State of Connecticut

Department of Mental Health and Addiction Services

Triennial State Substance Use Plan

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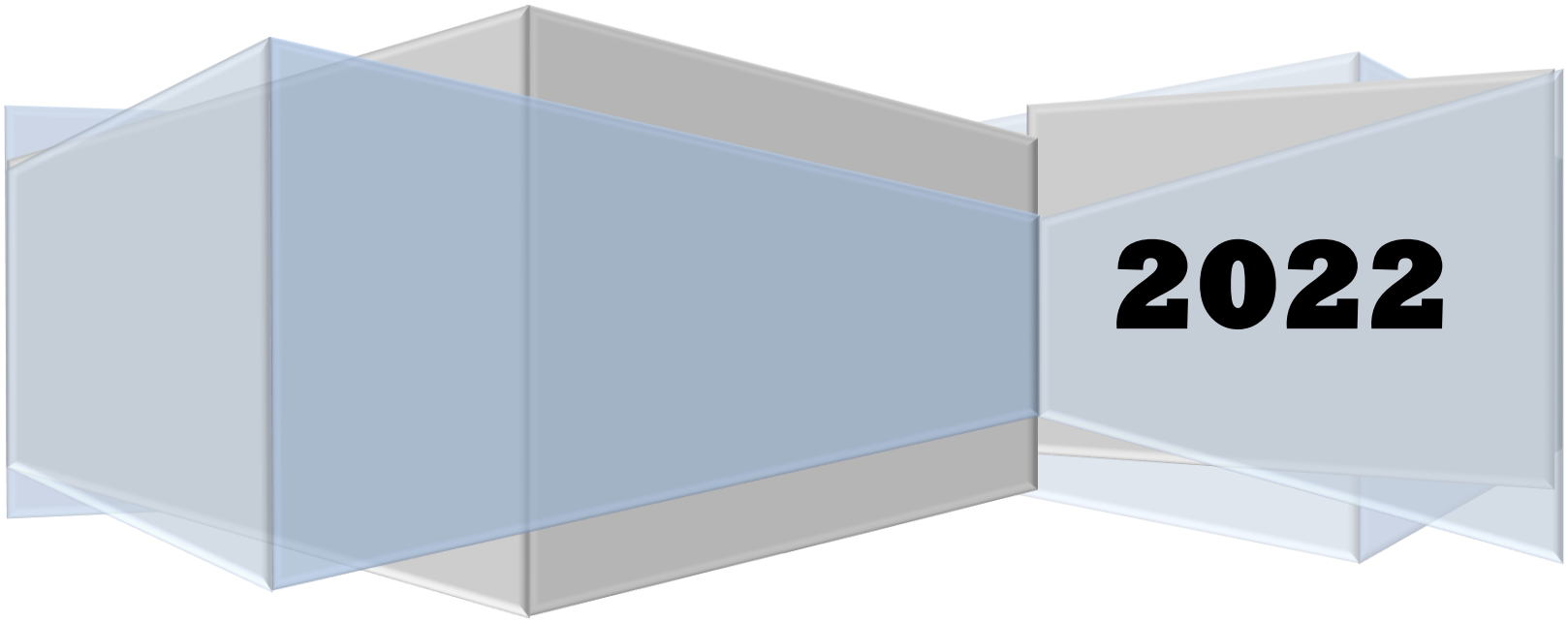


Table of Contents

Introduction

The Connecticut Department of Mental Health and Addiction Services has been directed through legislation to triennially develop a state substance use plan. The plan historically has served to capture information about all of the state funded substance use services regardless of which agency provides them. Therefore, this report includes information from any of thestate agencies (executive and judicial branches) that are involved in delivering substance use services. The report defines a range of strategies that will guide the state's efforts and then includes information about the accomplishments that were achieved over the past three years.

Since the last plan was developed, Connecticut and the nation were heavily impacted by COVID-19. The pandemic has had major impacts on the substance use system in Connecticut in two of the three years included in this report. The impact began in the late spring of 2020 and has been influencing the service system since that time. While the service system has begun to rebound from its impacts, COVID-19 continues to negatively affect the service system as the pandemic has waxed and waned. The most recent progressions associated with COVID-19 seem to indicate that the country should be prepared for new variants and periodic spikes.

There was a reduction in services throughout the pandemic, which is evidenced by lower admission rates across the system and decreased numbers of individuals served. There are multiple reasons for this reduction: providers reduced capacity especially within the residential services system as they tried to comply with restrictions imposed by the pandemic such as social distancing and quarantining; service reductions occurred in outpatient services as providers restricted in-person services; agencies adapted as insurers began to permit the use of telehealth services as a new mechanism for service provision (some providers that were more technologically sophisticated were better positioned to make that change); and some people were less likely to seek services during the height of the pandemic due to public health restrictions and overall uncertainty of virus contagion.

Another issue has continued to heavily impact the focus of many of the state agencies' activities. Connecticut has remained in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. This was a substantial issue when the Triennial Reports in both 2016 and 2019 were developed. Despite a comprehensive effort to address this issue, overdose deaths continue to escalate. Fentanyl is now the main contributor toward the rising overdose deaths. The use of opioids and opioid use disorders (OUD's) remain a top priority in the state and will continue to be a focus of state agencies over the next three years.

As a substance use service system, DMHAS must maintain a comprehensive treatment system while also dealing with these newly emerging issues or threats. This triennial report will include goals and strategies focused on the pandemic's impact on the service system while also continuing efforts to address the opioid crisis. This triennial report will build on core strategies and actions that were included in the 2019 plan. Like the previous report, this year's report will continue its focus on the opioid epidemic by including a Triennial Report Opioid Annex. Much has been done over the past three years to address the opioid epidemic but more work remains. This triennial

report will also include a distinct section focused on substance use and women, as dictated by enacted legislation in fiscal year 2018.

The Department would like to thank Governor Lamont, the Connecticut legislature and all of the state agencies that are involved in this important work. Connecticut remains a national leader in the provision of behavioral health services thanks to the leadership at multiple levels within state government. The Commissioners and staff at each of the agencies providing substance use services in the state continue to deliver a number of innovative activities designed to enhance that state's service system while also working to address emerging issues. This report provides information about the many accomplishments that were achieved in the past three years while focusing attention on areas where more needs to be done.

Background and Legislative Intent

Legislation originally enacted in 2002 required the Department of Mental Health and Addiction Services (DMHAS) to submit the state's substance use plan biennially. That legislation required DMHAS to submit the Report to the Legislature, Office of Policy and Management and the Alcohol and Drug Policy Council. The legislation was amended in 2013, shifting the report cycle to a triennial basis and the language requiring DMHAS to submit the plan to the groups described above was eliminated. The initial Triennial Report was completed in 2016. Legislation that occurred in the 2018 legislative session required DMHAS to include a report on women with substance use issues in the Triennial Report. The 2019 Triennial Report added that section in order to comply with the recently enacted legislation.

The state's substance use plan includes comprehensive strategies for the prevention, treatment, and reduction of alcohol and drug use problems. The legislation is specific about various elements that must be included in the report. The legislation requires a mission statement, a vision statement, and goals for providing treatment and recovery support services to individuals with substance use disorders. In addition, the Department is required to report on emerging substance use trends, statistical and demographic information about the individuals being served in the state substance use treatment system, and the performance measures used to evaluate program effectiveness. The plan organizes actions under six key strategy areas. As in past years, information provided by any sister state agencies regarding the substance use services they have provided and will provide during the next reporting cycle is included.

The 2022 Triennial Report will continue to draw heavily on the work of the Alcohol and Drug Policy Council (ADPC) and the charge that was given to them during Governor Malloy's tenure. During the 2015 legislative session, Governor Dannel Malloy introduced and signed "An Act Concerning Substance Abuse and Opioid Overdose Prevention" into law. That bill, Public Act 15-198, reconstituted the Alcohol and Drug Policy Council with the Commissioners of DMHAS and DCF as co-chairs. Currently, Commissioner Navarretta (DMHAS) and Commissioner Dorantes (DCF) serve as the co-chairs.

DMHAS Mission and Vision

MISSION STATEMENT

The mission of the Department of Mental Health and Addiction Services is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect.

VISION STATEMENT

Connecticut envisions a recovery-oriented system of behavioral health care which offers all State's citizens, across the lifespan, an array of accessible services and recovery supports and the ability to choose those services which are most effective in addressing their particular behavioral health condition or combination of conditions. These services and supports will be culturally and gender responsive, build on personal, family, and community strengths, and have as their primary and explicit aim the promotion of the person/family's resilience, recovery, and inclusion in community life. Finally, services and supports will be provided in an integrated and coordinated fashion within the context of a locally managed system of care in collaboration with the surrounding community, thereby ensuring continuity of care both over time (e.g., across episodes) and across agency boundaries, thus maximizing the person's opportunities for establishing, or re-establishing, a safe, dignified, and meaningful life in the community of his or her choice. Connecticut's vision is based on the following underlying values:

- The belief that recovery from mental illnesses and substance use disorders is possible and expected;
- An emphasis on the role of positive relationships, family supports, maintaining recovery, achieving sobriety, and promoting personal growth and development;
- The priority of an individual or family to determine their pathway to recovery, stability, and self-sufficiency;
- The importance of cultural inclusion, cultural competence and gender- and age-responsiveness in designing and delivering behavioral health services and recovery supports;
- The central role of hope and empowerment in changing the course of individual's lives; and
- The necessity of state agencies, community providers, and consumer/recovery communities coming together to develop and implement a comprehensive continuum of behavioral health promotion, prevention, early intervention, treatment, and rehabilitative services.

DMHAS Statewide Substance Use Service System

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health and substance use prevention and treatment throughout Connecticut.

While the Department's prevention programs serve all Connecticut citizens regardless of age, its treatment mandate is to serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, pregnant women who use substances, persons with traumatic brain injury or hearing impairment, those with co-occurring substance use and mental illness, and special populations transitioning out of the Department of Children and Families.

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance use. As such, it provides a variety of treatment services on a regional basis to persons with substance use disorders, including withdrawal management, intensive and intermediate residential services, and medication assisted treatment/medication for opioid use disorder, which encompasses Opioid Treatment Programs/methadone maintenance, buprenorphine and naltrexone. Opioid Treatment Programs (OTP's) reflects current terminology used to describe services that were previously classified as methadone maintenance. The system also provides outpatient, partial hospitalization, and recovery supports services. **DMHAS' budget for substance use services in FY 21 was just over $142,000,000** and blends state general funds with federal discretionary grants and block grant funds.

DMHAS continues to benefit from federal support for substance use services. The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided block grant funding as well as discretionary grants for substance use services. While some discretionary grants have expired since our last report, DMHAS has received new discretionary grants. In addition, SAMHSA has recognized the devastating impact the pandemic has had on behavioral health services. As a result, SAMHSA provided one-time, supplemental, time-limited funding in the amount of $32,000,000 in additional to regular, annualized Substance Abuse and Prevention Treatment (SAPT) Block Grant funds. This amount combines Supplemental Block Grant funds and specialized funding received through the federal ARPA program. The grant periods for these funds differ with one grant extending into 2023 and several other grants extending until September 30, 2025.

The DMHAS substance use treatment system includes over 50 private not-for-profit providers over 300 programs. These services include those provided to individuals with co-occurring disorders as many people who struggle with mental illnesses also struggle with alcohol and/or drug addiction. Building our capacities to treat co-occurring disorders has been a priority of DMHAS for the past 10 years. Contracted providers deliver a comprehensive spectrum of services that includes withdrawal management, residential, outpatient, and case management programs. This provider

system also offers a range of services within Opioid Treatment Programs (OTP's) which focus specifically on opioid addiction. These programs were previously labeled as methadone maintenance programs but OTP's reflects more common usage. The state is fortunate to have over 25 OTP's across the state that provide methadone to persons with Opioid Use Disorders (OUD's) and has worked to increase access to all three evidenced based medications (methadone, buprenorphine and naloxone) used to treat opioid use disorder (OUD).

