consultation between specialists serving individuals' physical needs and specialists serving an individual's BH needs· Implemented a behavioral health telehealth platform and made clinicians available via telehealth to increase rapid access to care · Provided training and education to all providers with a focus on a whole-person approach, reducing the stigma associated with mental health issues and suicide prevention · Provided IDN partners with comprehensive care gap reports, Healthcare Effectiveness Data and Information Set (HEDIS) rates, and under/over-utilization reports· Provided education about appropriate ED use, the importance of routine PCP visits, BH screening, maintaining BH Provider appointments, and the availability of our 24/7 nurse advice line to their entire provider network· Supported expanded implementation of Medications for Opioid Use Disorder (MOUD) for people with substance use disorders in conjunction with the Doorways established in New Hampshire. Doorways are points of entry for people seeking help for substance use.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care

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a) Adults with serious mental illness
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b) Adults with substance use disorders
b) Adults with substance use disorders
c) Children and youth with serious emotional disturbances or substance use disorders
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a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

In 2020, the New Hampshire Department of Health and Human Services (DHHS) contracted with Collective Medical Technologies (now Point-Click-Care, which acquired the original contractor). This company provides the software infrastructure to support event notification, admission/discharge/transfer (ADT), and shared care plan development through an online and integrated platform utilized by over 50% of New Hampshire's community hospitals, many nursing homes, FQHCs, CMHCs, other clinics, State IMDs, the Department's three MCOs, etc. This platform can be integrated with various electronic medical record/health information technology solutions to quickly capture and transmit ADT data between a patient's applicable providers to support effective and prompt care coordination.
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As part of the Department's SUD/SMI/SED IMD waiver demonstration in 2022, the Department also launched plans to implement a closed-loop referral solution after engagement with the solution ended under another demonstration (the Department's 2015-2020 1115 demonstration, known as Building Capacity for Transformation). In that demonstration, a closed-loop referral solution was selected and implemented by the participating IDNs. After the conclusion of the first demonstration, the Department sought and secured legislation for authority to pursue a new statewide closed-loop referral solution. Once fully implemented (target mid-2024), this solution will ensure that medical and non-medical community-based providers and organizations have a platform that can share client/patient-specific information to effectuate referrals between providers of the services needed by the individual. Interfaces and interoperability with the Collective Medical ADT event notification system, key provider groups, and State agencies' case management or electronic business information systems will be incorporated. These emerging technologies are included in the Department's SUD/SMI/SED IMD waiver demonstration and are supported through funding with CMS.
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To ensure effective implementation of these solutions and support community-based provider engagement, the Department launched a Care Coordination Initiative in 2022, including Senior Project Management resources and Executive Sponsorship. A Statewide Governance Committee will also be incorporated to ensure that a multi-organization/agency approach to the ongoing success of these solutions is consistently and collaboratively pursued.
launched a Care Coordination Initiative in 2022, including Senior Project Management resources and Executive Sponsorship. A Statewide Governance Committee will also be incorporated to ensure that a multi-organization/agency approach to the ongoing success of these solutions is consistently and collaboratively pursued.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Within Departmental contracts with providers, including the community mental health centers and three Managed Care Organizations, the Department includes provisions to assess individual needs, inclusive of mental health and substance use disorders, and to provide the needed services or refer individuals to applicable providers, as well as to work together on collaborative care approaches, etc. This becomes a more consistent and supported focus for Medicaid beneficiaries who need

