



# State of New Hampshire

DEPARTMENT OF SAFETY  
OFFICE OF THE COMMISSIONER  
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603/271-2791

JOHN J. BARTHELMES  
COMMISSIONER

To: Governor Maggie Wood Hassan  
From: Commissioner John Barthelmes, NH Department of Safety  
Date: November 19, 2014  
Re: Task Force Recommendations for Naloxone Availability

It is with great honor that I submit the attached report on behalf of the Strategic Task Force convened at your request to provide information and recommendations relative to expanded access to opioid antagonists to prevent deaths related to opiate overdose.

In the daily work of the Department and in the thoughtful and diligent work of the task force, we are painfully aware of the tragedies that families and communities across New Hampshire are facing related to opioid abuse.

This awareness was at the center of the task force's work, and I want to commend each member for their significant effort, professionalism, attention to detail, passion, and compassion that was evident in every communication and conversation.

The recommendations enclosed herein are a product of information gathered and consensus gained after careful review and consideration of options available to reduce opioid-related deaths through wider availability of naloxone.

In our deliberations, several substantive topic areas emerged that were not directly related to naloxone availability, our requested charge, but that would benefit from special attention as state leadership explores further ways to address opiate addiction and overdose. The task force summarized these theme areas in its report for future consideration.

On behalf of task force members, we thank you for the opportunity to serve in the role designated to us and are ready and willing to serve in such a capacity moving forward.

Please let me know if the task force can provide additional detail or context to this report, and thank you for your leadership on this critical health and safety issue.

**STRATEGIC TASK FORCE ON PREVENTING DEATH FROM OPIOID OVERDOSE  
RECOMMENDATIONS FOR GOVERNOR HASSAN**

November 21, 2014

The State of New Hampshire is experiencing an unprecedented rise in overdose cases and deaths, as are many other states. Protecting our citizens is of primary importance and requires a unique, immediate and multifaceted approach with new tools to combat this epidemic.

As directed by New Hampshire Governor Maggie Wood Hassan in a letter to Commissioner John Barthelmes dated September 8<sup>th</sup> 2014 (Appendix A), the New Hampshire Department of Safety convened a strategic task force to study options for increasing availability of naloxone for the purposes of intervening in opioid overdose emergencies to prevent death and to develop recommendations for action.

The group convened four times between October 1 and November 18, with significant information-gathering in advance of meetings for the task force's consideration, reflection, and decision-making.

The Task Force's charge was to gather and consider information in order to answer the following question: *What recommendations does the work group have to ensure that New Hampshire is protecting its citizens against the harmful effects of opioid overdoses through the availability and administration of opioid antagonists<sup>1</sup>?*

After thoughtful discussion and careful consideration, the Strategic Task Force recommends the following actions **as immediately as possible** to address a growing overdose problem that is taking the life of NH residents at a rate of **one every two days**:

**ALLOW POLICE AND FIRE PERSONNEL TO CARRY NALOXONE**

1. Permit police and fire department personnel, not currently licensed by EMS, to become licensed to carry and administer intranasal naloxone in order to intervene medically in instances when New Hampshire citizens may be experiencing an overdose and Emergency Medical Services has not yet arrived. Permission could be granted to interested police and fire departments by tying the new services into the existing EMS system through the following recommended steps:

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<sup>1</sup> Although the term *opioid antagonists* refers to drugs other than naloxone that may be used for other medical purposes (e.g. naltrexone), the task force focused on naloxone as it is the opioid antagonist that is used to reverse opioid overdose.

- a. Establish a new Emergency Medical Service license level for EMS Units and Providers whereby units are allowed to have the medication, equipment, and policies to provider medication under protocol. RSA 153-A empowers the Commissioner of the Department of Safety, through rulemaking, to establish new EMS licensure levels (153-A:11 II), license issuance procedures (RSA 153-A:20 V), levels of qualifications (RSA 153-A:20 VI), and training (RSA 153-A:20 VIII).
- b. Streamline the EMS Unit licensure and Medical Resource Hospital<sup>2</sup> approval process: RSA 153-A:20, I empowers the Commissioner of the Department of Safety, through rulemaking, to adopt rules pertaining to the licensing and operation of Emergency Medical Service Units. Adopt rules relevant to police and fire organizations administering an intranasal opioid antagonist.
- c. Establish adequate training standards: Issuance of the new license level is incumbent upon completion of adequate training, both didactic and practical, in First/Aid and rescue breathing and intranasal medication administration, specifically naloxone. Completion of the training and education would enable issuance of the new license level. Training requirements shall at a minimum include:
  - i. Naloxone-specific training, including scene safety, assessment of the overdose patient, intranasal administration, duration of effectiveness, withdrawal management, dealing with possible combative behavior, medical priority of situation, providing treatment and recovery resource information, and other topics specific to naloxone (three hours); and
  - ii. First Aid and CPR/rescue breathing (four hours); personnel with current certification could be exempted.
- d. Establish operational requirements for police and fire organizations under this new level of EMS license: Adopt rules relevant to naloxone procurement, storage, administration, documentation, and restocking. Provide information on the average cost per dose and recommended number of doses to be stored and carried per trained staff person.
- e. Disseminate information on the establishment of the new license level and associated requirements to police and fire organizations, facilitated through the Bureau of EMS, with assistance and input from the NH Chiefs of Police Association, the Professional Firefighters of NH, and other relevant organizations. Information should include:
  - i. New EMS Unit and Provider license levels, activation date, application criteria and administration protocols;
  - ii. Operational considerations for the department to administer the medication, including the number and type of personnel to license within departments interested in this service level for communities;

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<sup>2</sup> Medical Resource Hospitals are acute care hospitals in New Hampshire that provide medical oversight, direction and guidance to local EMS service units.

- iii. Resource information on treatment and recovery support services available in the state and local communities to disseminate to residents who may be involved in opioid abuse and their family members; and
- iv. Other relevant information to support departments interested in having personnel licensed to carry and administer naloxone.

#### **ALLOW FRIENDS AND FAMILY TO ACCESS NALOXONE KITS**

- 2. Permit friends and family members of individuals with a history of opioid abuse to access prescription, non-narcotic intranasal naloxone overdose reversal kits. Access could be made available through standing order prescriptions at local pharmacies.

To establish effective protocols associated with this recommendation, require that doses of naloxone available to friends and family be packaged with information regarding treatment and recovery resources for opioid dependence and the duty of anyone administering naloxone per RSA 508: 12 to “to place the person under the care of a physician, nurse, or other person qualified to care for such person as soon as possible and to obey the instructions of such person”. Information should, at a minimum, include the following:

- i. Directions to call 911 as the first action in the event of an overdose;
- ii. Instructions for administering naloxone safely, including actions to take to improve respiration before, during and after naloxone administration; and
- iii. Resource information on treatment and recovery supports available to individuals with opioid dependence and their families and friends.

#### **ALLOW MEDICAL AND HEALTH PROGRAMS AND FACILITIES TO FACILITATE EXPANDED ACCESS TO NALOXONE KITS**

- 3. Allow and encourage health care and treatment programs and facilities working with opioid dependent individuals to facilitate access to naloxone kits for clients and their families. Such access expansion may involve policies that encourage clients to request a naloxone prescription from their primary care physician, through the standing order prescription approach suggested relative to friend and family access, or by other means.