DMHAS also provides a range of substance use services within state-operated facilities and hospitals. Hospital level withdrawal management and intensive residential services are provided in Middletown and in Hartford. All of the state-operated Local Mental Health Authorities (LMHAs) offer specialized Medication-Assisted Treatment services through outpatient treatment programs. Specialized services for HIV-infected individuals include counseling, testing, support and coping therapies, alternative therapies and case management. Where appropriate, referrals are made to DPH's Partner Notification Services and individuals are linked to follow-up treatment. Over the last 15 years, DMHAS has focused on treating individuals with co-occurring disorders in the state-operated facilities and hospitals.

The department also provides a comprehensive array of prevention services, designed to promote the overall health and wellness of individuals and communities by delaying or preventing substance use; these include information dissemination, education, alternative activities, strengthening communities, promoting positive values, problem identification, and referral to services. Through this model, attitudes and behaviors that contribute to alcohol and other drug use are changed, leading to healthier communities. DMHAS administers and funds 156 prevention councils covering 169 towns, and approximately 60 community-based prevention programs provide services statewide or at the regional or local level.

DMHAS served approximately 43,242 unduplicated individuals with substance use disorders in FY21. This was a 25% reduction from the number of unduplicated individuals served in FY20. FY21 admissions also were decreased by about 23% when compared to the previous fiscal year. The most highly utilized levels of care or programs were the Pre-Trial Intervention Program, OTP's providing methadone maintenance, inpatient and residential, and outpatient services.

For a more complete analysis of DMHAS' annual statistical information, please reference the 2021 Annual Statistical Report at the following link. This provides a much more comprehensive analysis of DMHAS' substance use service system:

https://portal.ct.gov/-/media/DMHAS/EQMI/AnnualReports/DMHAS-Annual-Statistical-Report-2021.pdf.

The DMHAS Commissioner and Executive Group are advised by many constituency and stakeholder groups. One such group is the State Board of Mental Health and Addiction Services, a 40-member advisory group consisting of 15 gubernatorial appointees, the chairperson, one designee each from the 5 Regional Behavioral Health Advocacy Organizations (RBHAO's), and other representatives of consumer interests. The RBHAO's were formed in 2018 in an effort to integrate substance use and mental health advocacy organizations. DMHAS initiated a competitive

bid process for the services that were previously provided by the Regional Mental Health Boards and the Regional Advocacy Councils. This resulted in the selection of five RBHAO's.

Connecticut is fortunate to have a number of other state agencies that continue to deliver substance use treatment and prevention services. The Departments of Children and Families (DCF), Social Services (DSS), Public Health (DPH), Correction (DOC), Department of Consumer Protection (DCP), and the Judicial Branch Court Support Services Division (CSSD) all provide a range of treatment and prevention services that are focused on the unique individuals these agencies serve. The report will detail major initiatives that each Department is involved in and the amount of funding that is being used to support substance use prevention and treatment services.

Evidence Based Practices

DMHAS is actively working to expand the adoption of evidence-based practices within our substance use treatment system. Evidence-based practices (EBP's) in the behavioral health system refers to pharmacotherapies or behavioral therapies. Pharmacotherapies include treatments such as methadone, buprenorphine, and naltrexone, which are commonly used to treat opioid addiction, as well as alcohol and nicotine addictions. Evidence-based behavioral therapies include therapies such as Cognitive Behavioral Therapy (CBT), Contingency Management, and Motivational Interviewing (MI), which have been shown to be effective with certain populations. Over the past five or more years, DMHAS has focused a considerable amount of effort toward expanding the use of medications for opioid use disorder (MOUD) like buprenorphine and naltrexone. The number of individuals receiving these services continues to grow.

Connecticut utilizes a number of evidence-based practices within its substance use system. Foremost among these services is DMHAS' use of \Medications for Opioid Use Disorder (MOUD's), which is considered the gold standard for treating opioid addiction. DMHAS has a statewide network of funded OTP's (providing methadone maintenance) that served over 13,500 individuals during FY21. This FY21 number increases to 22,032 (including unduplicated individuals served in non-DMHAS-funded OTP's). There are now over 25 distinct clinics, some of which have opened in response to growing needs of certain communities.

DMHAS has continued to work to increase the number of physicians who prescribe buprenorphine, a form of MOUD that has proven to be effective in dealing with opioid addiction. Although less regulated than methadone, the federal government restricts who can prescribe buprenorphine and the number of individuals each prescriber can "treat". Buprenorphine is a synthetic opioid medication that does not produce the euphoria and sedation caused by heroin. It has other advantages in that it reduces withdrawal symptoms and has a lower risk for overdose. Buprenorphine can be provided in its pure form or may be combined with naloxone in a more common formulation of the drug called Suboxone.

In FY21, DMHAS served approximately 640 unduplicated individuals in specialized, federally funded, buprenorphine programs. This number is an underestimate of the number of individuals now using buprenorphine or vivitrol as the DMHAS data system does not capture Medicaid

prescription or claims data. Recent data provided by Beacon Health Options for calendar year 2021 shows that 10,776 Medicaid individuals had received buprenorphine during that period, an increase from 7,200 individuals in our 2019 Triennial Report. The increased number of individuals receiving this form of MOUD demonstrates that efforts to increase access to alternative forms of MOUD have been successful.

Behavioral therapies are used across the DMHAS substance use system in many of the operated and contracted agencies. These therapies include CBT, Contingency Management and Motivational Interviewing (MI). In recent years, DMHAS has focused more heavily on MI because of its effectiveness in engaging individuals in treatment.

For over 15 years, DMHAS has focused on promoting best practices in the areas of co-occurring disorders, trauma informed treatment, and specialty services that are responsive to the needs of women in treatment. These discrete areas of practice have been fostered through training, expert consultation, learning collaboratives, and the use of data to inform practice improvement activities. Each of these is described in greater detail below:

- **Co-Occurring Disorders / Integrated Care Initiatives -** Many individuals with substance use disorders have mental health disorders. For over 10 years, DMHAS has focused heavily on fostering integrated care. One aspect focused on ensuring that providers were screening all individuals for both mental health and substance use disorders. Efforts have been directed at increasing system capacities to provide co-occurring treatment, regardless of where a client presents for treatment. Over the past year, DMHAS has implemented an updated focus on Integrated Care, starting with a focus on those with co-occurring mental health and substance use disorders. This is a multi-faceted effort led by the Commissioner, COO and Medical Director, with day-to-day activities conducted by members of the Community Services Division, including two consultants/trainers, and Evaluation, Quality Management and Improvement (EQMI).

- **Women's Services Practice Improvement Collaborative –** This is a collaborative venture with the Women's Consortium designed to promote gender sensitive practices in the DMHAS system. DMHAS funds a number of specialty treatment programs for women or women and children. These programs, DMHAS, and the Consortium meet on a regular basis to exchange lessons learned and problem solve about how to implement gender responsive treatment within these agencies.

Legislative Initiatives Impacting Substance Use Service Delivery

Connecticut has taken a number of steps over the past ten years to make Narcan more widely available. Legislation was first introduced in 2011 and each successive legislative session has introduced new pieces of legislation that have made Narcan more accessible. A Good Samaritan law was introduced in 2011 that protected people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012 allowed prescribers (physicians, surgeons, Physicians' Assistants, APRNs, dentists, and

podiatrists) to prescribe, dispense or administer Narcan to any person to prevent or treat a drug overdose and the prescriber is protected from civil liability and criminal prosecution. In 2014, the protection from civil liability and criminal prosecution was extended to the person administering the Narcan in response to an overdose. Legislation enacted in 2015 allows pharmacists who have been trained / certified to prescribe and dispense Narcan directly to customers requesting it. Most recently, PA 18-166 allowed prescribers to develop agreements with organizations wishing to train and distribute Narcan. All of these changes have supported efforts to make Narcan widely available.

A comprehensive report of all legislative initiatives focused on Connecticut's Opioid Drug Abuse Laws can be found at the following link: https://www.cga.ct.gov/2021/rpt/pdf/2021-R-0197.pdf . This report was prepared by the Connecticut Office of Legislative Research and was issued in November 2021. It examines legislative and policy initiatives in the following areas: Patient Care and Treatment, Access to Opioid Agonists, Prescription Drug Monitoring, Opioid and Controlled Substance Monitoring, Health Insurance and Drug Disposal.

Connecticut Alcohol and Drug Policy Council

The Connecticut **Alcohol and Drug Policy Council (ADPC)** is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use in Connecticut. Governor Malloy reconstituted the ADPC through legislation that was enacted in 2015. The Council, co-chaired by the Commissioners of DMHAS and DCF, is charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens -- across the lifespan and from all regions of the state. Governor Malloy provided a charge to the ADPC in late October 2015, which was focused on the opioid crisis in Connecticut. He requested that they study and make recommendations in the following areas:

- Best practices in the treatment of alcohol and substance use disorders, including Medication Assisted Treatment (MAT/MOUD) and other evidence-based treatment strategies.
- A coordinated, audience specific, prevention message including modern messaging to be used by school districts, parents, medical professionals, municipal leaders, state, agencies, and law enforcement.
- A collaborative effort, with medical professionals including doctors, nurse practitioners, dentists, and physician assistants to educate all prescribers on the dangers of overprescribing narcotics and the current best practices in identifying substance use disorder and the resources available for treatment.
- A strategy to make the overdose reversing drug naloxone widely available and affordable to first responders, in pharmacies and to any individual who may be able to use it to reverse an overdose.

In his charge to the Council, Governor Malloy encouraged members to make recommendations on issues requiring legislative change, administrative actions and statewide cooperation. Governor Lamont has continued this focus of the ADPC and supported its efforts, including attendance at a meeting of the ADPC in 2022 with Attorney General Tong.

The work of the ADPC has been influenced by the Connecticut Opioid Response (CORE) team, which was created to supplement and support the work of the ADPC by creating a focused set of tactics and methods for immediate deployment in order to have a rapid impact on the number of opioid overdose deaths in Connecticut. The CORE team was asked to focus on evidence-based strategies with measurable and achievable outcomes. The CORE Plan was published in October 2016 and has helped to guide efforts of the ADPC. The CORE Plan can be found at the following link: https://portal.ct.gov/CORE

In 2019, DMHAS collaborated with the CORE Team to create a website dedicated to the CORE plan: www.ctcore.org.

Four ADPC subcommittees (Prevention, Screening and Early Intervention; Treatment; Recovery; and Criminal Justice) are working in areas related to the general charge. These subcommittees, which have broad membership and include state and community partners as well as persons with lived experience, have been meeting over the past six years. These subcommittees have spurred a number of actions to address the opioid epidemic. The subcommittees and their goals and progress to date are described in detail in the Opioid Annex.

Emerging Trends in the Substance Use System

The State Substance Use Plan responds to emerging trends that affect substance use service delivery in the state. Two trends have significantly affected the substance use service system over the past several years and a new development related to Medicaid services will now impact the system moving forward. The pandemic and continued opioid epidemic are factors that impacted our service system most heavily in the past three years, while a recently implemented Medicaid Demonstration Waiver will make residential services Medicaid reimbursable and expand access to all Medicaid eligibility groups. These issues will be discussed further below.

Pandemic

As reported earlier, the pandemic has reduced capacity and the number of individuals typically served within the substance use system. This reduction has been evident in new admissions and the number of unduplicated individuals served. The reduction was most evident in FY21 when DMHAS data reflects a 25 % decrease in unduplicated individuals when compared to FY20 and a 23% decrease in admissions into the substance use system. This occurred because providers have been required to adhere to public health safety measures by reducing bed capacity throughout the pandemic and imposed restrictions on the amounts of in-person services that were offered. Early in the pandemic, some providers were forced to close or limit admissions to residential services as they responded to outbreaks within their facilities.