targeted case management services.
A children's system of care framework has been developed and implemented to provide a continuum of care across the system that assesses/identifies needs, provides early intervention and community-based services, intensive community-based supports, episodes of residential treatment, and acute and crisis care. The system of care includes care coordination roles across the continuum. For youth with complex needs, including Severe Emotional Disturbance, in addition to the above approaches, coordinated individualized care plans can be developed to address a youth and family's needs. Contracted Care Management Entities (CMEs) can facilitate and coordinate access to a full array of community-based services, utilizing the evidence-based practice of High-Fidelity Wraparound. Within New Hampshire's Wraparound model, the CMEs utilize the Child Adolescent Needs and Strengths assessment tool to help identify needs and strengths, incorporate decision-making into the development of the care plans, and provide outcome measurement to manage the course of treatment more effectively.
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The Department was awarded a 1-year Planning Grant from SAMHSA on March 15, 2023, to look at the Certified Community Behavioral Health Clinic (CCBHC) model for New Hampshire. This model supports further integrating services and support for individuals with co-occurring mental and substance use disorders. Three CMHCs in New Hampshire are developing CCBHC models in their programs based on SAMHSA grants they have engaged in independently. The Department's grant work has included work internally among Departmental sub-units to analyze systemic capacities, explore opportunities from a whole-system perspective, and work with stakeholders to explore the CCBHC model to evolve the behavioral health system in New Hampshire. The Department is currently reviewing its readiness assessment and planning for implementation to more efficiently and effectively meet the needs of individuals with co-occurring disorders through integrated treatment and care coordination as key components of the CCBHC model.
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The state's crisis response system is an integrated model responding to mental health and substance use crises. To that end, all crisis response staff are specialty trained to screen for and address both substance use disorders and mental disorders.
crisis response staff are specialty trained to screen for and address both substance use disorders and mental disorders.
The state has also initiated a targeted, two-year program to provide training and technical assistance to improve knowledge and skills among staff in CMHCs and substance use disorder treatment facilities. Participants will learn skills for co-occurring disorders treatment.
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Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. 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[6]. 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, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 populations 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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 and is 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ◉ Yes ○ No

e) Gender identity ◉ Yes ○ No

f) Age ◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ◉ No

7. Does the state have any activities related to this section that you would like to highlight?

New Hampshire continues to perform routine quality improvement initiatives for all data submitted to the Mental Health and Substance Use Databases (Phoenix, WITS, and RedCap) to reduce null, missing, incomplete and inaccurate data identified. This includes elements of
both client and service data.

Please indicate areas of technical assistance needed related to this section

BDAS offers numerous trainings throughout the year to its providers on identifying, preventing and reducing racial and health disparities for its clients.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD 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 IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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 General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. Each KIT 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [ ] Use of financial and non-financial incentives for providers or consumers.
- **d)** [ ] Provider involvement in planning value-based purchasing.
- **e)** [ ] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [x] Quality measures focused on consumer outcomes rather than care processes.
- **g)** [ ] Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

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

The State would like TA on alternative reimbursement models specifically value based reimbursement

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 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 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG 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 made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

   The State will be providing in this next FFY a series of modules to assist sub-recipients in understanding federal program requirements this will include both in-person and webinar formats

   Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

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**[56] 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 approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

NH has no identified tribes

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

  Overdose Prevention

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☑ Monitoring the Future
- **f)** ☑ Communities that Care
- **g)** ☐ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

New Hampshire Service to Science serves as the Evidence-Based Workgroup for New Hampshire, bringing substance use prevention programs that have been developed in the state through the process of becoming designated as Evidence-Based. The term "Service to Science" is used by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to identify interventions developed by local and community organizations that have yet to establish their efficacy through research and/or rigorous evaluation. New Hampshire's process is aligned with SAMHSA's nomination process which was developed to: 1) determine the strength of theoretical frameworks used in the development of the intervention, 2) determine and evaluate intermediate outcomes relevant to the intervention's intended purpose, and 3) address the risk and protective factors and cultural context influencing alcohol and other drug behaviors in New Hampshire. New Hampshire Service to Science categorizes programs into three tiers of evidence-base. The Service to Science Expert Panel uses a basic screening tool to determine if a program meets Tier I criteria. Tiers II and III are determined based on a comprehensive review and scoring of a program's Service to Science application materials.
• Tier I: An innovative program is implemented by an established group/organization and fills a previously unmet need. A program is designated as innovative if it is based on sound research/theory, implemented in a way that can be replicated, addresses and impacts risk and protective factors linked to substance misuse and has considered program evaluation and/or there is a desire to expand evaluation efforts.
• Tier II: A promising practice is designated when the program is need-based and design is well-grounded in theory and/or research-base. Promising practices link program activities to research-based outcomes—- this is demonstrated with a logic model that connects all program activities to indicated outcomes. Promising practices demonstrate program delivery/Implementation, have developed evaluation designs and have collected pilot outcomes.
• Tier III: An evidence-based program has a comprehensive staff training and program implementation manual. Evidence-based programs have stabilized the # of people served and has measured program fidelity, key outcomes and participant satisfaction. They have achieved meaningful results (short-term at minimum) and demonstrated that results are used for quality assurance and disseminated to key stakeholders.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Within the assessment step, the National CLAS standards are integrated consistently and universally. Whenever a program, project, and/or awareness campaign is being deliberated for development, implementation and/or dissemination, input and feedback from the populations being messaged to are invited and included within the developmental process as well as being mindful of the reading level of the average individual and how those new to the country may interpret the information being shared. Many stakeholders take part in this process to guarantee that equitability and inclusion has been incorporated.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