#### **PROTECT THOSE WHO ADMINISTER NALOXONE TO REVERSE OVERDOSE FROM CIVIL LIABILITY**

- 4. Protect those who administer naloxone to reverse overdose from civil liability. Such protections will require the Attorney General’s Office to review existing legislation, including

RSA 508:12 and RSA 153-a, to determine and execute necessary amendments to applicable statutes.

As the task force considered information to develop these recommendations, several important issues emerged that fell outside the boundaries of the charge established by Governor Hassan but that warranted their mention in this report. By listing these issues, it is the task force's hope that they be addressed in some way as essential companions to increasing naloxone availability so that the state does not "treat the symptom rather than the patient", in the words of one task force member.

As this phrase implies, treating the symptom of opioid overdose is critical in terms of preventing death; however, to effectively prevent death, a comprehensive strategy of public awareness, early intervention, and widely available treatment and recovery support services for opioid addiction is as critical.

Therefore, the task force also shares critical topic areas that emerged during its charge for the Governor's consideration:

**ESTABLISH ADDICTION HOTLINE AND PUBLIC INFORMATION CAMPAIGN**

Establish and communicate broadly through news and social media channels, public health networks, and other communication channels a means by which the public can contact the state for immediate information on treatment options for individuals with opioid dependence or abuse and to provide support and resource information for friends and family members of those addicted to opioids.

**EXPAND TREATMENT AND RECOVERY SUPPORT SERVICES**

Expand the availability and diversity of early intervention, treatment and recovery supports services in the state so that individuals struggling with opioid addiction and their families have open and immediate access to such services. The scarcity and limitations of existing resources was recognized by the task force as critical to reducing opioid-related deaths and to reversing the addiction problem that is plaguing communities across the state.

**PROMOTE PROFESSIONAL AND PUBLIC EDUCATION RELATIVE TO RISKS OF OVERDOSE AND ADDICTION WITH MISUSE OF OPIOID PAIN RELIEVERS AND RELATED RISKS**

Increase communication with health and medical professionals and the general public relative to the risks of overdose and addiction with misuse of opioid pain relievers, the rising problem of heroin use, and current statistics on overdose deaths in New Hampshire.

**DATA COLLECTION, ANALYSIS AND UTILIZATION**

Improve data collection, analysis and utilization to address identified data gaps that include but are not limited to the inability to connect data on naloxone administration by EMS with patient records of immediate and long-term health outcomes and diagnoses.

The recommendations for naloxone availability as well as the service and resource needs identified to prevent opioid dependence provided in this report are the result of the thoughtful, diligent and earnest efforts of the strategic task force members invited and convened at the Governor's request.

These members, listed below, express their gratitude for Governor Hassan's attention to this devastating health crisis that is affecting New Hampshire citizens in every community and from every walk of life. *Each member expressed his/her willingness to continue to serve the Governor's interests should further detail for naloxone recommendations or to develop recommendations for expanded topic areas be requested.*

**STRATEGIC TASK FORCE MEMBERS:**

Commissioner John Barthelmes, Dept of Safety  
Dr. Seddon Savage, Dartmouth Geisel School of Medicine  
Chief Richard Crate, Chiefs of Police Association  
David Lang, Professional Firefighters Association of NH  
Joseph Harding, NH DHHS  
Dr. David Strang, Lakes Region General Hospital  
Lisa Muré, CHI/NH Center for Excellence

James Vara, Asistant Attorney General  
Colonel Robert Quinn, NH State Police  
Nick Mercuri, Bureau of EMS  
Paul DiMaggio, Atkinson resident  
Melissa Silvey, Goodwin Health  
Tricia Lucas, New Futures  
Rekha Sreedhara, CHI/NH Center for Excellence

The recommendations presented in the preceding pages were developed by the strategic task force based on information gathered in response to the request by Governor Hassan. A summary of information gathered and considered for each question posed is provided in this section.

**1. Are appropriately administered opioid antagonists a demonstrated means to protect against opioid overdose deaths? If so, how have other states made such antagonists available for use and administration?**

Yes. Appropriately administered opioid antagonists are a demonstrated means to protect against opioid overdose deaths. Below is a summary of research establishing their effectiveness as well as endorsements of its use by the American Society for Addiction Medicine and the American Medical Society.

Research Citation	Findings
Community-Based Opioid Overdose Prevention Programs Providing Naloxone, <i>Morbidity and Mortality Weekly Report</i> , Centers for Disease Control and Prevention, Vol 61:6.	According to one nationwide study conducted in 2010 by the Harm Reduction Coalition, 48 programs reported providing training and distribution of naloxone to 53,032 individuals resulting in 10,171 overdose reversals. <sup>1</sup>
Expanded Access to Naloxone for Critical Response to the Epidemic of Opioid Overdose Mortality. <i>American Journal of Public Health</i> . 2009 March; 99(3): 402–407. Daniel Kim, et al.	Data from recent pilot programs demonstrate that lay persons are consistently successful in safely administering naloxone and reversing opioid overdose. Current evidence supports the extensive scale-up of access to naloxone. We present advantages and limitations associated with a range of possible policy and program responses.
Naloxone treatment in opioid addiction: the risks and benefits. <i>Expert Opinion on Drug Safety</i> . 2007 Mar;6(2):125-32. van Dorp E1, Yassen A, Dahan A.	Naloxone has a long clinical history of successful use and is presently considered a safe drug over a wide dose range (up to 10 mg). In opioid-dependent patients, naloxone is used in the treatment of opioid-overdose-induced respiratory depression, in (ultra)rapid detoxification and in combination with buprenorphine for maintenance therapy (to prevent intravenous abuse).
Endorsing Organization	Endorsement
American Society for Addiction Medicine (ASAM)	ASAM supports the increased use of naloxone in cases of unintentional opioid overdose, in light of the fact that naloxone has been proven to be an effective, fast-acting, inexpensive and non-addictive opioid antagonist with minimal side effects, when used at the proper dosage, for preventing the often fatal respiratory arrest which characterizes the advanced stages of prescription or illegal drug overdose. ASAM supports broadened accessibility to naloxone for individuals commonly in a position to initiate early response to evidence of drug overdose, to include a) early responders to calls for emergency medical assistance (EMTs and paramedics); b) corrections officers; c) law enforcement officers; d) staff of state and community-based public and private organizations serving populations at high risk for drug overdose;

and e) family members, significant others, companions.

American Medical Society (AMS)

AMS's 2012 annual meeting adopted a policy to support further implementation of community-based programs that offer naloxone and other opioid overdose prevention services. The policy also encourages education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. "Fatalities caused by opioid overdose can devastate families and communities, and we must do more to prevent these deaths," said Dr. Harris. "Educating both physicians and patients about the availability of naloxone and supporting the accessibility of this lifesaving drug will help to prevent unnecessary deaths." (AMS web site 10/28/14)

Other states have employed a range of strategies to make antagonists available for use and administration. A brief summary of information from selected states is provided below.