The impact was also felt in outpatient services where governmental restrictions served to curtail in-person services. Outpatient services experienced a reduction in unduplicated individuals served and a similar reduction in admissions. The reduction of in-person services required providers to rapidly adjust to relying more heavily on telehealth services. Some providers were more adept and were better able to respond to these changes. Others with less information technology capacity, struggled to adapt to these new demands. Lastly, people were less likely to seek out and engage in services at the beginning of the pandemic due to contagion concerns.

Increased Federal Funding for Substance Use Services

The federal government has recognized that the pandemic has strained behavioral health services in the country and has provided states with increased funding for mental health and substance use services. The federal government made funding available beginning in 2020. DMHAS has received over $32,000,000 in funding to address substance use needs that have arisen during and as a result of the pandemic. These one-time supplemental funds were delivered via the Substance Abuse and Prevention Treatment (SAPT) Block Grant and originated from the Coronavirus Response and Relief fund, as well as the American Rescue Plan Act (ARPA).

Opioid Epidemic

Another trend of concern is the continuation of the opioid epidemic. The 2019 Triennial Report showed a slight reduction in opioid-related admissions and overdose deaths, indicating the possibility that the epidemic had plateaued and might be in decline. At that time, opioid-related admissions into Connecticut's treatment system actually declined in FY 2018, decreasing from approximately 31,000 admissions in FY17 to approximately 29,000 admissions in FY18. Admissions related to opioids for the first six months of FY19 also reflect a continued decline when compared to the same period in FY18. At that time, slight decreases in overdose deaths were noted.

Unfortunately, this trend related to overdoses has not continued. Overdose deaths are rising, fueled largely by expanded use of fentanyl. In the past, fentanyl was mixed or cut with heroin but in the last three years, fentanyl is being used to manufacture counterfeit drugs in pill form. The DEA has cautioned that these pills are made to look like prescription opioid drugs but increasingly are being manufactured to mimic stimulant and other drugs. The expanded use of fentanyl is killing unsuspecting users at alarming rates. These counterfeit pills are often being manufactured in China and distributed by Mexican drug cartels in the United States. The DEA has cautioned that the presence of counterfeit pills with over 2 milligrams of fentanyl, a dose that is considered deadly, is increasing.

Overdose deaths have continued to rise. Calendar year 2020 accounted for 1,378 fatal drug overdoses in Connecticut, an increase of 14.3% from CY19. Calendar year 2021 accounted for 1,531 fatal drug overdoses, an increase of 11.1% from CY20.

The disturbing trend that was described above regarding the impact of fentanyl is demonstrated in an analysis of the drugs involved in overdose deaths. In CY18, fentanyl was involved in 75% of

all overdose deaths. Fentanyl-involved overdose deaths increased in CY19 to 82%. In 2020, the average percentage of fentanyl involved deaths further increased to 85%. The percentage of fentanyl-involved deaths in CY21 was 86%.

The continued problem with opioids in the state can be observed in trends compiled from DMHAS' data collection system. Data for FY21 demonstrates that heroin and opioids account for approximately 42% of all substance use treatment admissions while alcohol is reported to be the primary drug involved in approximately 37% of these admissions. Admissions related to marijuana comprise about 8% of substance use treatment admissions in FY21. In the last Triennial Report, it was observed that cocaine and crack admissions accounted for almost 7.5% of admissions to the substance use treatment system. This was seen as a disturbing trend because that had been a significant increase over prior years. This has not increased and cocaine and crack accounted for approximately 5.8% of admissions to the substance use service system in FY 21.

1115 Demonstration Waiver for Substance Use Disorder (SUD) Inpatient and Residential Treatment

One other development that is likely to have a major impact on the future of substance use delivery in the state is the 1115 waiver, which was implemented in Connecticut at the end of FY22. The 1115 Demonstration waiver will allow SUD residential services to be Medicaid billable and expand access to all Medicaid eligibility groups within the state. Prior to the waiver, only a small number of residential services were a part of the Medicaid continuum of care. The State's intent is to re-invest dollars into the SUD service system which allows for more robust staffing and improved connection to care.

The Demonstration Waiver is designed to ensure a comprehensive American Society of Addiction Medicine (ASAM) levels of care (LOCs) service array is available as part of an essential continuum of care for Medicaid enrolled individuals with Opioid Use Disorders (OUD) and other Substance Use Disorders (SUDs). Currently, Connecticut Medicaid covers all ambulatory ASAM LOCs 1.0 through 2.5, as well as inpatient withdrawal management (ASAM level 4-WM). In addition, Connecticut submitted a Medicaid State Plan Amendment (SPA) which, after approval by CMS, will enable the state to receive federal Medicaid matching funds for SUD residential and outpatient levels of care provided under the federally approved SUD section 1115 demonstration waiver. The Demonstration will permit DSS to provide critical access to medically necessary SUD treatment services in the most appropriate setting for the member as part of a comprehensive continuum of SUD treatment services.

The waiver will have an impact on the DMHAS Substance Use budget. Some of these residential services were funded through DMHAS' Behavioral Health Recovery Program (BHRP). With the waiver approved, these funds will be transferred out of the DMHAS budget to DSS. It will appear in the future that DMHAS is spending less on substance use services but this will be related to the service expansion that will occur under the Waiver. In actuality, more substance use services will be made available to Medicaid recipients. DMHAS will continue to fund these levels of care for those individuals who are uninsured or unentitled.

Plan Development

The 2022 State Substance Use Plan is organized under the same key strategy areas which were included in the 2019 State Substance Use Plan. Each strategy area lists a number of action steps that will be taken over the next three years to address substance use issues. The plan and the Opioid Annex cuts across all state agencies (including JB-CSSD) involved in substance use treatment and prevention and is heavily influenced by recent trends in Connecticut. Many action steps continue to relate to the opioid crisis as much attention has been focused on trying to reverse this epidemic. However, many action steps continue to focus on managing and maintaining a comprehensive substance use system which focuses on prevention and health promotion and treatment of substance use disorders. Each strategy area will be followed by a summary of the accomplishments that have occurred over the past three years.

Throughout the report, the reader may notice changes related to language used to describe substance use services and disorders, specific substances, or the classification of program types or levels of care. These changes are being made to reflect more current terminology being used on the national level and are slowly coming into more common usage. The more current terminology used in the report include the following:

Opioid Use Disorders (OUD's) – term used to describe individuals with a chronic disorder involving the use of opioids with serious consequences that may lead to relapse, death, or disability.

Opioid Treatment Programs (OTP's) – term used to describe programs or services that previously were classified as methadone maintenance. OTP's must provide a range of services including initial medical examination, initial and periodic assessment services, counseling, drug use testing, and medication administration using only those drugs approved to treat opioid use disorders. This includes methadone, buprenorphine, and levomethadyl acetate (LAAM).

Withdrawal Management Services – term used to describe programs or services that used to be classified as detoxification.

Medications for Opioid Use Disorders (MOUD's) – terms used to describe any medication being used to treat opioid use disorder. This includes methadone, buprenorphine, and naltrexone.

Substance Use – term now being used to describe what previously was labeled substance abuse. The term 'substance abuse' was believed to be stigmatizing.

6 Key Strategies for a Comprehensive and Coordinated State Substance Use Plan

1 STRATEGIES RELATED TO PREVENTION AND EDUCATION

- Prevent substance use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals. Reduce stigma associated with seeking treatment.

2 STRATEGIES RELATED TO TREATMENT

- Expand access to broad spectrum of substance use services.
- Increase the use of evidence-based treatments (EBP's) including methadone maintenance and buprenorphine

3 STRATEGIES RELATED TO RECOVERY

- Increase the use of peers and natural supports.
- Maintain recovery supports.

4 STRATEGIES RELATED TO CRIMINAL JUSTICE

- Implement criminal justice reforms that will increase diversionary options.
- Increase the availability of substance use treatment, especially medication fooooooooo addiction treatment in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail

5 STRATEGIES RELATED TO COLLABORATION AND COST EFFECTIVENESS

- Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.

6 STRATEGIES RELATED TO ACCOUNTABILITY AND QUALITY CARE

- Ensure that providers deliver high quality services.
- Use data to improve care throughout the system.

Strategy 1: Strategies Related to Prevention and Education 2022

• **Deliver timely, efficient, effective, developmentally appropriate and culturally sensitive prevention strategies, practices and programs through a skilled network of service providers and use of evidence-based practices**	
Action Step: Design and implement data collection and management systems that disseminate and utilize epidemiological data to promote informed decision-making through a data-portal, newsletter, or social media. Provide technical assistance and training on evaluation-related tasks and topics	**Action Step:** Enhance Connecticut's mental health promotion and suicide prevention, intervention and response infrastructure, capacity and readiness to address gaps and reduce non-fatal suicide attempts and suicide deaths among youth and young adults
Action Step: Provide resources to university prevention professionals to systematically measure the scope of drug misuse issues on campuses, build relationships with key stakeholders and plan and implement drug misuse prevention efforts	**Action Step:** Build the capacity of college campuses, broadcast media and workplaces to prevent substance use, underage drinking and violence among youth and promote positive health outcomes for all young people in Connecticut
Action Step: Implement initiatives in select CT communities to prevent substance use in youth age 12-17, identified through the application of the comprehensive Strategic Prevention planning framework	**Action Step**: Educate tobacco merchants, youth, communities and the general public about the state laws prohibiting the sale of tobacco products to youth under the age of 21
Action Step: Assess regional behavioral health needs; develop regional priority reports that identify services gaps; pursue resources and coordinate community efforts to prevent and treat substance use, mental health and gambling disorders	**Action Step:** Enforce State laws that prohibit youth access to tobacco products by inspecting retailers across the state in order to maintain a retailer violation rate at or below 20 percent
Action Step: Prevent youth access to tobacco by enforcing federal laws that prohibit sales of tobacco products to minors and restrict advertising and labeling	**Action Step:** Disseminate information via print, broadcast and electronic media on substance use, mental health and other related issues
Action Step: Provide K-12 schools including educators, students and affiliated families, organizations, and communities with the most current information and services on programs, practices, and interventions to mitigate the impact of substance misuse and other behavioral health problems in students	**Action Step:** Deliver training and technical assistance to communities and prevention professionals in community mobilization, coalition development, implementation of evidence-based strategies and environmental approaches to address substance use
Action Step: Develop and implement municipal-based alcohol and other drug prevention initiatives that address community needs	**Action Step:** Implement multi-faceted prevention strategies to prevent non-prescription opioid use and the progression from use of prescription opioids to the use of readily accessible and inexpensive heroin and fentanyl

Action Step: Implement strategies that address alcohol, tobacco and other drug (ATOD) use and mental health promotion for fathers in communities across the state	**Action Step:** Increase awareness of the dangers of sharing medication for individuals age 18 and older, and the risks of overprescribing for prescribers and others in the medical community

PREVENTION INFRASTRUCTURE

DMHAS has created a prevention infrastructure that supports efforts on the state, regional and local levels. Investments have been made in essential infrastructure components to help individuals and communities combat the problems posed by substance use and mental health disorders. These components include but are not limited to: 1) an ongoing planning process that uncovers needs and gaps; 2) a well informed and educated prevention workforce; 3) coordination of substance use and mental health efforts across multiple sectors; and 4) data systems and processes that facilitate prevention program monitoring and evaluation. This investment ensures that the system can respond to evolving needs and resources to allow the key functions of prevention to continue, building a foundation for collaboration across the continuum of care. This infrastructure facilitated many gains over the last 3 years.