New Hampshire Service to Science ensures sustainability as part of the Strategic Prevention Framework process as well as through guidance and technical assistance to programs. They aid these programs in identifying and determining methods

for sustaining their work as well as expand their prevention efforts to have other agencies and organizations implement their prevention efforts within other communities and/or other populations.

b) If no, please explain in the box below.

Narratve Question

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Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The Prevention Certification Board (PCB) of New Hampshire is an all-volunteer board with the important role of providing oversight for the process of certifying individuals as Prevention Specialists in the State of New Hampshire through IC&RC credentialing. The board also has the responsibility of reviewing and approving Continuing Education (CEUs) for Certified Prevention Specialists for various types of training events (workshops, webinars, trainings, conferences, etc). Prevention Certification provides public protection by ensuring that prevention services are provided in an appropriate, ethical manner using the latest evidence-based practices. It requires prevention specialists to demonstrate competence through a rigorous credentialing and examination process that promotes personal and professional growth, increased recognition, and professionalism of the field. Unified by adherence to the highest standards of quality and integrity, Prevention Specialists holding an IC&RC Prevention Specialist certification have created an international network of prevention specialists with worldwide recognition and respect.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

The New Hampshire Technical Assistance Center (NHTAC) facilitates a Prevention Community of Practice (CoP) providing a forum for prevention specialists and professionals to share their perspectives, explore solutions and emerging trends, connect with peers, and take away insights to improve their prevention practices. This CoP connects substance misuse prevention professionals to: 1) increase knowledge of best practice; 2) build collegiality and professional mentoring; 3) improve communication between and within systems of care addressing substance misuse; and 4) promote recovery and resiliency oriented principles and practices. NHTAC also offers specialized support and technical assistance by request for a variety of community needs and prevention initiatives. Additionally, New Hampshire Alcohol & Drug Abuse Counselors Association (NHADACA), a non-profit organization, has been advancing addiction professions and education in New Hampshire since 1986. Through workforce development activities, education and advocacy, they strive to enhance the knowledge and skills of addiction professionals, advance licensure, increase awareness of addiction issues in New Hampshire, and promote programs and policies that ensure access to high quality services for New Hampshire citizens struggling with addiction. NHADACA supports the substance use workforce through various programs including essential training for substance use and other mental health credentialing in New Hampshire, with over 100 professional development events per year, their events include multi-day conferences, symposium, forums, virtual live events and on demand webinars. While their trainings are affordably priced, they do offer scholarships for those in need to ensure

financial barrier does not impede individuals from pursuing their desired credentialing.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

The State of New Hampshire implement the Strategic Prevention Framework (SPF) with each of its 13 regions researching, surveying, and developing a 3 year prevention strategic plan with input from partners, providers, and other stakeholders as well as feedback for community members and under-resourced/vulnerable populations. These plans then inform the annual workplans undertaken by each region regarding their upcoming and/or ongoing prevention efforts and evolving goals for their communities. In addition, each region produces a Community Health Improvement Plan (CHIP) that spans 5 years and is also developed through a collaborative process among many partners in each region to ensure broad support for the goals and objectives established within the plans. The activities that will be undertaken to achieve those goals and objectives is based on a collective impact approach – where every partners' strengths and assets are brought to bear on a common concern in coordination with others to maximize the overall effectiveness through coordinated, collaborative efforts. These two documents offer mirror each other in regards to the goals and objectives that communities would like to achieve for substance prevention and misuse within their region.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Within the capacity building step, the National CLAS standards are integrated consistently and universally. Always being mindful of the reading level of the average individual, how the populations we are serving/supporting digest information, and how those new to the country may interpret information is always in the forefront of our communication efforts. The State of New Hampshire has the ability to have information translated as well as examined for the effectiveness of the communication, knowing that clear and understandable communication will ensure that capacity is being built effectively for inclusiveness, robustness, and durability.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