State	Strategies employed to make antagonists available for use and administration
New York	Since 2006, <b>New York</b> has distributed naloxone to patients with the provision of medical supervision. Naloxone is <i>purchased by the city and state health departments and is distributed through hospitals, harm-reduction programs and other entities at no cost to patients</i> . Some hospitals are <u>providing naloxone to family members and one police department pilot program is also providing the antidote</u> . As a result, more than 20,000 kits have been distributed with more than <i>500 overdose reversals</i> . Additionally, <i>in February 2014 a bill was passed allowing doctors and nurses to write standing orders, prescriptions that can be used for anyone, which will be issued to community-based drug treatment programs</i> . These programs will train people on the signs of overdose and provide naloxone kits. <sup>ii</sup>
Rhode Island	<b>Rhode Island</b> has a "collaborative practice agreement" between the <i>Board of Pharmacy, a medical prescriber and the Walgreens pharmacy chain that allows anyone to walk into a Walgreens and obtain naloxone</i> . Twenty-six Walgreens Pharmacies have come on board since the program started a year ago. The pharmacy has a written prescription and provides <u>fifteen minutes of training and an information sheet for anyone who requests naloxone</u> . Additionally, plans are underway to carry naloxone in every State Police cruiser. <sup>iii</sup>
Massachusetts	In <b>Massachusetts</b> , the Overdose Education and Naloxone Distribution (OEND) program, offered in 19 communities, <u>provided bystanders</u> with nasal naloxone rescue kits and training on how to prevent, recognize, and respond to an overdose. <i>2,912 bystanders were trained with 327 rescues reported</i> . Findings suggest that opioid overdose death rates were significantly reduced in communities in which the program was implemented compared to those in which it was not. <sup>iv</sup> Another program offered by the state included offering workshops in five Boston communities for interested residents which provided overdose prevention training, information on how to access naloxone, an overview of substance abuse treatment in Boston, assistance with accessing services, and the opportunity to meet with neighborhood substance abuse coalitions. <sup>v</sup>

State	Strategies employed to make antagonists available for use and administration
Ohio	In 2013, <b>Ohio</b> approved expanding its EMS scope of practice to allow <u>emergency medical responders and emergency medical technicians</u> to administer intranasal naloxone to anyone suffering from an opioid overdose. <i>Administration requires approval from the medical director, a written protocol, and training.</i> <sup>vi</sup>
Multiple	Please see Appendix D for a table from National Association of State Alcohol and Drug Abuse Directors (NASADAD) that provides state-by-state comparison of legislation and other information related to naloxone access; also, Appendix E summarizes the prescribing and immunity strategies of several states.

**2. How many first responders are there in New Hampshire and what communities do they serve? How many of our first responders are now authorized to administer naloxone in New Hampshire? Are they affiliated with fire departments, police departments, ambulance services, other? Are there communities without access to first responders trained in naloxone administration?**

There are currently 5,181 licensed EMS first responders in New Hampshire. This does not include police and some firefighters who may be classified as first responders but who are not a licensed provider of Emergency Medical Services.

License Level	# licensed	# trained in naloxone administration	% of licensed trained in naloxone administration
Emergency Medical Responder	243	1,539	54%
Emergency Medical Technician (EMT)	2,611		
Mid-Level/Advanced EMT	1,323	Included in Advanced EMT mandatory training	100%
Paramedic	1,004	Included in Paramedic mandatory training	100%
<b>Total</b>	<b>5,181</b>	<b>3,856</b>	<b>74.4%</b>

Of the 5,181, approximately 74% are now trained to carry and administer naloxone. Before the on-line training was developed and made available in August, anyone certified in the top two levels of EMS provider levels (Advanced EMT/EMT-I or Paramedic) were already trained, or 100% of those in the top two provider levels of EMS.

Since the Department of Safety's approval of the lower two levels of EMS providers (Emergency Medical Responder or Basic Responder and Basic EMT) to be trained, and the on-line training was made available, 1,539 or approximately 54% of the lower two tiers have been trained.

In terms of communities with access to first responders trained in naloxone administration, New Hampshire communities offer different levels of EMS response through public or private coverage.

These levels include Advanced Life Support (ALS), Basic Life Support (BLS), and First Responder or “fast squad” response. ALS services are the highest support going beyond the task performed by an EMT, which would include pre-hospitalization response and stabilization including cardiac monitoring, intravenous (IV) fluids, and administering IV medications. ALS response will always include at least one Advanced EMT, EMT-Intermediate, or Paramedic. BLS services include transportation and assistance for certain types of care. Finally, the first responder or fast squad response is itself response only as their level of care is limited; it does not include transportation availability.

Therefore, all communities have access to emergency medical services that can administer naloxone, although response time varies by community.

**3. *When and where are opioid antagonists, such as Narcan, being administered? What information is available to confirm its effectiveness in treating overdoses in New Hampshire? What are the associated risks?***

Attached to this report is a map of naloxone doses administered over the most recent 24 month period in New Hampshire. Please see Appendix B for geographic distribution of naloxone administrations for the past 24 months. Note that naloxone may be used for a variety of medical conditions that may or may not be associated with opioid overdose.

EMS provider data entered into the state’s TEMSIS<sup>3</sup> system reveal that at least 72% of naloxone administrations were determined to be effective, although provider impression of effectiveness is subjective, and providers may not be able to determine whether other emergency procedures such as rescue breathing or CPR administered in conjunction with naloxone were the determinants of overdose reversal. The remaining 28% of cases included incidences where provider impressions reflected that naloxone was not effective (20%) and incidences of non-report (8%).

Risks related to naloxone use in opioid-dependent patients are: i) the induction of an acute withdrawal syndrome (the occurrence of vomiting and aspiration is potentially life threatening); ii) the effect of naloxone wearing off prematurely when used for treatment of opioid-induced respiratory depression; and iii) in patients treated for severe pain with an opioid, high-dose naloxone and/or rapidly infused naloxone may cause catecholamine release and consequently pulmonary edema and cardiac arrhythmias. These risks warrant the cautious use of naloxone and adequate monitoring of the cardiorespiratory status of the patient after naloxone administration where indicated<sup>vii</sup>.

The Bureau of EMS articulates that potential risks include rapid onset of withdrawal (nausea, vomiting) and potential relapse because naloxone has a shorter half-life than opioids. Therefore, a person may relapse into overdose after a period of appearing ‘well’ shortly after naloxone administration. Additional potential risks and side effects may include chest pain, agitation, tachycardia, sweating/shivering, hives, and allergic reaction. Rare side effects may also include seizures, abnormal

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<sup>3</sup> TEMSIS is New Hampshire’s Trauma and Emergency Medical Services Information System.

heart rhythm, low blood pressure, accelerated heartbeat, easily angered/annoyed, nervousness, over-excitement, and pulmonary edema.