Five Statewide Service Delivery Agents that support prevention programs statewide:

- DMHAS Prevention Training and Technical Assistance Services Center's (TTASC) goal is to increase prevention workforce competencies, utilizing the SAMHSA Strategic Prevention Framework five-step process, training and technical assistance for improved access by prevention workers most relevant, responsive and culturally appropriate prevention education, and training resources in collaboration with Department staff. It accomplishes this goal by organizing events such as learning communities, facilitating access to professional development offerings, providing customized technical assistance, and promoting individual and organizational networking.

- The Connecticut Clearinghouse/Connecticut Center for Prevention, Wellness and Recovery (CCPWR) is the State's premier information resource center that disseminates thousands of pamphlets, posters, fact sheets, books, e-books, and curricula on prevention, substance use, mental health promotion and a variety of other topics to individuals statewide. The mobile resource van allows materials to be easily accessible at local events across the state. Clearinghouse staff administer the comprehensive DMHAS statewide prevention listserv, the Change the Script opioid awareness campaign, and the drugfreect.org website. They provide logistical support and the coordination of activities related to the successful implementation of the Tobacco Merchant Education campaign, the Healthy Campus initiative, the Community Readiness Survey, Mental Health First Aid trainings, and National Prevention Week.

- The Governor's Prevention Partnership (GPP) equips, empowers, and connects organizations, communities, and families to prevent substance use, underage drinking, and violence among

youth and promotes positive outcomes for all young people in Connecticut. The Partnership provides ongoing training and technical assistance to promote mentoring recruitment and best practices, safe school environments, and healthy communities. Additionally, The Partnership builds awareness of youth prevention programs through its partnerships with print and broadcast media across the state.

- The DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health collects, manages, analyzes and disseminates epidemiological and evaluation data through their SEOW Prevention Data Portal, an interactive repository for behavioral health data, epidemiological profiles, presentations and products. The CPES convenes the Statewide Epidemiological Outcomes Work Group (SEOW), comprised of representatives from state agencies and organizations connected in various ways to Connecticut's data infrastructure. The SEOW meets quarterly to prioritize and share data, with an emphasis on Alcohol, Tobacco, or Other Drugs (ATOD) prevention and use data and mental health promotion data, and those efforts inform and expand the content and functionality of the Portal. The CPES also provides TA and training on data and evaluation topics to prevention partners and providers statewide.

- Five Regional Behavioral Health Action Organizations (RBHAOs) operate as subcontractors to DMHAS to carry out ATOD prevention initiatives, among their other mission-driven objectives. In 2018, gambling prevention efforts were also added into the overall mission, funding and deliverables of the RBHAOs as youth who gamble are more likely to engage in other risk-taking activities, such as using alcohol, tobacco, vaping and other drugs. These private non-profit organizations, comprised of a board of directors of community stakeholders, and staff build capacity of communities to identify gaps and coordinate and leverage resources for behavioral health services. Working closely with the Local Prevention Councils in their region, the RBHAOs may conduct comprehensive analyses of community needs, provide support to build data capacity and produce Sub-Regional Profiles to establish local substance use prevention priorities. The RBHAOs are:

    - The Hub: Behavioral Health Action Organization for Southwestern CT
    - Alliance for Prevention Wellness - BHCare
    - Supporting and Engaging Resources for Action and Change (SERAC)
    - Amplify, Inc
    - Western CT Coalition

Other entities integral to the DMHAS Prevention infrastructure include:

- State Epidemiological Working Group (SEOW): DMHAS first established the SEOW in 2005 under the SPF-SIG initiative funded by SAMHSA, CSAP to conduct careful data reviews and analyses on the causes and consequences of substance use to guide prevention decision

making. The SEOW facilitates dissemination and sharing of data and assists in supporting the work of prevention practitioners across the state planning and monitoring prevention strategies. Its membership consists of several state agencies, local community evaluators and other Prevention professionals.

- The Evidence-Based Workgroup is a DMHAS-convened volunteer workgroup of prevention and evaluation specialists who reviews the research behind prevention programs to ensure local entities are implementing programs that address the needs and conditions in a way that is supported by the research.

- 156 Local Prevention Councils (LPCs) address primary prevention in the 169 communities throughout the state of Connecticut. The LPCs include representatives who are elected officials, police officers, educators, faith/spiritual leaders, business leaders, social and human service providers, and parents, among others. These multi town coalitions and related local-level entities ensure that community-led prevention efforts are accessible to residents across the state. The support these local entities have from the CT Clearinghouse, RHBAOs, TTASC and CPES helps create a cost-effective, strategic use of resources, and align priorities across the system.

- Campus/Community-Based ATOD Prevention Initiatives including:

    1. The 11 Prevention in Connecticut Communities (PCCs), which are community-based programs/coalitions charged with implementing evidence-based strategies to prevent underage drinking and other problem. The CSC programs use the SAMHSA Strategic Prevention Framework (SPF) 5 Step process to address youth alcohol use in addition to other priority substances such as marijuana and prescription drug abuse.

    2. A statewide Healthy Campus Coalition comprised of Connecticut colleges and universities who are participating in activities to address the reduction of ATOD use and abuse amongst their student populations.

    3. The SPF for Prescription Drugs (SPF-Rx) is awarded to 4 health districts to reduce non-medical use of prescription drugs and prevention of opioid overdoses. The SPF-Rx programs focus on raising awareness about the dangers of sharing medications for individuals age 12 and over and work with prescribers and dispensers to be aware of the risks of overprescribing through the Academic Detailing for Opioid Safety (ADOPS) initiative.

- Regional Suicide Advisory Boards (RSABs) are comprised of five regional networks that implement sustainable evidence-based suicide prevention and mental health promotion policies, practices and programs in communities across the state for youth and young adults.

- The MOSAIX Impact prevention data collection system is the cloud-based data collection platform used to meet DMHAS's Prevention data requirements.

The Prevention Infrastructure efforts are advised and informed by other State Advisory Councils such as the Prevention Subcommittee of the Connecticut Alcohol and Drug Policy Council (ADPC) and the CT Suicide Advisory Board (CTSAB).

Accomplishments

The **Strategic Prevention Framework for Prescription Drugs (SPF Rx)** grant ended in 2021. State and local level prevention capacity and infrastructure were enhanced – funds were braided across the departments of Mental Health & Addiction Services (DMHAS), Public Health (DPH) and Consumer Protection (DCP) to develop and launch an opioid public awareness campaign; an evidence-based academic detailing model was implemented with medical and pharmaceutical prescribers; and, coalitions launched opioid misuse prevention interventions. The CT Office of the Chief Medical Examiner (OCME) trend data showed a decline in the heroin involved deaths and an increase in the fentanyl involved deaths for adults 18 and over. During the period of the initiative physician and pharmacist enrollment in the CT Prescription Monitoring and Reporting System (CPMRS) increased as well as the use of the system. There was also a notable decrease in the number of prescriptions written for opioids.

Connecticut's **Partnerships for Success 2015 (PFS 2015)** initiative, funded from October 1, 2015 to September 30, 2020, completed five years of implementation of the Strategic Prevention Framework (SPF). Over the course of the PFS 2015, the Department of Mental Health and Addiction Services (DMHAS) addressed the priority problems of underage drinking and non-medical use of prescription drugs (NMUPD). This occurred through data-driven strategic planning, data collection and data systems development, state and community capacity-building for prevention, and leveraging, re-directing, and re-aligning statewide funding for prevention.

The overall goals of Connecticut's PFS 2015 initiative were to:

1. Reduce the prevalence of underage alcohol use and alcohol-related consequences at the state and community levels for 12 to 20-year-olds and;

2. Expand prevention efforts to reduce the onset and progression of prescription drug misuse or abuse in 12 to 25-year-olds at both the state and community levels.

At the state level, the consumption and intervening performance targets for both underage drinking and NMUPD showed improvement from baseline to follow-up during PFS 2015. These results are consistent with a conclusion that PFS 2015 positively impacted 30-day alcohol use and prescription drug misuse among adolescents and young adults. In addition, prescriber utilization of Connecticut's CPMRS increased during the project period and the number of opioid

prescriptions dropped. The change in prescriber behavior was supported in addition to PFS 2015 by the SPF Rx and SOR initiatives that ran concurrently with PFS 2015.

The evaluation demonstrated that PFS 2015 was effective at increasing the capacity of subrecipient coalitions to address underage drinking and NMUPD in their communities. Subrecipients fared well in meeting the capacity outcomes outlined in their local evaluation plans for PFS 2015 with 17 out of 20 (85%) of such outcomes met. Data also showed that:

- statewide readiness to prevent substance misuse increased significantly from 2016 to 2020
- subrecipients demonstrated greater capacity to address substance misuse at the community level
- subrecipient communities obtained subsequent funding to sustain the gains made from the initiative
- paid Youth Peer Advocates (YPA) contributed to the 66 community-level projects by increasing the coalitions' social media presence, spreading the word about substance use prevention in the community, and engaging youth to participate in these local efforts, and
- success was achieved in the development of a survey to access 18 to 25-year-olds, a hard-to-reach population at high risk for alcohol and other substance use.

Overall, the PFS 2015 resulted in positive effects at the community level in selected outcomes, but perhaps more importantly, in prevention capacity at the community and state levels. Additionally, the insights and lessons learned, helped to inform current prevention efforts in Connecticut.

SUICIDE PREVENTION AND MENTAL HEALTH PROMOTION

Connecticut's Networks of Care for Suicide Prevention (NCSP) project was designed to implement evidence-based suicide prevention, intervention and response strategies to reduce non-fatal suicide attempts and suicide deaths among youths and young adults, ages 10 to 24 years old in Connecticut. The NCSP took a two-level approach, implementing suicide prevention activities statewide and in a specific selected community, in an Intensive Community Based Effort (ICBE). At both the statewide and ICBE levels, the NCSP built suicide prevention infrastructure and increased access to trainings, resources, and other materials to build suicide prevention capacity; promoted suicide prevention in health care by encouraging healthcare organizations to adopt the Zero Suicide Framework; promoted identification, referral, and follow up for youths at risk for suicide; and fostered the enhancement of suicide prevention-related data collection systems.

Some specific activities included establishing five Regional Networks of Care (RNC), to coordinate suicide-prevention services and deliver suicide prevention-related trainings statewide; establishing a Community Network of Care (CNC) in the selected ICBE community, Manchester; and encouraging the implementation of the Gizmo mental health curriculum in schools statewide.

Connecticut's Department of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), and Department of Public Health (DPH) co-directed the NCSP.

PRESCRIPTION DRUGS AND OPIOIDS

Under the **Strategic Prevention Framework for Prescription Drugs (SPF Rx)** 2016 initiative prevention capacity and infrastructure accomplishments have been implemented at a high level and quality of inter-agency collaboration and coordination increased. Throughout the five years of funding (2016-2021) all long-term program objectives targeting declines in prescription opioid availability, misuse, overdose and death have been achieved. Four health districts in high burdened communities were funded to promote the campaign and conduct opioid awareness and education activities including Academic Detailing on Opioid Safety (ADOPS). A number of expansions and improvements were made to the CT Prescription Monitoring and Reporting System (CPMRS). Upwards of 5 million clinical alerts and notifications were sent to users and over 75 hospitals and healthcare institutions have been able to link their patients' electronic health records to the CPMRS. SPF-Rx 2016 ended in September 2021.

SPF-Rx 2021 began in September 2021. Through this funding, curriculum is in process of being developed for students at UConn School of Pharmacy and UConn, Masters in Public Health program as part of a Service Learning Program. The Service Learning Program will place students in health districts and departments in high burdened communities to implement opioid use disorder prevention programming. A workgroup of the Statewide Epidemiological and Outcomes Workgroup (SEOW) is in process of being established to collect, analyze and distribute data from the CT Prescription Monitoring and Reporting System (CPMRS). This is in collaboration with the Department of Consumer Protection, Department of Public Health and UConn Health Center.