New Hampshire ensures sustainability for capacity building with the utilization of the Strategic Prevention Framework process. Collaborating and contracting with multiple partners and subject matter experts allows for a wide ranges of ways in which technical assistance, program support, and prevention guidance can be provided. Sustainability and capacity building can then be successfully realized and achieved based on the particular and unique needs of the communities being aiding by the prevention efforts of the agencies and organizations serving those in New Hampshire.

b) If no, please explain in the box below.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Recently updated, the NH Governor's Commission Action Plan Update (SFY23-SFY25) is a three-year strategic plan that serves as a blueprint for shared efforts with a focus on alignment, coordination, innovation and accountability. The plan encompasses best practices and other key strategy recommendations made by Commission members, Commission Task Forces, and other key stakeholders. Access the plan at https://nhcenterforexcellence.org/wp-content/uploads/2022/07/Gov-Comm_2022_Final_Linked-1.pdf.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and

strategies are evidence based

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8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Within the planning step, the National CLAS standards are integrated from the beginning and throughout the formulation and preparation of prevention efforts. The use of precise language and intentional word selection within planning increases the chances for better outcomes and greater accomplishments. The State of New Hampshire has access to tools and experts to ensure that CLAS standards are adhered to accurately and consistently.

b) If no, please explain in the box below.

n/a

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

New Hampshire ensures sustainability for the planning step as part of a pillar within the Strategic Prevention Framework process. During the planning step, not only are prevention plans devised for the present and immediate future, but projecting planning into the prospective future is as considered and conceive at the same time.

b) If no, please explain in the box below.

n/a

Narratve Question

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Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Regional Public Health Networks (RPHNs); Student Assistance Program (SAP) Network; Referral, Education, Assistance and Prevention Program (REAP)

b) Education:

Regional Public Health Networks (RPHNs); Student Assistance Program (SAP) Network; Referral, Education, Assistance and Prevention Program (REAP)

c) Alternatives:

Regional Public Health Networks (RPHNs); Student Assistance Program (SAP) Network; Referral, Education, Assistance and Prevention Program (REAP)

d) Problem Identification and Referral:

Regional Public Health Networks (RPHNs); Student Assistance Program (SAP) Network; Referral, Education, Assistance and

Prevention Program (REAP)

e) Community-Based Processes:

Regional Public Health Networks (RPHNs)

f) Environmental:

Regional Public Health Networks (RPHNs); Student Assistance Program (SAP) Network; Referral, Education, Assistance and Prevention Program (REAP)

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? ○ Yes ◉ No

a) If yes, please describe.

Data is reported and collected into a secure, online platform which does allow for the state to then seek and separate out activities and prevention efforts based on funding source as a search criteria. Reports may be created and executed to identify SUPTRS BG dollars that are used to fund solely primary prevention supports and services.

4. Does your state integrate National CLAS Standards into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

The National CLAS standards have been uniformly utilized and integrated during the assessment step, capacity building step, and planning step, with the implementation step continuing this action. Cultural competency is fundamental to the Strategic Prevention Framework, woven within each step, and New Hampshire is diligent in making sure it is represented throughout every step of the process.

b) If no, please explain in the box below.

n/a

5. Does your state integrate sustainability into the implementation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Just as cultural competency is woven within each step of the Strategic Prevention Framework, so too is sustainability. Sustainability has been integrated during the assessment step, capacity building step, and planning step, with the implementation step continuing this action. New Hampshire provides sustainability as well as creates, supports, and identify sustainability opportunities projections for prevention efforts within the state.

b) If no, please explain in the box below

n/a

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Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

n/a

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☐ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☐ Number of evidence based programs/practices/policies implemented
- **e)** ☐ Attendance
- **f)** ☐ Demographic information
- **g)** ☐ Other (please describe):

Data is collected on the SUBG funded prevention strategies through the Youth Risk Behavior Survey (YRBS) and the National Survey on Drug Use and Health (NSDUH) to provide insights into various aspects of program implementation, delivery, and reach. By collecting and analyzing data through the YRBS and NSDUH, NH gains valuable insights into the implementation, delivery, and effectiveness of SUBG-funded prevention strategies.