**4. How many New Hampshire first responders have successfully completed the training developed by the NH Bureau of Emergency Medical Services?**

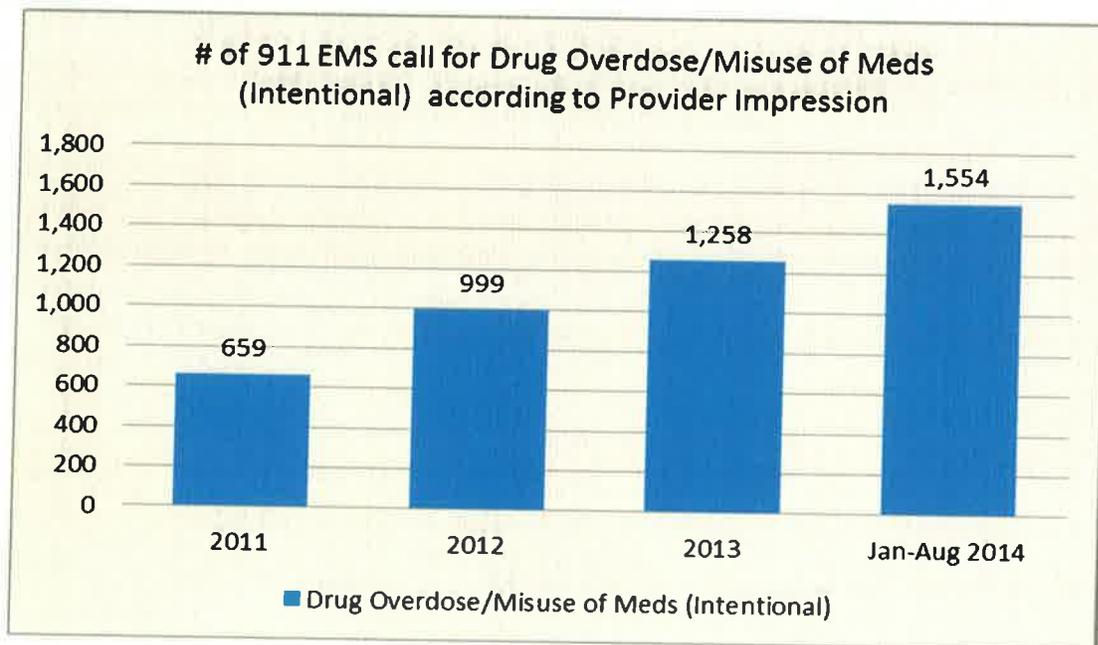
Since the Bureau of EMS developed a new on-line training for naloxone administration in late summer of 2014 for its lower two levels of EMTs, 1,539 first responders in the lower two levels of EMTs have been trained as of October 31, 2014. Training continues to be available and accessed by first responders.

**5. Are police departments interested in accessing the training developed by the Bureau of EMS?**

Chief Richard Crate, president of the NH Chiefs of Police Association, administered an informal phone and email survey of police chiefs across the state to assess interest in naloxone training and administration. Of the 110 responding departments, 55 were interested, 53 were not, and two were unsure.

**6. What are the statistics relevant to overdoses and drug-related incidents occurring in New Hampshire?**

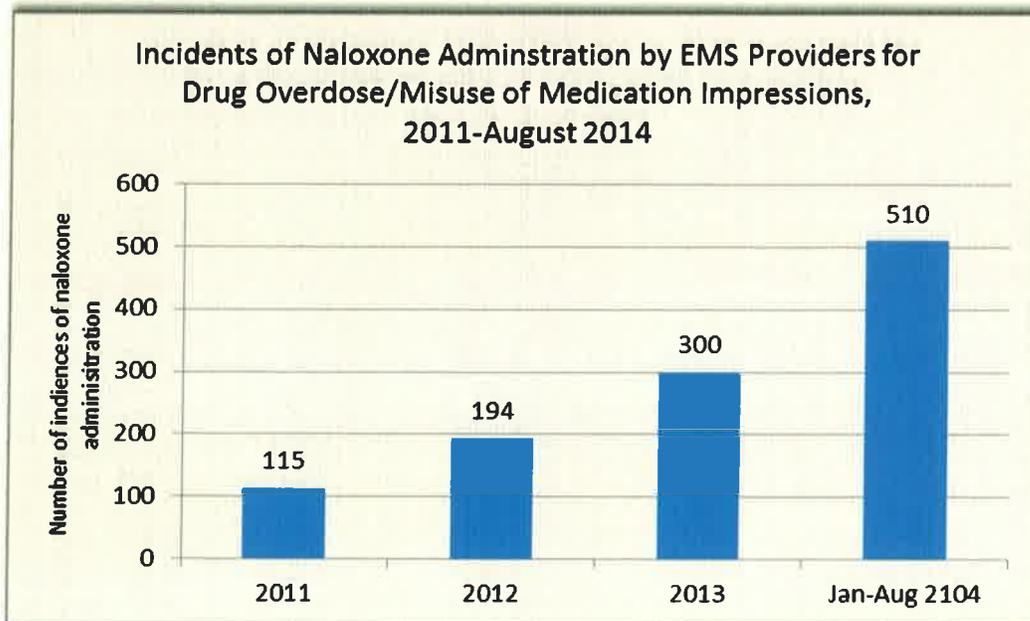
According to data from the Bureau of EMS, the number of 911 calls for emergency services related to drug overdose or intentional misuse of medication has increased significantly each year, from 659 in 2011 to 1,554 for the first eight months of 2014.



Source: NH Bureau of Emergency Medical Services

EMS data also reflect that incidences of naloxone administration in cases of drug overdose or misuse of medication have been increasing over the last several years. In 2011, New Hampshire EMS providers

administered naloxone 115 times in instances of perceived drug overdose or medication misuse. This number increased to 300 in 2013, and to 510 in the first eight months of 2014.

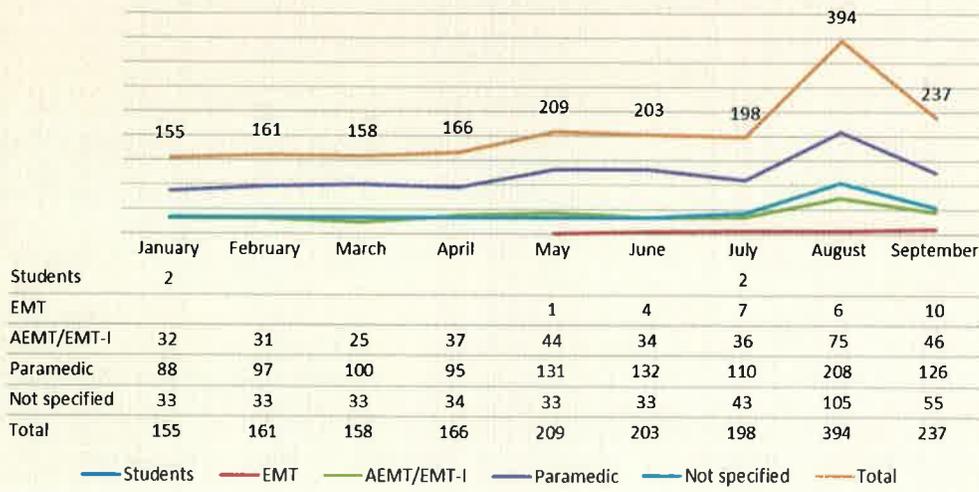


Source: NH Bureau of Emergency Medical Services

The following graph shows the monthly count of naloxone doses<sup>4</sup> administered in 2014 in cases of suspected opioid overdose. There is a significant increase between July and August when trainings were underway. Although naloxone administration for a wide range of medical emergencies has been increasing moderately, naloxone administration specifically for drug overdose or medication misuse has increased substantially, from 16.5% of naloxone doses in 2011 to 49% of doses administered between January and August 2014.

<sup>4</sup> Please note that data referring to “doses” may include duplicated counts in that multiple doses may be administered to the same patient within one recorded incidence of naloxone administration.