Through the **State Opioid Response** (SOR) initiatives, a number of strategies and activities addressing multiple targets in a variety of settings were implemented to prevent opioid misuse and non-medical use of prescription drugs. As a result: 5,200 opioid overdose reversal kits were distributed; 19 colleges implemented campus based public awareness/education events that served over 16,575 persons; the Change the Script campaign has expanded messaging and reach; the drugfreect.org website has been updated; parent trainings were held in English and Spanish across the state to teach parents how to effectively communicate with children on the dangers of drug use; 150 micro grants were awarded to communities to deploy the Change the Script campaign, provide opioid use disorder awareness, and implement safe storage and disposal activities; 13 health districts/departments facilitated the Academic Detailing on Opioid Safety (ADOPS) program with 150 prescribers/pharmacists; 24 health and behavioral healthcare sites distributed medication lockboxes and performed lethal means counseling; the Recovery Friendly Workplace Toolkit was implemented with employers across the state; a Guiding Document was developed to assist school districts to select and implement a prevention curriculum; several in person and interactive web based trainings and a webinar were developed along with accompanying users guides on opioid education and awareness; and evaluation of all activities.

The **2021 Covid-19 Block Grant Supplement** provided opportunities to expand current strategies and activities for substance misuse prevention. These include: an update of the Statewide Epidemiological and Outcomes Workgroup's Data Portal to feature more data visualization options; a survey to identify if substance misuse/use increased among CT residents during the Covid-19 pandemic; the expansion of the local Let's Mention Prevention campaign to focus on preventing underage drinking; a Youth Vaping Prevention campaign currently under development; funding for 8 Certified Fatherhood Programs to receive training and technical assistance to implement prevention interventions; 10 student trainings planned in English and Spanish across the state to teach youth the dangers of drug use; funds to 150 Local Prevention Coalitions for ATOD prevention and mental health promotion strategies; and upgrades to tobacco compliance inspection software.

Planning for the federally funded **America Rescue Plan Act** (ARPA) initiatives has occurred and implementation of strategies and activities related to substance misuse prevention has begun. Activities will include: the development and implementation of a School-based Center for Prevention Education and Advocacy; expansion of the statewide Evidence Based Workgroup; provide scholarships for individuals obtaining the Certified Prevention Specialist credential; the collection, analysis and monitoring of cannabis data; expansion of prevention programing for youth; staffing for the Youth Advisory Board; training videos for the Academic Detailing on Opioid Safety (ADOPS) initiative; the procurement of a second mobile resource van; and enhancements to the drugfreect.org website.

PREVENTION OF TOBACCO USE BY MINORS

The Tobacco Prevention and Enforcement Program (TPEP) utilizes DMHAS prevention staff to implement the Synar Amendment requirements. TPEP's primary mission is to enforce state and federal youth access laws. Activities include completion of the Annual Synar Report, un-announced inspections of retail outlets to ensure compliance with age and photo identification and advertising/labeling restrictions. State inspectors enforce state youth access laws and federal inspectors enforce federal youth access laws. TPEP also administers the Merchant Education and Awareness Campaign. This campaign has included a quarterly newsletter called the Responsible Connecticut Retailer or RCR. The RCR provides immediate communication to retailers across the state about changes in the law and provides education and awareness. The new "What You Do Matters" awareness campaign was launched in October 2021, advising retailers to never sell these products to a person under 21 years old and always check the photo ID of anyone who appears under the age of 30 years old when selling tobacco or electronic cigarettes.

COMMUNITY PREVENTION ACTIVITIES

Eight community coalitions and 12 towns were funded under the PFS 2015 initiative to implement prevention strategies in their service areas. Strategies implemented include: Social Marketing Campaigns (Change the Script and individual town campaign), Enforcement (Alcohol Compliance

Checks, Surveillance), Raising Awareness and Training/Education (Community events, presentations, PSAs) and Capacity building (coalition). School and local survey data collected by the community coalitions showed a decrease in youth alcohol use and non-medical use of prescription drugs by those 12-20 years old. Six of the eight Prevention Coordinators obtained their Certified Prevention Specialist credential. Following the end of the PFS 2015 initiative in September 2020, seven out of the eight community coalitions secured federal grant funding to continue implementing prevention strategies.

The 12 community coalitions and 15 towns funded under the **CT SPF Coalitions** (CSC) initiative implemented prevention strategies and updated information briefs and forums to inform their communities of overall successes throughout the six years of funding. Strategies implemented include: Enforcement, Raising Awareness and Training/Education, and Capacity Building. Coalition staffs have obtained professional credentials as Certified Prevention Specialist through ongoing education services provided by DMHAS. At the end of the CSC initiative in June 2021, 10 out of the 12 coalitions secured federal or state grant funding to continue implementing prevention strategies.

The **Prevention in CT Communities** (PCC) initiative began in July 2021, replacing the CSC initiative. 10 community coalitions and 12 towns funded under the PCC initiative have completed a needs assessment and strategic plan. Implementation plans and evaluation plans will be developed prior to implementation to strategies in the spring of 2022. Priority substances selected are alcohol, tobacco/ENDS, and cannabis. Strategies selected for implementation include: Social Marketing Campaigns (Let's #Mention Prevention, local campaigns, and other statewide campaigns to be developed), Enforcement (Alcohol and Tobacco/ENDS Compliance Checks, Surveillance), Raising Awareness &Training & Education, and Capacity building.

Strategy 2: Strategies Related to Treatment 2022

• **Expand access to broad spectrum of substance use services.** • **Increase the use of evidence-based treatments (EBPs)**	
Action Step: Maintain comprehensive substance use treatment system	**Action Step:** Maintain the statewide toll-free call line to connect callers to withdrawal management and provide transportation to withdrawal management and SUD residential treatment if no other transport is available.
Action Step: Maintain real-time bed availability website for all DMHAS-operated and funded substance use residential services	**Action Step:** Maintain statewide network of walk-in assessment centers
Action Step: Maintain specialized clinic-based MAT where individuals can receive MAT, peer support and employment services	**Action Step:** Increase capacity in substance use outpatient programs and outreach programs to prescribe buprenorphine and naltrexone
Action Step: Improve MAT inductions in withdrawal managements programs along with follow-up care upon discharge	**Action Step:** Apply for federal funding to expand substance use services
Action Step: Provide specialized services to DCF-involved parents with substance use problems	**Action Step:** Increase adoption and expansion of EBPs through Learning Collaboratives with providers

Accomplishments

COMPREHENSIVE TREATMENT SYSTEM

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance use. As such, it provides a variety of treatment services to persons with substance use disorders, including outpatient, intensive outpatient, opioid treatment programs (OTP's), residential withdrawal management, residential treatment (i.e., intensive, co-occurring enhanced intensive, intermediate, long-term, parenting and pregnant women, transitional/halfway house), and aftercare. DMHAS' FY 21 budget for substance use services was over 142 million dollars and blends state general funds with federal block grant funds, and discretionary federal grants. The DMHAS substance use treatment system includes approximately 51 providers with over 300 programs.

INCREASED ACCESS TO SERVICES

Rapid access to treatment is another essential component of a comprehensive strategy designed to address the opioid epidemic. Connecticut has responded to the opioid crisis by implementing a toll

free number where services related to opioid addiction can be accessed. The Wheeler Clinic operates the Access Call Line. The toll free line is staffed 24/7 and links callers to withdrawal management, residential treatment, and a network of walk-in centers where somebody can receive a same day evaluation of their needs. The 24/7 call line number is: **1-800-563-4086**. The Call Line is receiving approximately 3,000 calls monthly. Call Line services also provide transportation to those individuals who need to be connected to withdrawal management or residential services. Two providers offer these transportation services statewide, Columbus House and Intercommunity. Priority is given to transporting people to withdrawal management and residential treatment. Over 300 rides per month are being provided.

Real-Time Web-Based Addiction Services Bed Availability

In November 2017, DMHAS launched a real-time web-based addiction services bed availability system. DMHAS operated and funded programs update the site at least daily to inform the public on the current availability of withdrawal management, residential treatment, recovery house, and sober house services. There are more than 1200 beds represented on this site.

Walk-In Evaluation Centers

Over 50 programs continue to conduct same-day evaluations in order to link individuals to the most appropriate level of care. These walk-in centers and their locations can be accessed at the following link: https://portal.ct.gov/DMHASwalk-in

Mobile MAT and Mobile Employment Services

DMHAS has increased the number of mobile services available to individuals with SUD. DMHAS funds five Mobile MAT vans that offer buprenorphine and naltrexone medications and peer coaching. DMHAS funds five Mobile Employment Services programs, one in each DMHAS region. Employment specialists go to DMHAS-funded Halfway Houses, Recovery Houses, and Sober Houses to help individuals obtain and maintain employment, an important part of recovery for many people.

Increase in Use of Medications for Opioid use disorder in Withdrawal Management

Many withdrawal management programs historically followed an abstinence-based medical detoxification protocol, discharging or transferring a client once the addicting medication was tapered to zero. The period after withdrawal is an especially high-risk time for opioid-use relapse, as well as accidental overdose and/or death due to decreased physical tolerance. Thus, induction on MAT during withdrawal management and a seamless transition/warm hand-off to follow-up care can save lives for individuals choosing to support their recovery with medication.

In October 2018, Beacon Health Options, under the auspices of the Connecticut Behavioral Health Partnership (CTBHP), along with InterCommunity Inc., and Hartford Healthcare's Rushford

Center launched the Changing Pathways project. Changing Pathways uses a person-centered, multidisciplinary approach to incorporate MAT induction into withdrawal management care. The three essential components of the Changing Pathways model are:

1. Frequent and thorough education of individuals with OUD on MOUD
2. Offering individuals with OUD the option to be inducted on MOUD during their withdrawal management/detox stay (instead of being detoxed to zero)
3. Comprehensive discharge planning and seamless warm transfers to guarantee continuation of MOUD post-discharge

These three essential components have numerous benefits for providers and individuals with OUD. MOUD has been shown to reduce the risk of relapse and overdose, support individuals significantly in sustaining long-term recovery, and to allow individuals to better tend to other behavioral and/or medical issues they are facing compared to individuals who pursue treatment without medication.[i]

The Changing Pathways project has continued to expand. Three Freestanding Withdrawal Management providers (Rushford, InterCommunity and SCADD) and one in-patient psychiatric facility (Hartford Hospital) have transitioned to a Sustainability Phase. In the Sustainability Phase, providers receive monthly induction volume data as well as outcome measurement data. Meetings will occur no less than quarterly, but more often if necessary.

In 2022, Changing Pathways will be piloted to include a community hospital to assess the feasibility of expanding the model across hospital settings beyond inpatient psychiatric facilities. Providers considering adopting the Changing Pathways model will be encouraged to offer all three types of MOUD to their individuals: buprenorphine, methadone, and naltrexone.

Finally, CTBHP has created a toolkit to act as an implementation guide for providers considering the adoption of this model in their organization. Necessary implementation steps, including understanding leadership support, assessing organizational capacity, establishing workflows and implementation plans, and continuous quality improvement activities are part of the planning. CTBHP recommends that interested providers consider these steps and any necessary adaptations to practice/policy in alignment with the mission and goals of their organization, in order to provide the highest quality care for their individuals with OUD.