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

c) ☐ Binge use

d) ☐ Perception of harm

e) ☐ Disapproval of use

f) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☐ Other (please describe):

The outcome data collected through the Youth Risk Behavior Survey (YRBS) and the National Survey on Drug Use and Health (NSDUH) are crucial for evaluating the effectiveness of the state's prevention strategies. Both surveys provide valuable insights into various risk behaviors among youth and adults, including substance use, mental health issues, and other behaviors that impact overall well-being.

5. Does your state integrate the National CLAS Standards into the evaluation step? ○ Yes ◉ No

a) If yes, please explain in the box below.

n/a

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ○ Yes ◉ No

a) If yes, please describe in the box below.

n/a

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief Intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Detox (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive Outpatient	◉ Yes	○ No
viii)	Inpatient/Residential	◉ Yes	○ No
ix)	Aftercare; Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	○ Yes	◉ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to PWWDC are included in the BDAS treatment contracts and monitored yearly as a part of that process. When issues are identified, providers are required to submit and regularly report on corrective action plans utilizing SMART goals and objectives. In order to enhance the State's ability to monitor the contracts, in 2020 BDAS collaborated with the Bureau of Program Quality (BPQ) to improve and streamline the audit process as a whole; and improve the audit tool used, as well as the final reports to providers.

In 2020, the State also contracted with the Arkansas Foundation for Medical Care (AFMC) to utilize their secure web platform to maintain an online database of survey results, analysis results, and produce statistical reports. Starting in the fall of 2021, AFMC began conducting a yearly basis a state-wide evaluation of all NH Block Grant sub-recipients, which includes an evaluation of services related to PWWDC. AFMC combines virtual site visits, data obtained from the yearly audit, and NOMS data, to produce a report on the NH system as a whole.

BDAS has continued to have a work group to monitor and improve upon the quality of the data that is entered into the Web Information Technology System (WITS), the BDAS database in which BDAS contractors report clinical and billing data to BDAS. This data includes NOMs and data related to PWWDC. BDAS continues to monitor bi-monthly WITS data entry and reporting, including information regarding PWWDC. BDAS reports the results to treatment providers and institutes corrective action plans if needed. Lastly, we are in the process of hiring for a new position, who, among other things, will assist with spot-checking provider records.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs, if applicable	(●) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(●) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(●) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	(●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to PWID are included in the BDAS treatment contracts and monitored yearly as a part of that process. When issues are identified, providers are required to submit and regularly report on corrective action plans utilizing SMART goals and objectives. In order to enhance the State's ability to monitor the contracts, in 2020 BDAS collaborated with the Bureau of Program Quality (BPQ) to improve and streamline the audit process as a whole; and improve the audit tool used, as well as the final reports to providers.
In 2020 the State also contracted with the Arkansas Foundation for Medical Care (AFMC) to utilize their secure web platform to maintain an online database of survey results, analysis results, and produce statistical reports. Starting in the fall of 2021, AFMC began conducting on a yearly basis a state-wide evaluation of all NH Block Grant sub-recipients, which included an evaluation of services related to PWID. AFMC combines virtual site visits, data obtained from the yearly audit, and NOMS data, to produce a report on the NH system as a whole.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (●) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (●) No
c)	Established co-located SUD professionals within FQHCs	(●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to TB are included in the BDAS treatment contracts and monitored yearly as a part of that process. When issues are identified, providers are required to submit and regularly report on corrective action plans utilizing SMART goals and objectives. In order to enhance the State's ability to monitor the contracts, BDAS collaborated with the Bureau of Program Quality (BPQ) to improve and streamline the audit process as a whole; and improve the audit tool used, as well as the final reports to providers.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas

○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services

○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?

● Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

● Yes ○ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program?