### Naloxone Doses Administered in New Hampshire - 2014

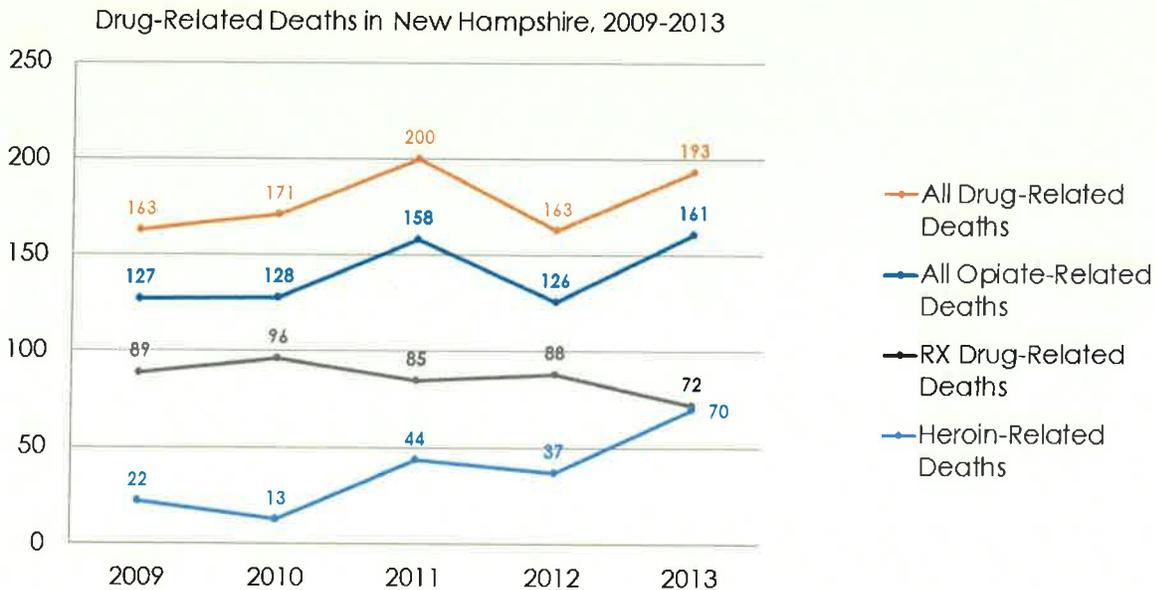


Data compiled by the newly formed New Hampshire Drug Monitoring Initiative of the NH Information and Analysis Center shows increases in other opiate use and overdose indicators. The Initiative's September 2014 report shows data from the NH Division of Public Health Services reflecting an increase in emergency department visits related to heroin increasing from 106 in 2012 to 224 in 2013.

During the first nine months of 2014, there have already been 203 heroin-related ED visits, ranging from lows of 16 per month in February and April to a high of 31 in September. By comparison, the highest per month number of heroin ED visits in 2012 was 14. Counties reporting the highest number of heroin-related ED visits in August and September were Hillsborough, Merrimack, and Rockingham. August and September ED visits were primarily for patients between the ages of 20 and 39, and approximately twice as many males as females.

The Drug Monitoring Initiative also reported that 128 individuals 25 years old and younger and 322 individuals 26 and older were admitted to state-funded treatment programs for heroin and prescription opiate dependence between August and September of this year.

As the graph below indicates, according to data provided by the NH Medical Examiner's Office, the number of prescription drug related deaths decreased between 2010 and 2013, from 96 to 72. During the same time period, however, the number of heroin related deaths increased from 13 to 70, a five-fold increase. A recent communication from the Medical Examiner's office indicates that opiate-related deaths may be on track to double in 2014.



Geospatial maps have been created to depict EMS calls related to drug overdose and drug-related deaths for different geographic areas of the state. Please see Appendix C for a geographic depiction of opioid-related and heroin-related deaths<sup>5</sup>.

In general, data and information from the Department of Safety, the Medical Examiner's Office, and individual Emergency Rooms is indicating that heroin use is usurping prescription opioid abuse in terms of the prevalence of medical emergencies such as overdose.

**7. What other options are there for treating overdoses?**

The Bureau of EMS indicates that CPR/rescue breathing is considered the main tool to combat overdose deaths for anyone responding to an overdose situation, as the main concern for these patients is the respiratory depression caused by the opioid. In addition, the administration of oxygen may be effective when combined with CPR/rescue breathing.

**8. Should anyone else be given authority to administer naloxone or a similar opioid antagonist and how would such authority be implemented?**

Please see task force recommendations at the beginning of this report.

**9. What are the costs and benefits associated with broader administration of opioid antagonists?**

The main costs include the medication and training. Intranasal naloxone kits cost approximately \$20-\$40 per dose. There are incidences when multiple doses are used on a call. On-line training is available

<sup>5</sup> Heroin-related deaths are a subset of opioid-related deaths, a broader category that includes multiple prescription and illicit opioids.

through the Bureau of EMS at no to nominal cost, but there is an associated cost to the practical component of CPR/Rescue breathing and First Aid. The costs of practical training include instructor's time, supplies, and issuing certification. Other costs are personnel time for up 8 hours of training; development and printing costs for resource information about treatment and recovery services available to people experiencing opioid dependence; and other operational costs.

The benefits of wider naloxone availability will be in terms of lives saved, increases in individuals seeking treatment for opioid dependence, and a much broader awareness of the danger of opioid use and of treatment and recovery opportunities available.

***10. What recommendations does the work group have to ensure that New Hampshire is protecting its citizens against the harmful effects of opioid overdoses through the availability and administration of opioid antagonists?***

Please see task force recommendations at the beginning of this report.

## APPENDIX A: GOVERNOR HASSAN LETTER OF REQUEST



MARGARET WOOD HASSAN  
Governor

### STATE OF NEW HAMPSHIRE OFFICE OF THE GOVERNOR

September 8, 2014

John Barthelmes  
Commissioner  
New Hampshire Department of Safety  
33 Hazen Drive  
Concord, NH 03301

Re. Combating the Overdose Deaths Caused by Heroin and Other Opioids in New Hampshire – Strategic Task Force

Dear Commissioner Barthelmes:

The rising rates of opioid abuse and the resulting increase in prescription drug and heroin overdoses represent one of the most pressing public health and safety challenges facing New Hampshire. Drug-related deaths have been increasing in New Hampshire, consistently surpassing the number of traffic-related deaths since 2009. The recent rise in heroin abuse is directly related to the increase in prescription drug abuse. Emergency Department visits related to heroin have also escalated in recent years and heroin-related deaths have increased exponentially since 2010.

This spike in heroin abuse in New Hampshire reflects regional and national trends and is a major public health challenge. We have undertaken a number of important efforts with stakeholders and the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery to implement strategies to combat drug abuse in New Hampshire and to prevent overdose deaths. In addition, I have joined with four other New England governors in an effort to develop a regional strategy that builds on our statewide efforts.

As part of those efforts, the Department of Safety has made it possible for an additional 2,625 emergency medical first responders to administer opioid antagonists with appropriate training, and correspondingly developed state-of-the-art training modules for first responders in order to prepare them for the treatment of individuals suffering an opioid overdose.

While these steps represent significant public safety improvements, there is still more to do, and the need to answer additional questions about the use and availability of Narcan or other opioid antagonists in order to determine how to continue to strengthen our response to the opioid addiction crisis. The Prescription Drug Abuse Task Force co-chair, Assistant Attorney General James Vara, has agreed to assist you, or your designee, in leading a work group to investigate

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TDD Access: Relay NH 1-800-735-2964

what further action New Hampshire should take to ensure our state's readiness to prevent overdose injuries and deaths in New Hampshire. The Information and Analysis Center of the Department of Safety established pursuant to RSA 651-F will play a critical role in providing information to the Subcommittee as it works towards developing its strategic recommendation.