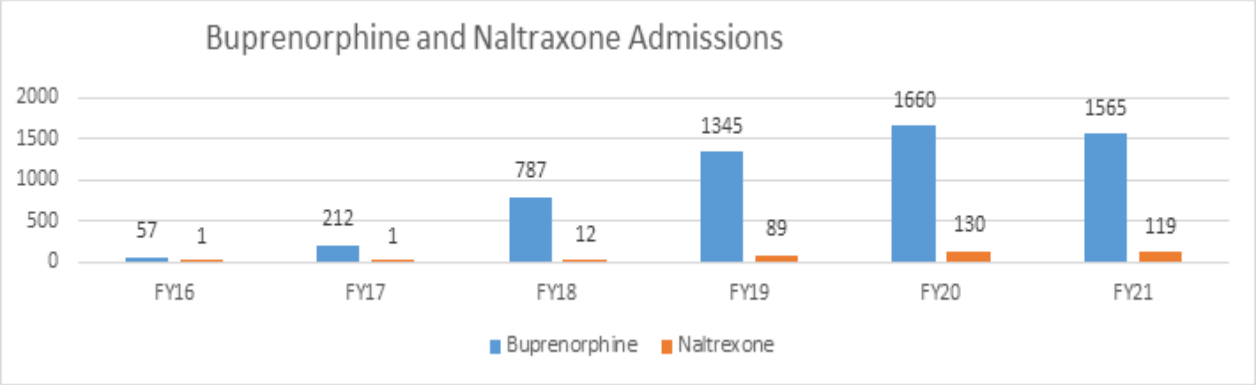
CLINIC-BASED MAT

The support and expansion of Clinic Based Medication for Addiction Treatment/Medication (CB-MAT) for Opioid Use Disorder (MOUD) has been a priority in Connecticut as an alternative to office-based opioid treatment (OBOT) for those individuals who are without private insurance or the means to otherwise pay a private practitioner. Currently, DMHAS is providing or funding this service in 16 clinics across the state. CB-MAT is offered in traditional licensed outpatient clinics

or Federally Qualified Health Centers that typically offer an array of other behavioral health, recovery and primary care supports. Those in treatment have the benefit of accessing this menu of services all under "one roof". The medications offered within state-funded CB-MAT programs are buprenorphine and naltrexone. Naloxone prescriptions or kits are available. Depending on the particular clinic, a multi-disciplinary team is available for clinical and recovery support that may include individual, group and family therapy, recovery coach services, employment support, psychiatric services, primary care and dental care. In the "Enhanced MAT" clinics, DMHAS has been able to support the hiring of a full-time Recovery Coach in addition to a full-time employment specialist.

INCREASE IN USE OF MEDICATIONS FOR OUD OVERALL

Via the addition of CB-MAT clinics and learning collaboratives for MAT providers, CT has seen improved access to medications for Opioid Use disorder. The following table shows an increase of admissions to these programs from 2016 to 2021.



INCREASED NALOXONE DISTRIBUTION

DMHAS has prioritized the distribution of life-saving naloxone. The following number of naloxone kits were distributed to treatment and recovery support providers, hospital emergency departments, police, and others:

2019: 11,581

2020: 13,162

2021: 14,986

2022 through April 29, 2022 : 7,600

Evidence-Based Practices and Learning Collaboratives

DMHAS facilitates a number of learning collaboratives with providers to enhance addiction services, including collaboratives on Withdrawal Management, Methadone, Mobile MAT, Mobile Employment, Residential Treatment, Recovery Houses, How Can We Help Outreach services, and Infectious Disease Education/Testing. DMHAS has a workforce development division that disseminates a catalogue of trainings and DMHAS contracts with the CT Women's Consortium (CWC) to facilitate trainings on addiction related topics; both are available to DMHAS staff and the DMHAS-contracted workforce in private non- profit providers.

1115 Waiver

Over the past three years, DMHAS has worked closely with DSS, DCF, OPM, and JBCSSD on developing and submitting CT's application to the Centers for Medicare and Medicaid Services (CMS) for a Medicaid 1115 waiver that will bring SUD residential treatment services into the Medicaid system as a reimbursable service. This has been a very big project and CMS approved CT's application on April 14, 2022. The residential treatment providers in this network have 24 months to meet the CT treatment standards. The State partners will continue to work closely together during this implementation phase. More details are available here: Substance Use Disorder Demonstration Project

Strategy 3: Strategies Related to Recovery 2022

• **Increase the use of peers and natural supports.** • **Maintain recovery supports.**	
Action Step: Expand the use of peers in DMHAS-funded or operated services	**Action Step:** Expand the use of peers in hospital emergency departments.
Action Step: Increase use of telephonic aftercare	**Action Step:** Provide short-term Supported Recovery Housing
Action Step: Expand wellness programs	**Action Step:** Maintain high levels of consumer satisfaction
Action Step: Expand use of natural supports	**Action Step:** Continue to develop the certified peer workforce

Accomplishments

DMHAS has worked with Connecticut's recovery community on a number of initiatives that support recovery. These activities include the development of peer supports, telephonic support, the use of Recovery Centers, use of peers in treatment programs, and programs oriented at wellness. These are described in further detail below.

CCAR Recovery Coach Academy

As part of DMHAS' contract with the Connecticut Community for Addiction Recovery (CCAR), CCAR provides Recovery Coach training to individuals who want to work with people with SUDs. Coaches work in a variety of settings (e.g., ED, methadone clinics, and outpatient clinics). The training is a five-day intensive curriculum.

CCAR Telephone recovery support program

As part of DMHAS' contract with the Connecticut Community for Addiction Recovery, CCAR provides telephonic services to individuals who choose to participate. They may currently be in treatment, or 12-step groups, or recently discharged from addiction treatment facilities. This service is open to anyone with a SUD who feels that a regular check-in would be beneficial to them. In 2021, CCAR reported that they called over 1,000 persons a week and had over 12,500 conversations with persons in recovery over the course of the year. The Program is viewed as a cost effective method to provide support to persons in recovery and quickly link those individuals back to treatment when they may require additional support. It also helps connect persons in recovery with 12-step groups and other natural supports within the community. The service is provided by CCAR volunteers who are trained.

Wellness and Integrated Health

Connecticut's advocacy community offers a number of activities focused on wellness and holistic health. Examples include things like Toivo, CCAR's Recovery Centers, and wellness programs like those at Connecticut Valley Hospital. Toivo, by Advocacy Unlimited, is an initiative that includes statewide classes, workshops, and a mind/body focused wellness center where people can engage in yoga, meditation, fitness activities, and other creative and expressive activities. DMHAS also has a statewide Integrative Medicine Collaborative, including quarterly meetings and an annual conference that draws hundreds of participants.

Supported Recovery Housing

DMHAS contracts with Advanced Behavioral Health to maintain a network of short-term Supported Recovery Housing (i.e., sober housing). Statewide, there are currently 21 contracted Recovery House providers offering structured sober living in 72 locations, which have over 300 beds. Approximately 2,200 individuals were served in 2021. The program provides short-term funding to support persons in recovery who may be transitioning out of treatment programs back into the community. The program provides temporary assistance until an individual can gain more permanent housing and employment. DMHAS-contracted Supported Recovery Houses were added to the DMHAS bed availability website in the fall of 2018.

Recovery Centers

CCAR's Recovery Centers are community anchors for recovery offering a range of supports including employment and housing services, training, and recovery social events. CCAR has historically had three distinct Recovery Centers in Hartford, Windham, and Bridgeport. A new Recovery Center opened in New Haven in 2019. A range of supports is offered at these centers by persons in recovery.

Recovery Coaches in Emergency Departments

In March 2017, the CT Department of Mental Health and Addiction Services (DMHAS) partnered with the Connecticut Community for Addiction Recovery (CCAR) to launch an initiative that pairs on-call recovery coaches with Emergency Departments in four hospitals in eastern Connecticut. The recovery coaches assist people who are admitted with opioid overdose, alcohol and other drug-related medical emergencies and connect them to treatment and other recovery support services. This program was expanded to 22 hospital emergency departments over the past three years through the support of federal grants. CT plans to continue expansion of this program in the coming years to cover all EDs in the state.

Recovery Coaches in multiple Programs

DMHAS funds recovery coaches in eight OTP's and recently in two withdrawal management programs. These staff were introduced as a way to increase engagement with individuals in substance use services.

OPIOID EDUCATION AND FAMILY SUPPORT GROUPS

Weekly opioid education and family support meetings are being provided in seven locations statewide. (New Haven; Hartford (2); Waterbury; Willimantic; Torrington; New London). These meetings are designed for family members who have loved ones that are misusing opioids. Family Hope and Loss groups for those grieving a loss of a loved one are available in Enfield and Middlefield.

Strategy 4: Strategies Related to Criminal Justice 2022

• **Implement criminal justice reforms that will increase diversionary options and the availability of substance use treatment in jails and prisons.** • **Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail**	
Action Step. Implement a Forensic Case Management program for Psychiatric Security Review Board clients who are in the process of re-entering the community from Whiting Forensic Hospital.	**Action Step:** Provide funding for Recovery Coaches to team up with Jail Diversion teams - Adding Recovery Coaches to three Jail Diversion teams in areas of the state that have high concentrations of opioid overdoses, which include Hartford, Waterbury and Bridgeport.
Action Step: Provide funding to expand the CSSD-operated Treatment Pathways Program (TPP) in three courts to eight courts. This program diverts persons with substance use disorders from jail and into treatment services.	**Action Step:** Increase housing opportunities for ex-offenders by proposing expansion of the Enhanced Forensic Respite Bed pilot program to three additional courts.
Action Step: Implement diversionary services for individuals arrested for crimes related to substance use by enhancing the utilization of Early Screening and Intervention Program.	**Action Step:** Fund and implement training for all stakeholders that address the criminogenic needs of individuals who have criminal justice involvement
Action Step: Provide substance use services to persons who are incarcerated by providing Department of Correction with funding to continue and enhance MAT programs in DOC facilities.	**Action Step:** Transition offenders with drug convictions to community substance use program utilizing specialized jail diversion programs like Alternative Drug Intervention, Women's jail diversion, and Treatment Pathways Program.
Action Step: Implemented the telephonic crisis response. This involves PNP's partnering with several shoreline police departments to provide immediate access to a clinician via telehealth**.**	

Accomplishments

Many individuals who are involved with the criminal justice system have struggled with substance use and may be at-risk for continued use when they return to the community. Others have been arrested for low-level crimes that were related to substance use. Connecticut has developed strong collaborations between DMHAS, DOC, Judicial Branch CSSD, and DCF that focus on diverting individuals, where appropriate, from prison or jail or focus on community re-entry after being released from prison.

SECOND CHANCE INITIATIVES

Legislation signed by Governor Malloy in June 2015 reduced penalties for drug possession and eliminated mandatory sentencing requirements. Funding was approved in that year's budget for

three initiatives that are part of the "Second Chance Society" including funding for the following programs: I-BEST, an employment program for ex-offenders in the Hartford area, Connecticut Collaborative on Re-Entry, a successful housing program aimed at individuals that repeatedly cycle in and out of the homeless service and correction systems, and a School-Based Diversion Initiative aimed at reducing suspension, expulsions, and school-based arrests in grades K-12.

DOC Methadone Maintenance Pilot

DOC, in collaboration with DMHAS, implemented a pilot program at New Haven Community Correctional Center in October of 2013, offering methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in November 2014. This was then expanded to the York, Osborne and Corrigan facilities. Individuals are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release.

The DOC currently serves approximately 615 inmates daily with Opioid Use Disorder Medications and Psycho-Behavioral Counseling in nine Correctional facilities. These programs are vendor based, except for York Correctional Institution, which is an internally Licensed and Accredited Opioid Treatment Program (OTP). During the expansion to include nine facilities, there have been significant achievements made to offer all three FDA approved medications: Methadone, Buprenorphine, and Extended-Release Naltrexone. Methadone and Extended-Release Naltrexone are available at all nine locations and Buprenorphine in two locations with the remaining seven facilities offering Suboxone strips as the roll-out continues in 2022.

Collaborative Contracting with Judicial Branch CSSD

DMHAS is currently involved in collaborative contracting projects with the Judicial Branch CSSD. This project combines funding and jointly purchases intensive, intermediate, and recovery house beds from DMHAS-contracted substance use providers. A certain number of beds are reserved for individuals from CSSD. The beds are used for diversion from jail and re-entry to the community.

