TREATMENT TASK FORCE

Governor's Commission on Alcohol and other Drugs

Task Force Chair: Stephanie Savard

September 18, 2020 Meeting Minutes		
Welcome & Introductions	**Participating Members:** Stephanie Savard, Jake Berry, Danni Bultemeier, Alex Casale, Monica Edgar, Susan Latham, Dianne Castrucci, Sara Cleveland, Sue Thistle, Emily Robbins, Shanna Large, Stephen Noyes, Kerran Vigroux **Participating Non-Members:** Paul Kiernan, John Karikas, Hannah Lessels, Joee Lindbeck, Susan McKeown, Peter Burke, Heather Smith, Donna Harbison	
Agenda Item	**Discussion**	**Action Steps**
Review of July Minutes	• Stephen Noyes motioned to approve the minutes. Monica Edgar seconded the motion. • 7 members voted to approve the minutes, and 0 members voted against approving the minutes. 5 members abstained from voting. The meeting minutes were approved.	• CHI will post the minutes on the Center's website.
New Business & Announcements	• Jamie Powers is stepping down from the Task Force and recommended Sara Cleveland as a replacement. Monica Edgar motioned to approve Sara Cleveland as a new Task Force member representing the Bureau of Drug and Alcohol Services. Dianne Castrucci seconded the motion. • All Task Force members unanimously voted to approve Sara Cleveland as a Treatment Task Force member. No members voted against approval or abstained from voting. Sara Cleveland was approved as a Task Force member.	
Involuntary Civil Commitment Act Review and Final Decision	• A multitude of resources have been shared with members to inform them about the benefits and shortcomings of ICC, including a literature review, presentations from state governments that have ICC in place, and testimonials from individuals with lived experience and medical professionals. • Members discussed the benefits and drawbacks of implementing an ICC program in New Hampshire. Task Force members listed the following as being reasons for supporting ICC: • Task Force members who have worked in clinical settings in states with ICC have said that they have had patients who said they benefited from their time involuntarily committed.	• Stephanie and members of the Task Force will finalize caveats to accompany their vote against ICC to present to the Governor's Commission.

	• ICC could lead to a decrease in crimes such as DWIs. • It is better for patients to be involuntarily committed than for them to be in the criminal justice system. • Other mandatory services, such as mandatory drug court, have proven to be effective in New Hampshire. • Task Force members who have worked in clinical settings have said that they have had patients who did not respond to other treatments and would have benefitted from ICC. • ICC would be beneficial for ensuring that patients who are taken to the emergency room because they are suffering from an overdose get the treatment they need and would be complementary and analogous to involuntary commitment services already in use for patients suffering from psychosis. • Task Force members listed the following as drawbacks of ICC or reasons for not supporting ICC: • There is not a guarantee that ICC would be implemented in a way that ensures the children of involuntarily committed mothers receive childcare. • For some patients, other treatments would be more effective than ICC. • In other states, police officers' involvement in the ICC process eroded trust in the ICC program and SUD services. • There is not a body of credible research showing conclusively that ICC is more effective than other treatments. • Some members fear that there could be racial and ethnic disparities in the rates at which people are committed. • Some members fear that ICC would lead to the treatment of SUD like a crime instead of like an addiction. • Some members feel that New Hampshire does not have the infrastructure to ensure that committed patients will always be treated therapeutically. • There is no guarantee that patients will have GALs or advocates. • ICC would open providers up to lawsuits if a patient's family wants the patient to be committed but the patient does not qualify and later dies due	

	to SUD. • ICC legislation could be created without input from SUD treatment experts or input from ASAM and end up not being therapeutic or effective. • Some Task Force members shared that while they are open to ICC if it is implemented in a way that ensure patients receive therapeutic treatment, they do not feel comfortable voting to recommend that legislators develop an ICC model because there is no guarantee the concerns that were voiced would be addressed. This led to a discussion of caveats that would be submitted along with the results of their vote. • Alex Casale motioned to not support the implementation of involuntary commitment for SUD in New Hampshire. Kerran Vigroux seconded the motion. However, Alex rescinded the motion to allow someone else to put forth a non-negative and therefore less confusing motion. • Jake Berry motioned to support the implementation of involuntary commitment for SUD in New Hampshire. Alex Casale seconded the motion. • 5 members voted to approve ICC, and 6 members voted not to approve ICC. 1 member abstained from voting, and 1 member who was present for roll call left before a vote was conducted. ICC was not approved by the Task Force. • Members discussed potential caveats to submit along with their No vote. The group established that they voted against ICC because they were concerned about current infrastructure and the capacity to ensure that the process was therapeutic, but if those concerns were addressed, the Task Force would potentially vote differently in the future. They also said that if the governor's commission voted to implement ICC they would want some treatment Task Force members and other treatment professionals to be involved in creating the program. Members also shared that they would like for the program to include childcare, allow for visitations, include patient advocates, be data-driven, be used only in extreme cases of SUD, not be recorded on a patient's criminal record, and to require cultural competency training for staff.	
State Plan and Specific Treatment Task	• An unofficial poll was conducted to determine which 3 priority areas out of 12 potential possibilities would be future areas of focus. The priority areas that were selected are to support practice change to integrate SUD services with mental	

Force Priorities	health services in general healthcare settings including emergency, to increase specialized treatment services for specific populations (e.g. veterans, youth, pregnant/parenting women and their families), and to provide training to all providers and service professionals related to trauma-informed best practices and harm reduction strategies.	
Policy Updates	• Jake Barry reported on legislative updates regarding GOERR funds that were allocated to behavioral health and SUD. $6 million was dedicated and will be dispersed through recovery housing, closed loop referral, SUD non-profits, outreach/public health, and recovery friendly workplace initiative.	

Next Meeting: Friday November 6, 2020, 9am-11am (Virtually); **Zoom Information:** https://jsi.zoom.us/j/819262402;
Call-In Information: 646-558-8656; **Meeting ID:** 946 1611 3705; **Passcode:** 989557