To this end, I ask that a work group meet and report to me on the following issues by October 31, 2014:

1. Are appropriately administered opioid antagonists a demonstrated means to protect against opioid overdose deaths? If so, how have other states made such antagonists available for use and administration?
2. How many first responders are there in New Hampshire and what communities do they serve? How many of our first responders are now authorized to administer Narcan in New Hampshire? Are they affiliated with fire departments, police departments, ambulance services, other? Are there communities without access to first responders trained in Narcan administration?
3. When and where are opioid antagonists, such as Narcan, being administered? What information is available to confirm its effectiveness in treating overdoses in New Hampshire? What are the associated risks?
4. How many New Hampshire first responders have successfully completed the training developed by the Bureau of Emergency Medical Services?
5. Are police departments interested in accessing the training developed by the Bureau of Emergency Medical Services?
6. What are the statistics relevant to overdoses and drug-related incidents occurring in New Hampshire?
7. What other options are there for treating overdoses?
8. Should anyone else be given authority to administer Narcan or a similar opioid antagonist and how would such authority be implemented?
9. What are the costs and benefits associated with broader administration of opioid antagonists?
10. What recommendations does the work group have to ensure that New Hampshire is protecting its citizens against the harmful effects of opioid overdoses through the availability and administration of opioid antagonists?

Members of the Task Force shall include the following:

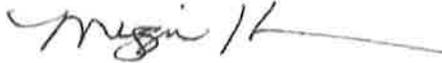
1. Commissioner of Safety, John Barthelmes, or designee, Co-Chair
2. James Vara, Co-Chair, Chief of NH Department of Justice, Drug Prosecution Unit
3. David Lang, New Hampshire Firefighters
4. Nick Mercuri, NH Department of Safety, Emergency Services
5. Colonel Robert Quinn, NH State Police
6. Joseph Harding, NH Bureau of Drug and Alcohol Services
7. Lisa Mure, Center for Excellence/Community Health Institute

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8. Tricia Lucas, Advocacy Director, New Futures
9. Chief Richard Crate, Enfield Police Department
10. Melissa Silvey, Goodwin Health Center/Regional Network Coordinator
11. D. Paul DiMaggio, Atkinson, NH
12. Seddon Savage, M.D.

Thank you for your ongoing hard work and attention to the safety of our New Hampshire citizens.

With every good wish,



Margaret Wood Hassan  
Governor

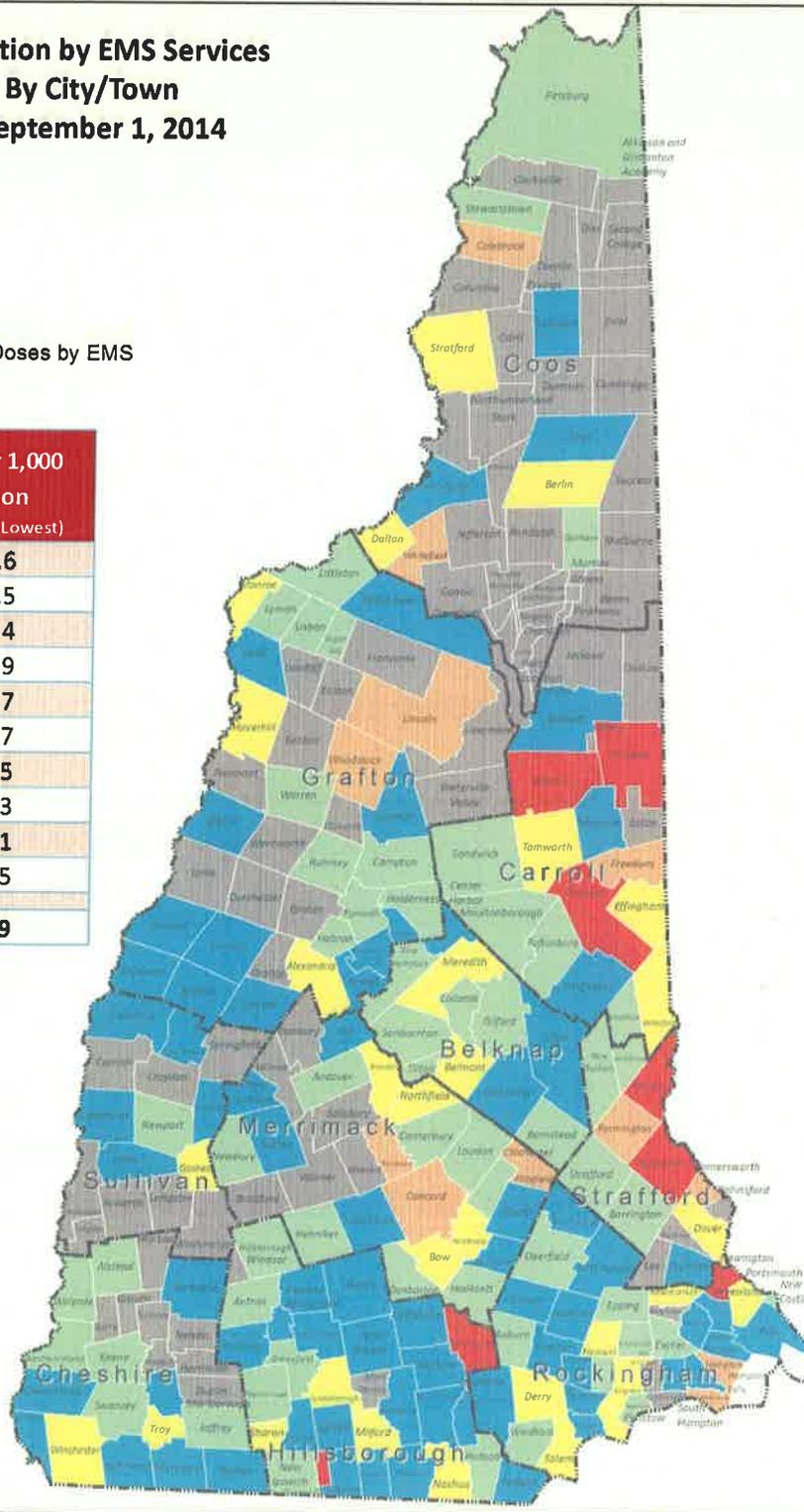
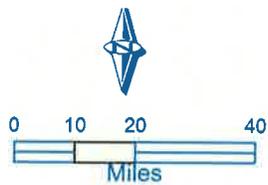
APPENDIX B: EMS NALOXONE ADMINISTRATION BY TOWN

**Naloxone Administration by EMS Services per 1,000 population By City/Town September 1, 2012-September 1, 2014**

- Less than 1
- 1
- 2
- 3
- 4-6
- No Reported Naloxone Doses by EMS

County	Rate per 1,000 population (Highest to Lowest)
Strafford	2.6
Carroll	2.5
Hillsborough	2.4
Merrimack	1.9
Belknap	1.7
Rockingham	1.7
Coos	1.5
Cheshire	1.3
Grafton	1.1
Sullivan	0.5
State	1.9