DMHAS Forensic Services

The DMHAS Division of Forensic Services funds community agencies to provide services to people with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism. The Women's Jail Diversion, Jail Diversion Substance Abuse (JDSA), Alternative Drug Intervention programs provide a full complement of clinical and support services to criminal court defendants with substance use disorders. The Pretrial Intervention Program is a suspended-prosecution diversion program for first-time DUI offenders and drug possession offenders that provides alcohol and drug education

groups or referral to a substance use treatment program. Transitional Case Management is a re-entry program that provides pre-release engagement and discharge planning and post-release OP substance use treatment and support services for men.

RE-ENTRY PILOT AT YORK CORRECTIONAL INSTITUTE

DMHAS provides funding and collaborates on this pilot working with the staff at York Correctional Institute and two private nonprofits, Safe Futures and Alliance for Living which provide in-reach and education to women who are nearing their end of sentence. The interventions focus on Intimate Partner Violence and Trauma.

ENHANCED FORENSIC RESPITE BED PILOT

Implemented the Enhanced Forensic Respite Bed pilot program. This pilot was inaugurated in late October 2021and provides three respite beds with intensive services for misdemeanor-only defendants who would otherwise likely be referred for competency to stand trial evaluation and possibly restoration.

TELEPHONIC/TELEHEALTH PARTNERSHIP PILOT

Implemented the telephonic/telehealth pilot crisis response. This involves PNP's partnering with several shoreline police departments to provide immediate access to a clinician via telehealth equipment. This pilot was designed, in part, to provide additional access and resources to police during the "off hours."

RECOVERY COACHING

Provided funding to work with CCAR (Connecticut Community for Addiction Recovery). The ASU trained approximately 25 staff and 10 inmates at Osborn Correctional Institution (OCI) in recovery coaching. This provides important professional development opportunities for staff and enables inmates to utilize these skills in their day-to-day recovery in the OCI therapeutic community. In addition, the inmates now have employment opportunities in recovery coaching upon release.

Strategy 5: Strategies Related to Collaboration and Cost Effectiveness

• **Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.**	
Action Steps: Improve quality of care through the expansion of data sharing	**Action Steps:** Increase inter-agency collaboration for treatment services
Action Steps: Increase inter-agency collaboration for prevention services	**Action Steps:** Maximize federal and state funding and avoid costly duplication of efforts

Accomplishments

State agencies are involved in multiple collaborations that focus on inmates, community re-entry and jail diversion, parents who use substances, and specialized supports for adolescents. Some of these collaborations have already been described under other strategies but they will be briefly reviewed below.

COLLABORATIVE CONTRACTING WITH DMHAS AND JUDICIAL BRANCH CSSD

DMHAS is involved in collaborative contracting projects with the Judicial Branch CSSD. This project combines funding and jointly purchases intensive, intermediate, and recovery house beds from DMHAS-contracted substance use providers. A certain number of beds are reserved for individuals from CSSD. The beds are used for diversion from jail and re-entry to the community.

JAIL DIVERSION AND RE-ENTRY PROGRAMS

The DMHAS Division of Forensic Services funds community agencies to provide services to people diagnosed with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism.

DOC METHADONE MAINTENANCE PILOT

This as described in greater detail on page 33 but DOC, in collaboration with DMHAS, implemented a pilot program at New Haven Community Correctional Center in October of 2013, offering methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in November 2014. Individuals are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. This was then expanded to the York, Osborne and Corrigan facilities. The DOC currently serves approximately 615 inmates daily with Opioid Use Disorder Medications and Psycho-Behavioral Counseling. There are currently MOUD programs in 9 Correctional facilities.

Adolescent Substance Use Services

DCF has maintained its focus on providing substance use services located in communities throughout the state that are accessible to all youth, and are evidence-based and family-focused. DCF's network of adolescent substance use treatment programs from SFY 2019 through SFY 2021 included:

- Intensive In-Home Treatment for youth opioid use
- Multidimensional Family Therapy (MDFT) in-home teams across 18 providers statewide;
- Multisystemic Therapy (MST) in-home teams across 3 providers covering nearly the entire state
- Residential substance use services offered in several locations.

These initiatives are described in greater detail in DCF's report.

Suicide Prevention

A number of state agencies are involved in Suicide Prevention efforts including DCF, DMHAS, JB-CSSD, Department of Education, and DPH. Other stakeholders are involved in these efforts to reduce suicides and to develop a coordinated and supportive response when suicides occur. While these services may focus on individuals with mental health concerns, suicide prevention efforts are also directed at persons with substance use problems who may feel suicidal.

Community Drug Take Back Programs

Another important initiative of DCP has been the establishment of a prescription drop box program that recently added pharmacies. There are now over 116 boxes in operation between the state police, municipal police, and local pharmacies which have collected over 268,750 pounds of unwanted medications since 2012.

Strategy 6: Strategies Related to Accountability and Quality Care

• **Ensure that providers deliver high quality services.** • **Use data to improve care throughout the system.**	
Action Step: Ensure providers submit timely and accurate data	**Action Step:** Establish performance measures for all SUD levels of care and benchmark performance annually
Action Step: Implement and enhance the DMHAS provider performance measurement system	**Action Step:** Monitor emerging needs and trends by compiling and reviewing Annual Statistical Data
Action Step: Increase the % of individuals with SUD who have continuous treatment exposures that exceed 90 days	**Action Step:** Utilize data systems to identify and address health disparities
Action Step: Ensure services are well utilized	

Accomplishments

DATA SYSTEMS

The Department uses two systems to capture substance use data. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers and was implemented in 2009. The second system WITS collects client level data from state-operated facilities. This system was implemented in mid-May 2014. Both systems capture a broad range of data including demographics, admission and discharge info, diagnostic information and the services individuals receive within our programs.

A new electronic health record is expected to be implemented in DMHAS-operated facilities by 2025. This will serve as an upgrade to the current WITS system and will assist the Department in achieving more sophisticated data collection and analysis for the programs in those facilities. These data systems have already greatly enhanced the department's ability to collect and report on all individuals served within our system, while tracking measureable outcomes. The new electronic medical record will only further strengthen our data collection capacities and foster more coordinated clinical care.

PERFORMANCE MEASURES AND PROVIDER QUALITY REPORTS

The data described above feeds our Performance Measurement System. DMHAS has developed contractually specified performance measures for each mental health and substance use level of care (i.e., withdrawal management/detoxification, intensive residential, outpatient). This system also establishes benchmarks for these performance measures. The Department of Mental Health and Addiction Services (DMHAS) introduced Provider Quality Dashboard Reports as part of a

comprehensive performance evaluation system in 2009. The quality reports are issued quarterly and posted to the DMHAS website. These reports can be found at the following link:

https://portal.ct.gov/EQMI-PQR

The link shows each performance measure for substance use levels of care, the goal, and the state average for each measure. This allows DMHAS' Quality and Monitoring Departments to review system averages as well as those of individual providers.

CONTINUOUS TREATMENT EXPOSURE

Another important measure that DMHAS tracks is one called continuous treatment exposure. National research has shown that continuous treatment episodes that exceed 90 days or more result in better outcomes. This measure cuts across all substance use levels of care. DMHAS first reported on this measure in our 2016 report. DMHAS examined individuals that were admitted or already active during a fiscal year to determine the percentage that remained in treatment with no interruption for greater than 90 days. Our results have continued to improve, reflecting the DMHAS system's emphasis on connecting those served to other levels of care as they move through the treatment spectrum. The information for FY 19, 20, and 21 is as follows:

FY 19: 60%

FY 20: 65%

FY 21: 70%

The percentage for FY 21 is an improvement of over 10% from the FY 18 percentage.

ANNUAL STATISTICAL REPORT

DMHAS developed an Annual Statistical Report that was first published in December 2014. That report examined two fiscal year's data. The next report was released in December 2015 which reported on SFY15 activity. The report is now being produced on an annual basis. The report includes information on individuals served, demographics, substance use trends and service utilization data. The report was intended to annually capture essential information about service delivery in the DMHAS behavioral health system. The SFY21 Annual Statistical Report can be found at the link listed below:

DMHAS-Annual-Statistical-Report-2021.pdf (ct.gov)

PRESCRIPTION DRUG MONITORING PROGRAM

The State's Department of Consumer Protection implemented a Prescription Monitoring Program (PMP) in 2008. The PMP was designed to collect prescription data for Schedule II through V drugs

into a central database that can be used by medical providers and pharmacists in the active treatment of their patients.

Annual Consumer Satisfaction Survey

DMHAS administers a Consumer Satisfaction Survey which typically receives over 25,000 respondents. The instrument was developed by states across the country that were looking for a tool that allowed them to compare results to national data. DMHAS consistently receives high marks on this survey and typically exceeds national outcomes. The Fiscal Year 2021 Annual Consumer Report is being finalized but when available can be found at the link below:

EQMI - Consumer Survey (ct.gov)

Other State Agency Substance Use Initiatives and Accomplishments

➢ Department of Children and Families

Statewide Substance Use System for Youth and Caregivers

Connecticut Department of Children and Families (DCF), established under Section 17a-2 of the Connecticut General Statutes, is a comprehensive children's agency that is responsible for child protective services and providing the state's children, youth and families with an integrated system of services and supports for mental health and substance use.[1] At any point in time, DCF serves approximately 36,000 children and 16,000 families across its programs and mandates. DCF has formal agreements (e.g., MOUs, contracts) with more than 130 agencies covering more than 75 service types. These agreements are with youth treatment agencies, local community collaboratives, administrative services organizations, family advocacy organizations, school districts, and faith-based and recovery support agencies. They include provisions for referrals, admission and discharge planning, service coordination and linkage, substance use and behavioral health services, community collaborative and managed service system coordination and involvement, and data management and quality assurance.

The Office of Intimate Partner Violence and Substance Use Treatment and Recovery is responsible for substance use programming at DCF. The Office resides within the Division of Clinical and Community Consultation and Support, which also includes children's behavioral health, regional resource group, therapeutic foster care, interagency collaboration, in-home parenting supports, anti-human trafficking, young adult housing and Families First programs. DCF-funded substance use programs offer children, youth, caregivers and their families a range of services for substance use with or without co-occurring mental health disorders that are rooted in best practice and evidence. The DCF substance use system includes a statewide network of providers serving youth as young as age 9, and their families, to prevent substance use problems as well as treatment and recovery support for youth up to age 24. Many of these services are available in clinics or homes, often preventing the need for more intensive or restrictive care such as in hospital, or congregate care settings. DCF's community-based services for adolescent substance use are entirely evidence-based and equipped to address problems related to the use of any substance, including opioids and prescription drugs, co-occurring mental health disorders, as well as problems at home, school, or with the legal system. More recently, DCF has begun investing in screening to increase early identification of substance use, and continuing care recovery support programs to help youth maintain progress made during treatment. DCFs adolescent substance use services are available to all families in Connecticut and do not require DCF involvement.

[1] See also C.G.S. § 17a-3.

DCF also provides specialized substance use treatment services for caregivers involved with child protective services. Since the last triennial report, and largely due to impacts of the opioid crisis on the child welfare system, DCF has grown its investment in caregiver services to reach families in every region of the state with evidence-based or evidence-informed treatment and recovery supports. Caregiver treatment services are provided exclusively in the family's home where they aim to prevent removal and placement of children or support timely permanency including reunification of the family when a removal has occurred. These goals are accomplished by providing families frequent and intensive services that address substance use and the multiple correlates that affect child well-being including child and parent trauma, mental health, parenting and attachment, housing, and employment. During this reporting period DCF also introduced three non-clinical substance use services under the SAFE Family Recovery (SAFE-FR) program. SAFE-FR services aim to increase identification of substance use problems among caregivers, help them engage and remain in treatment services when they are needed, and provide recovery support after treatment.