○ Yes ● No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ● No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ● Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ● Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ● Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ● Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ● Yes ○ No
- **f)** Explore expansion of services for:
  - **i)** MOUD — ● Yes ○ No
  - **ii)** Tele-Health — ● Yes ○ No
  - **iii)** Social Media Outreach — ○ Yes ● No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ● Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ● Yes ○ No
- **b)** Establish a program to provide trauma-informed care — ● Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ● Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ● Yes ○ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ○ Yes ● No
- **b)** An organized referral system to identify alternative providers? — ○ Yes ● No
- **c)** A system to maintain a list of referrals made by religious organizations? — ○ Yes ● No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ● Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ● Yes ○ No

b) Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

One of eleven block grant sub-recipients was subject to an IPR, which accounts for roughly 9% of block grant recipients.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ● No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ● Yes ○ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ● Yes ○ No

c) Performance-based accountability: ● Yes ○ No

d) Data collection and reporting requirements ● Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ● No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ● No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ● Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) Mental Health TTC? ● Yes ○ No

c) Addiction TTC? ● Yes ○ No

d) State Targeted Response TTC? ● Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ● No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ● No

b) Early Intervention Services Regarding HIV ○ Yes ● No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-330-A.htm
https://casetext.com/regulation/new-hampshire-administrative-code/title-he-department-of-health-and-human-services/subtitle-he-a-former-office-of-alcohol-and-drug-abuse-prevention/chapter-he-a-300-certification-and-operation-of-alcohol-and-other-drug-disorder-treatment-programs
PLEASE NOTE--Rules are currently being edited, as they have expired.

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

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.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

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

NH is working with DHHS' Bureau of Program Integrity and Quality Improvement and its contracted evaluator to update its CQI plan for FFY 2024-2025

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	○ Yes	● No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	● Yes	○ No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	● Yes	○ No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	● Yes	○ No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	● Yes	○ No
6.	Does the state use an evidence-based intervention to treat trauma?	● Yes	○ No

7. Does the state have any activities related to this section that you would like to highlight.

NH SUD providers adhere to trauma-informed models of care, as defined by SAMHSA, ensuring that their clinical standards and operating procedures focus on wellness and recovery. Through its contracted training provider, BDAS conducts numerous trainings throughout the year on the principles of trauma-informed models of care and evidenced based programs that use the models.

Additionally, BDAS conducted a pilot with two SUD providers on Secondary Exposure to Trauma working with supervisors to

identify potential burnout due to exposure to trauma and/or trauma in their workforce. The pilot also worked with supervisors and staff on techniques to identify when exposure to trauma is resulting in physical and behavioral health symptoms, coping mechanisms and when to seek professional help.

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

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

○ Yes ◉ No

4. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

NH's Substance Use System of Care utilizes 211 which operates 24/7 with trained information and referral specialist to provide information on SUD resources in NH. If a crisis is identified 211 will do a "warm" transfer to the closest Doorway of the caller. The Doorway will provide a telephone assessment and crisis stabilization. If needed, transportation will be provided to the caller to the most appropriate level of care. Any resident may also access the Doorway in person or via the telephone for similar services.

The New Hampshire 10-Year Mental Health Plan called for the transformation of New Hampshire's crisis system. Therefore, in 2019, New Hampshire began planning to expand and integrate crisis services across mental health and substance use disorder and ensure all levels of crisis care were available to children, youth, adults, and families statewide.

The transformation of crisis services is aligned with the national Crisis Now model and has been gradually implemented over the past two years. The New Hampshire Rapid Response (NHRR) crisis system launched on January 1, 2022. This system includes the New Hampshire Rapid Response Access Point (NHRRAP), a 24/7 crisis contact center, statewide integrated mobile crisis response teams (NHRR), and soon-to-be-established crisis

centers.

The NHRRAP is the centralized crisis contact (call, text, chat) center designed as the primary access point for crisis services. It offers phone-based triage, assessment, and de-escalation services 24 hours a day, 7 days a week. NHRRAP also can deploy the closest available mobile crisis team promptly. Prior to the transformation, at least 20 different numbers existed for someone in crisis. The goal of the NHRRAP was to have one number, regardless of the time of day and/or location of the caller, to call for behavioral health crisis support in New Hampshire. The State contracted with Carelon (formerly, Beacon Health Options) to provide the crisis contact center. Most calls (80%) are resolved at the "call" level. The NHRRAP number is 1-833-710-6477.

On July 16, 2022 the National Suicide Prevention Lifeline (NSPL) transitioned from a 10-digit number to the easy to remember number 9-8-8 (with the former 1-800-273-TALK still in place). Headrest has been the NSPL call center provider in New Hampshire for many years. Headrest continues as the primary call center for 988. Additionally, a Memorandum of Understanding between Headrest and Carelon was established to do a warm hand-off if necessary and provide backup. Headrest is primary on calls, texts and chats and Carelon is the secondary Lifeline call center for New Hampshire. There has been extensive work with the New Hampshire Department of Safety wherein protocols have been developed to identify and facilitate call transfers to the 988 system from 911 based on mutually developed level of care measures. Over 200 calls have been transferred from 911 to date.