Data Source: New Hampshire Bureau of EMS



## APPENDIX C: OPIATE- AND HEROIN-RELATED DEATHS AND DEATH RATE BY COUNTY

### Number of Opiate Related Overdose Deaths in New Hampshire, 2013

#### Deaths by City/Town

- 1 to 5 deaths (aggregated)
- # 6 or more (actual count provided)

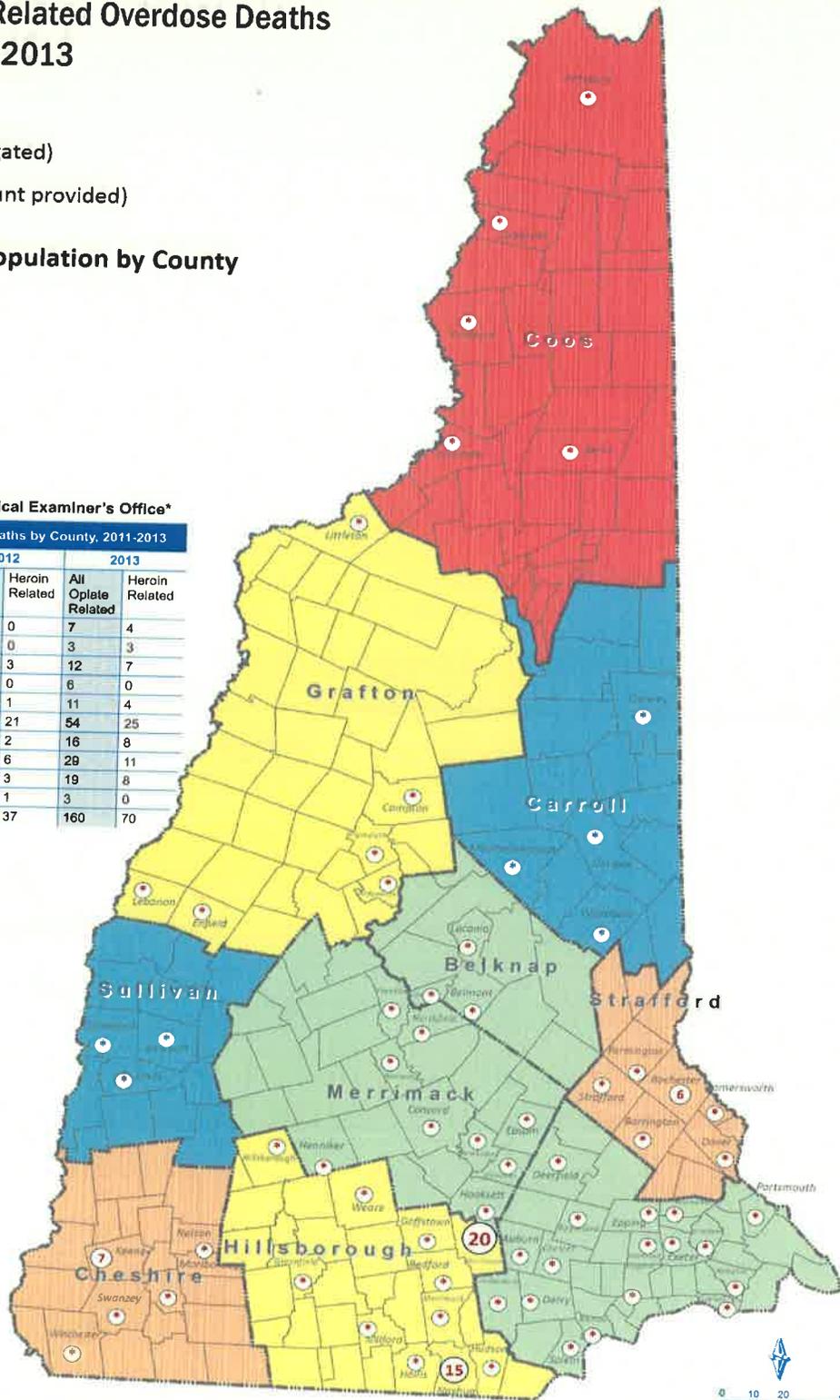
#### Deaths per 100,000 Population by County

- 7 - 8
- 9 - 12
- 13
- 14 - 16
- 17 - 18

Data Source: New Hampshire Medical Examiner's Office\*

Number of Opiate and Heroin Related Deaths by County, 2011-2013

County	2011		2012		2013	
	All Opiate Related	Heroin Related	All Opiate Related	Heroin Related	All Opiate Related	Heroin Related
Belknap	7	2	4	0	7	4
Carroll	4	0	4	0	3	3
Cheshire	9	3	11	3	12	7
Coos	5	0	3	0	6	0
Grafton	9	0	6	1	11	4
Hillsborough	56	19	45	21	54	25
Merrimack	14	5	11	2	16	8
Rockingham	35	12	25	6	29	11
Strafford	13	3	13	3	19	8
Sullivan	0	0	4	1	3	0
<b>TOTAL</b>	<b>152</b>	<b>44</b>	<b>126</b>	<b>37</b>	<b>160</b>	<b>70</b>



\*Determinations of drug involvement may change due to additional testing after initial autopsies; therefore, totals reflected here based on Medical Examiner data as of July 2014 may be different from previously reported data or from data available through the state's Division of Vital Records Administration.



APPENDIX D: NASADAD 2013 Overview of State Legislation to Increase Access to Treatment for Opioid Addiction

FIGURE 2: OVERVIEW OF RECENT ENACTED STATE OPIOID OVERDOSE LEGISLATION

States	Year	Citation	Good Samaritan	911 as Mitigating	3 <sup>rd</sup> Party Prescription	Standing Orders	Liability Protections	Naloxone Program	Educational Strategies
<b># States</b>		20	15	10	14	6	17	9	6
Alaska	2008	<a href="#">Stat. 12.55.155</a>		X					
California	2010	<a href="#">AB 2145</a>					X	X	
	2012	<a href="#">AB 472</a>	X						
	2013	<a href="#">AB 635</a>			X	X	X		
Colorado	2012	<a href="#">SB 12-020</a>	X						
	2013	<a href="#">SB 13-014</a>			X		X		
Connecticut	2011	<a href="#">Public Act No. 11-210</a>	X						
	2012	<a href="#">Public Act No. 12-159</a>					X		
Delaware	2013	<a href="#">SB No. 116</a>	X						
DC	2013	<a href="#">B19-0754</a>	X	X			X		X
Florida	2012	<a href="#">SB No. 278</a>	X						
Illinois	2009	<a href="#">Public Act 096-0361</a>			X	X	X	X	X
	2012	<a href="#">Public Act 097-0678</a>	X	X					
Kentucky	2013	<a href="#">HB 366</a>			X	X	X		
Maryland	2009	<a href="#">Crim. Proc. 1-210</a>		X					
	2013	<a href="#">SB 610</a>			X		X	X	
Massachusetts	2012	<a href="#">Ses. Law, Chap. 192, Sects 32 &amp; 11</a>	X	X	X		X		
New Jersey	2013	<a href="#">SB 2082</a>	X		X	X	X	X	X
New Mexico	2001	<a href="#">Stat. Ann. 24-23-1; NMAC 7.32.7-10</a>					X	X	
	2007	<a href="#">SB 0200</a>	X	X					
	2006	<a href="#">Public Health Law 3309</a>					X	X	
New York	2007	<a href="#">Tit. 10, 80.138 (Regulation)</a>			X				
	2011	<a href="#">S4454-B</a>	X	X					
	2012	<a href="#">A10623</a>							X
North Carolina	2013	<a href="#">SB 20</a>	X		X	X	X		
Oklahoma	2013	<a href="#">HB 1782</a>			X				
	2013	<a href="#">HB 1419</a>							X
Oregon	2013	<a href="#">SB 384</a>			X		X	X	
Rhode Island	2012	<a href="#">H 7248</a>	X	X			X		
Vermont	2013	<a href="#">Act No. 71; Act No. 75</a>	X	X	X	X	X	X	X
Virginia	2013	<a href="#">HB 1672</a>			X		X	X	