The NHRRAP can also schedule "Same day/Next day" appointments for callers whose crisis does not meet a level of deployment and/or requests to be seen later (if a credible safety plan is in place). These appointments take place at the Community Mental Health Centers (CMHCs).

Mobile response teams are available statewide when the NHRRAP cannot resolve the crisis on the phone (or the caller requests an in-person response). The NHRR teams are staffed by each of the State's 10 CMHCs. These teams operate 24/7, providing mobile crisis intervention services. Comprising two specially trained crisis responders, NHRR teams can respond to requests for crisis assessments and interventions within one hour of receiving calls. Once engaged with an individual, NHRR teams can offer services and supports for up to 30 days after the crisis, ensuring individuals remain stable and receive the necessary assistance within their community.

NHRR teams are deployed, via the NHRRAP, using a virtual platform. Deployments are to the closest available team, expecting teams to arrive in person within one hour. If the closest team is busy with another deployment (or isn't fully staffed with two responders), the next closest team is deployed. If the caller requests telehealth, the closest team with telehealth capability is given the dispatch.

A dispatch level is part of the deployment that indicates to the NHRR team if there are issues to consider before deploying. Levels 3 and 4 are recommended to include law enforcement as the primary responder or in conjunction with law enforcement.

Four (4) crisis apartment beds are available in each of the Nashua, Manchester, and Concord regions. Crisis Apartments serve individuals aged eighteen (18) years or older experiencing a mental health crisis, including co-occurring substance use disorders. These apartments offer a viable alternative to hospitalization and institutionalization, providing a supportive and secure environment during crises. Stays in Crisis Apartments can last up to 7 days per episode and sometimes longer when necessary.

The BMHS is working with contracted vendors to establish two Crisis Stabilization Centers (CSCs) in state fiscal year 2024. One Center will be in Plymouth, NH. The other will be in the southern part of the State. The Crisis Centers are for lengths of stay of no more than 23 hours and are designed for the stabilization of symptoms, safety planning, initial linkage to services, and follow-up telehealth appointments.

In addition, the BMHS applied for and received – training and technical assistance through SAMHSA to assist in the planning and development of the Crisis Stabilization Centers as well as support for and facilitation of implementation with our two CMHCs who will be the vendors for this project. An initial fact-finding meeting with BMHS and Advocates for Human Potential, Inc (AHP)., was held on Thursday Aug. 17th. AHP is working on an initial proposal for BMHS on potential options for crisis stabilization centers in New Hampshire.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: The Doorways ,211 and 988 provide 24/7 coverage to residents in need of crisis support. Additionally, NH's Rapid Response has 24/7 coverage for caller/text/chat.

Someone to respond: DHHS utilizes its Rapid Response mobile crisis response team to assist individuals and communities in access to in person crisis response. The NH Rapid Response in the northern part of the State use a unique model of having 2 Peer Support Specialists respond and having a Master's level Clinician be part of the team via telehealth. This model was proposed to address the rural nature of the area, the longer commutes, and the smaller population of staff who can work in these teams.

Somewhere to go: New Hampshire is in the early stages of implementing Crisis Stabilization Centers with 2 of the 10 CMHCs.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

NA

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

NA

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

NH BDAS anticipates technical assistance is needed to meet crisis response needs for individuals with disabilities, older adults, refugees, and others facing health disparities.

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block grant funding of recovery support services? (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

•The Bureau of Drug and Alcohol Services (BDAS) and the Bureau of Mental Health Services (BMHS) are separate bureaus. The bureaus are working collaboratively and providing cross training for the peer systems.
•From BMHS "Peer Support Agencies (PSAs) provide services statewide through 8 contracts and 14 physical locations across the state. These peer-run agencies offer peer support, education, connectedness to the community, activities, training, and supported employment opportunities among other services. Some of these peer agencies also provide peer respite and Recovery Orientated Step-up Step-down beds.
•The Recovery-Oriented Step-Up/Step-Down Programs provide short-term recovery-based transition services for adults (18 years of older) who are transitioning from inpatient or institutional settings into the community or who require a more intensive support to reduce the need for admission to an inpatient setting. These programs provide non-clinical peer supports with access to peer staff 24 hours a day 7 days per week. Staff focus on recovery-oriented peer support services that also work to coordinate and engage with outpatient community based clinical treatment providers."
•New Hampshire citizens over the age of 17 are welcome to visit any RCO location to receive peer recovery support services.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

•The state of New Hampshire's system of peer recovery supports including development and quality improvement is supported by unique model, a Facilitating Organization
•New Hampshire currently has 12 RCOs with a total of 19 recovery centers.
•All 12 RCOs are peer-led, and peer run agencies, they are all low barrier and no cost.
•The RCOs support multiple pathways to recovery and offer peer recovery coaching, telephone support, mutual aid groups, and family support programs. They also provide additional programming based on the desires/needs of the local recovery e.g., parenting programs, work readiness/placement, recreational programs and groups: mindfulness, art, yoga, hiking)
•Most of the centers include services on harm reduction, system navigation, and advocacy

5. Does the state have any activities that it would like to highlight?

•BDAS developed and implemented the New Hampshire Recovery Community Organization Standards of Excellence (NHRCOSOE) for each RCO to participate in a comprehensive review
•BDAS developed and Implemented the State's first public facing dashboard for Peer Recovery Support Services, providing aggregate data on demographics of participants engaged, activities and referrals made, and distribution of supplies from all state funded RCOs
•Many RCOs have expanded their programming and services beyond the requirements of their state-funded contract. RCOs have integrated into other community systems (drug courts, emergency departments, law enforcement, county/state corrections, local businesses, veteran's services, etc.

NH BDAS continues its commitment to the development of a robust, effective and accessible continuums of care in all regions of the state.
NH BDAS partners with the NH Department of Public Health Services to provide support and direction to regional public health networks (RPHNS) across the state. RPHNs work with regional stakeholders to identify and address priority health concerns in their regions and develop a plan to address them.
BDAS provides funding for Continuum of Care systems develop and substance misuse prevention work (aka Substance Misuse System – SMS) in each RPHN. SMS work has brought together prevention, treatment, recovery service providers and community coalitions, as well as representatives from the following sectors- Health, Safety, Government, Business, Education and Community – to work collaborative to identify substance misuse concerns and develop a plan to address them. These plans are integrated into and coordinate with the larger regional health improvement action plan in each region.

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

Alternative payment models for PRSS and RCOs

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17. Community Living and the Implementation of Olmstead - Requested

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 M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual 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 M/SUD 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 for 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 settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based 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. Does the state's Olmstead plan include:

- Housing services provided — Yes / No
- Home and community-based services — Yes / No
- Peer support services — Yes / No
- Employment services. — Yes / No

2. Does the state have a plan to transition individuals from hospital to community settings? — Yes / No

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?

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. 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 emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. 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 M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

[2]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.

[3]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.

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

[5]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ○ Yes ○ No

b) The resilience of children and youth with SED? ○ Yes ○ No

c) The recovery of children and youth with SUD? ○ Yes ○ No

d) The resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ○ Yes ○ No

b) Health care? ○ Yes ○ No

c) Juvenile justice? ○ Yes ○ No

d) Education? ○ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ○ Yes ○ No

b) Costs? ○ Yes ○ No

c) Outcomes for children and youth services? ○ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ○ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ○ Yes ○ No

b) for youth in foster care? ○ Yes ○ No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ○ Yes ○ No

d) Does the state have an established FEP program? ○ Yes ○ No

Does the state have an established CHRP program? ○ Yes ○ No

e) Is the state providing trauma informed care? ○ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

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

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22. Public Comment on the State Plan - Required

Narrative Question

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ● Yes ○ No

If yes, provide URL:

https://www.dhhs.nh.gov/programs-services/health-care/substance-misuse/substance-abuse-prevention-and-treatment-block-grant

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://www.dhhs.nh.gov/programs-services/health-care/substance-misuse/substance-abuse-prevention-and-treatment-block-grant

c) Other (e.g. public service announcements, print media) ○ Yes ● No

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

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23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

NH does not use SUPTRS BG funds for the DHHS Syringe Services Program

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

NH does not use SUPTR BG funds for the Syringe Services Program