**APPENDIX E: OTHER STATES' IMMUNITY AND NALOXONE PRESCRIBING STRATEGIES**

<b>PROFESSIONAL IMMUNITY</b>	<b>LAYPERSON IMMUNITY</b>	<b>PRESCRIPTION TO THIRD PARTIES</b>
<p>State: Connecticut Law: Conn. Gen Stat. § 17a-714a</p> <p>A licensed healthcare professional who is permitted by law to prescribe an opioid antagonist is immune from civil action or criminal prosecution if he or she, acting with reasonable care, prescribes, dispenses, or administers an opioid antagonist to treat or prevent a drug overdose.</p>	<p>A person is immune from civil action or criminal prosecution if he or she, acting with reasonable care, administers an opioid antagonist to a person he or she believes, in good faith, is experiencing an opioid-related drug overdose. A person, other than a licensed health care professional is immune from civil action or criminal prosecution if, in acting in the ordinary course of such person's employment, he or she administers an opioid antagonist.</p>	
<p>State: Maine Law: 22 Me Rev. Stat. Ann. § 2353</p> <p>A health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe and dispense an opioid antagonist to a person at risk of experiencing an opioid-related drug overdose, and such a prescription must be regarded as being issued for a legitimate medical purpose in the usual course of professional practice. A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist is immune from professional review, civil action, or criminal prosecution.</p>	<p>A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be experiencing an opioid-related drug overdose is immune from professional review, civil action, or criminal prosecution for such act.</p>	<p>A health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe and dispense an opioid antagonist to a to a family member or friend of a person at risk of experiencing an opioid-related drug overdose, or another person in a position to assist a person at risk of experiencing an opioid-related drug overdose, and such a prescription must be regarded as being issued for a legitimate medical purpose in the usual course of professional practice. A health care professional who, acting in good faith and with reasonable care,</p>

PROFESSIONAL IMMUNITY	LAYERPERSON IMMUNITY	PRESCRIPTION TO THIRD PARTIES
<p><b>Jurisdiction: Massachusetts</b></p> <p>A healthcare professional may prescribe and dispense Naloxone or another opioid antagonist to a person at risk of experiencing an opiate-related overdose, and such a prescription “shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.” If so, the professional is immune from professional review or criminal liability</p>	<p><b>Law: Mass. Gen. Laws Ann., ch 94C, § 19(d) and § 34A</b></p> <p>A person who, seeks medical assistance for someone experiencing a drug-related overdose or who, in good faith, administers naloxone to an individual appearing to experience an opiate-related overdose is immune from criminal prosecution for possession of a controlled substance.</p>	<p>prescribes or dispenses an opioid antagonist is immune from professional review, civil action, or criminal prosecution.</p> <p>A healthcare professional may lawfully prescribe and dispense Naloxone or another opioid antagonist to a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose, and such a prescription “shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.”</p>
<p><b>State: Rhode Island</b></p> <p>A health care professional with a current license may, directly or by standing order, prescribe, dispense, and distribute naloxone (Narcan) to an individual at risk of experiencing an opioid-related overdose. Such a healthcare professional is immune from professional review, civil action, or criminal prosecution</p>	<p><b>Law: R.I. Gen. Laws §§ 21-28.8-1 to 21-28.8-5</b></p> <p>A person may administer an opioid antagonist to another person if: he or she believes, in good faith, that the other person is experiencing a drug overdose; and he or she acts with reasonable care in administering the drug to the other person. Such person who administers an opioid antagonist to another person is immune from civil liability or criminal prosecution, as use of naloxone (Narcan) is considered to be first aid or emergency treatment, and any person may lawfully possess naloxone (Narcan).</p>	<p><b>R23-1-OPIOID R.I. Code R. §§ 1 to 312</b></p> <p>A health care professional with a current license may, directly or by standing order, prescribe, dispense, and distribute naloxone (Narcan) a family member, friend, or other person in a position to assist an individual at risk of experiencing an opioid-related overdose.</p>
<p><b>State: Vermont</b></p> <p>A healthcare professional, acting in good faith, may, directly or by standing order, prescribe,</p>	<p><b>Law: Vt. Stat. Ann., tit. 18, § 4240(c) to (e)</b></p> <p>A person may administer an opioid antagonist to a victim if he or she believes, in good faith, that</p>	<p>A healthcare professional, acting in good faith, may, directly</p>

PROFESSIONAL IMMUNITY	LAYERPERSON IMMUNITY	PRESCRIPTION TO THIRD PARTIES
<p>dispense, and distribute an opioid antagonist to someone educated about opioid-related overdose prevention and treatment and who is at risk of experiencing an opioid-related overdose. The professional is immune from civil liability or criminal prosecution with regard to the subsequent use of the opioid antagonist, unless the health professional's actions with regard to prescribing, dispensing, or distributing the opioid antagonist constituted recklessness, gross negligence, or intentional misconduct.</p>	<p>the victim is experiencing an opioid-related overdose. Such a person is immune from civil liability or criminal prosecution for administering the opioid antagonist unless the person's actions constituted recklessness, gross negligence, or intentional misconduct.</p>	<p>or by standing order, prescribe, dispense, and distribute an opioid antagonist to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose and who is educated about opioid-related overdose prevention and treatment.</p>

<sup>i</sup> Community-Based Opioid Overdose Prevention Programs Providing Naloxone, *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, Vol 61:6.

<sup>ii</sup> *How to Stop Heroin Deaths*, New York Times (February 6, 2014), [http://www.nytimes.com/2014/02/07/opinion/how-to-stop-heroin-deaths.html?\\_r=0](http://www.nytimes.com/2014/02/07/opinion/how-to-stop-heroin-deaths.html?_r=0).

<sup>iii</sup> *Rhode Island makes lifesaving overdose drug easily available*, Providence Journal (February 15, 2014), <http://www.providencejournal.com/breaking-news/content/20140215-rhode-island-makes-lifesaving-overdose-drug-easily-available.ece>.

<sup>iv</sup> Walley, A., et al. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ: British Medical Journal* 346.

<sup>v</sup> <http://www.bostonmagazine.com/health/blog/2014/02/13/mayor-marty-walsh/>

<sup>vi</sup> As heroin problems surge, states expand access to overdose reversal drug, *The Christian Science Monitor* (February 20, 2014), <http://www.csmonitor.com/USA/2014/0220/As-heroin-problems-surge-states-expand-access-to-overdose-reversal-drug-video>.

<sup>vii</sup> Naloxone treatment in opioid addiction: the risks and benefits. *Expert Opinion on Drug Safety*. 2007 Mar;6(2):125-32. van Dorp E1, Yassen A, Dahan A.