Moving into the next triennial, DCF intends to focus its efforts in three main areas:

- Expanding access to recovery support services
- Enhancing integration of services for mental health, substance use, and intimate partner violence
- Increasing early identification of substance use problems and connections to care

DCF Data and Reporting Systems

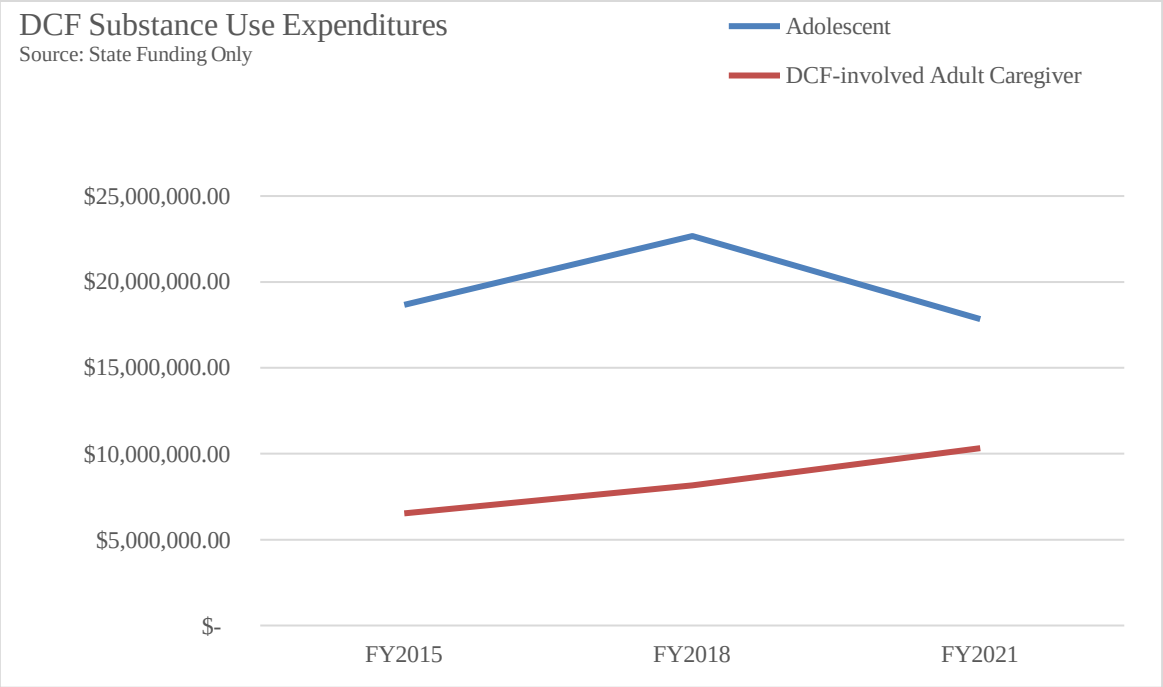
DCF uses a variety of data to plan, design and monitor its service system and these data sources are reported here. All DCF funded substance use treatment programs are required to use an evidence-based assessment called the Global Appraisal of Individual Needs (GAIN) and its associated reporting system, GAIN Assessment Building System (ABS). Since SFY09 the Department also has collected standardized information from substance use providers through the Provider Information Exchange (PIE) portal. Evidence-based practice models in use by the Department also collect and report on information on individuals they serve. During this reporting period, funding from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA/CSAT) allowed the Department to leverage the CT Behavioral Health Partnership to develop a financial map of expenditures for youth substance use and mental health services using Medicaid claims data. Data from the GAIN, PIE, evidence-based programs, and Medicaid claims systems enhance DCF's ability to identify the population served, conduct needs assessment, compare client information across programs, assess patterns of service utilization based on claims data, implement systematic monitoring of outcomes, analyze program-specific goals and meet its statutory obligation to report on programs to the legislature, other funders, and community stakeholders.

DCF Substance Use Funding and Expenditures

The Department's investment in substance use services for youth and their families is one component of how the system is financed. Agencies providing DCF-supported clinical substance use services rely on a mix of state grants, self-payments, private sources, and third party revenue. While many of the evidence-based services are eligible for Medicaid and other third party reimbursement, third party payments often are too small to cover the costs of training and quality assurance for evidence-based programs and other non-clinical program costs, or have restrictions on payment for services delivered in non-traditional settings like in homes. Continued state support is essential for these programs to remain in operation and deliver high quality care.

Over the last three fiscal years, the Department's total expenditures for substance use services has declined slightly by 2%, even when Federal sources of support (e.g., discretionary grants) are included in the calculation. Looking at the overall budget alone conceals expenditure changes in adolescent and caregiver substance use expenditures over time (Figure 1). Fiscal year 2021 marks the first year in recent history that adolescent SUD expenditures declined.

Figure 1. DCF State Funded Expenditures on Substance Use Services



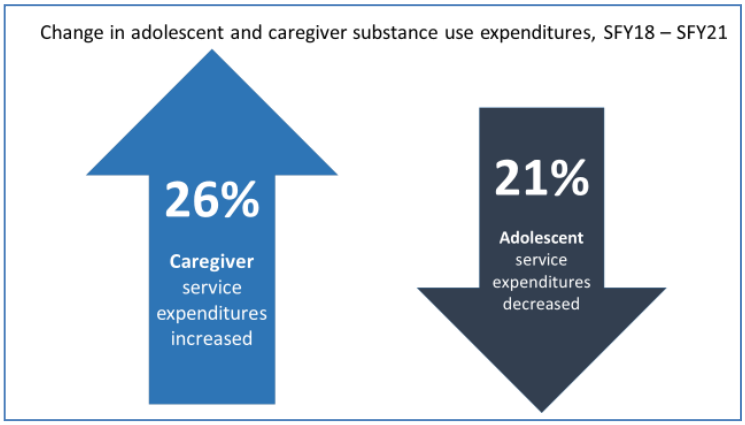
Since the last triennial report state expenditures on adolescent substance use services shrank by 21% while expenditures for caregiver services grew by 26%. The observed decrease in adolescent expenditures is partly due to the transfer of juvenile parole services and funding to the Judicial Branch Court Support Services Division. Table 1 details expenditures by program type.

Table 1. DCF Substance Use Expenditures by Population Served and Service Type, SFY15, SFY18 and SFY21.

Service Type	Source	FY2015	FY2018	FY 2021	% Change since FY18
ADOLESCENT SERVICES & QA		**Expenditure**	**Expenditure**	**Expenditure**	
Outpatient Treatment	State	1,668,587.00	1,730,226.00	1,243,508	-28%
Home-based Treatment	State	13,581,515.00	16,042,684.00	13,343,485.00	-17%
Home-based Treatment for Opioid Use	Federal			352,000.00	
Residential Treatment	State	2,665,449.00	4,045,448.00	1,418,501.00	-65%
Evidence-based Practice QA	State	754,406.00	855,570.00	1,832,710.00	114%
SMART Recovery Groups	Federal	-	-	336,819.68	
Adolescent Services & QA Total	**State Only**	**18,669,957.00**	**22,673,928.00**	**17,838,204.00**	**-21%**
Adolescent Services & QA Total	**Federal Only**			**688,819.68**	
Adolescent Services & QA Total	**State & Federal**	**$18,669,957.00**	**$22,673,928.00**	**$18,527,023.68**	**-18%**
CAREGIVER SERVICES & QA					
Project SAFE Recovery Programs	State	1,637,942.00	1,241,770.00	-	
Substance Exposed Infants Coordination	State	-	-	60,528.75	
CAPTA - United Way	Federal			131258.82	
SAFE Family Recovery	State	-	-	2,790,971.00	
MST-Building Stronger Families	State	1,658,949.00	2,610,017.00	2,941,344.00	13%
Family Based Recovery*	State & Federal	2,894,460.00	3,983,397.00	4,043,196.00	2%
Family Based Recovery QA	State			489,743.00	
MST-BSF Consultation & QA	State	341,840.00	334,840.00	1,282,710.00	283%
Caregiver Services & QA Total	**State Only**	**6,533,191.00**	**8,170,024.00**	**10,325,782.75**	**26%**
Caregiver Services & QA Total^	**Federal Only**			**131,258.82**	
Caregiver Services & QA Total	**State & Federal**	**$6,533,191.00**	**$8,170,024.00**	**$11,739,751.57**	**44%**
TOTAL Substance Use Expenditures	**State & Federal**	**$25,203,148.00**	**$30,843,952.00**	**$30,266,775.25**	-2%

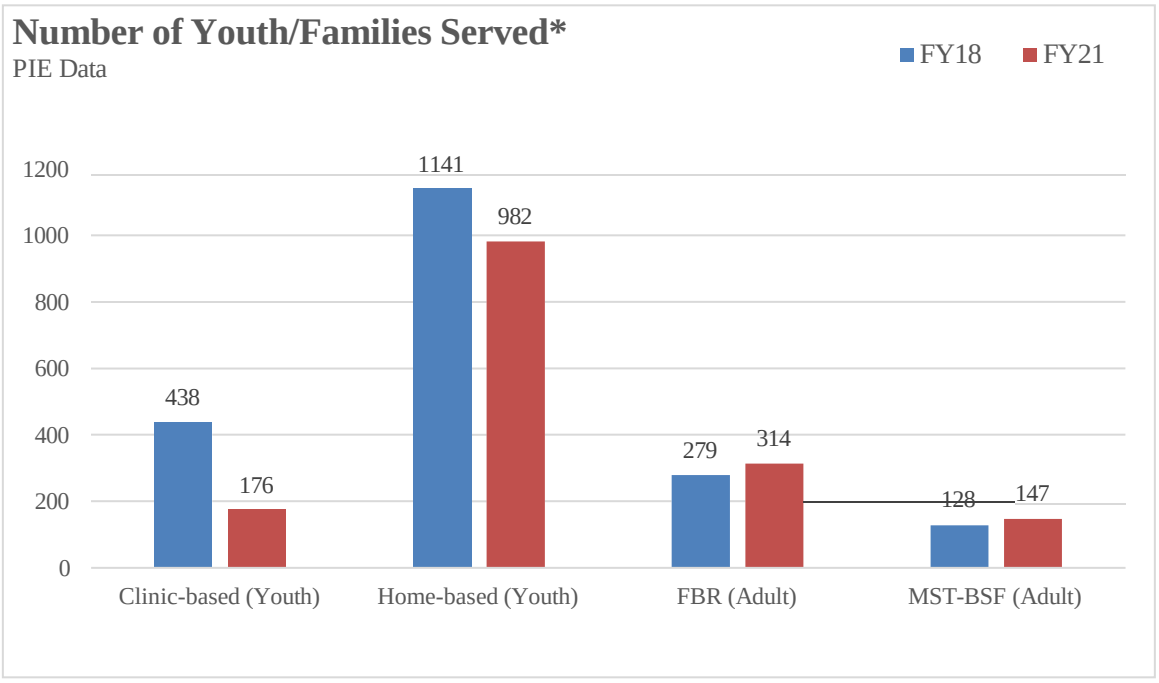
*For part of the reporting period, FBR was covered by two Federal sources not identified in this table.
^Not including the federal monies that partially funded FBR for a portion of the reporting period.

Adolescent residential treatment saw the biggest single-service decrease in expenditures (-65%) during the last triennial. Among caregiver services, MST-Building Stronger Families services and quality assurance expenditures increased the most - by nearly 300%. This growth resulted from expansion of MST-BSF to make it more available across the state.



Consistent with the changes in expenditures over time, fewer youth were served during this reporting period while more adult caregivers and their families received services (Figure 2).

Figure 2. Number of Youth and Families Served, PIE Data, FY2018 & FY2021.

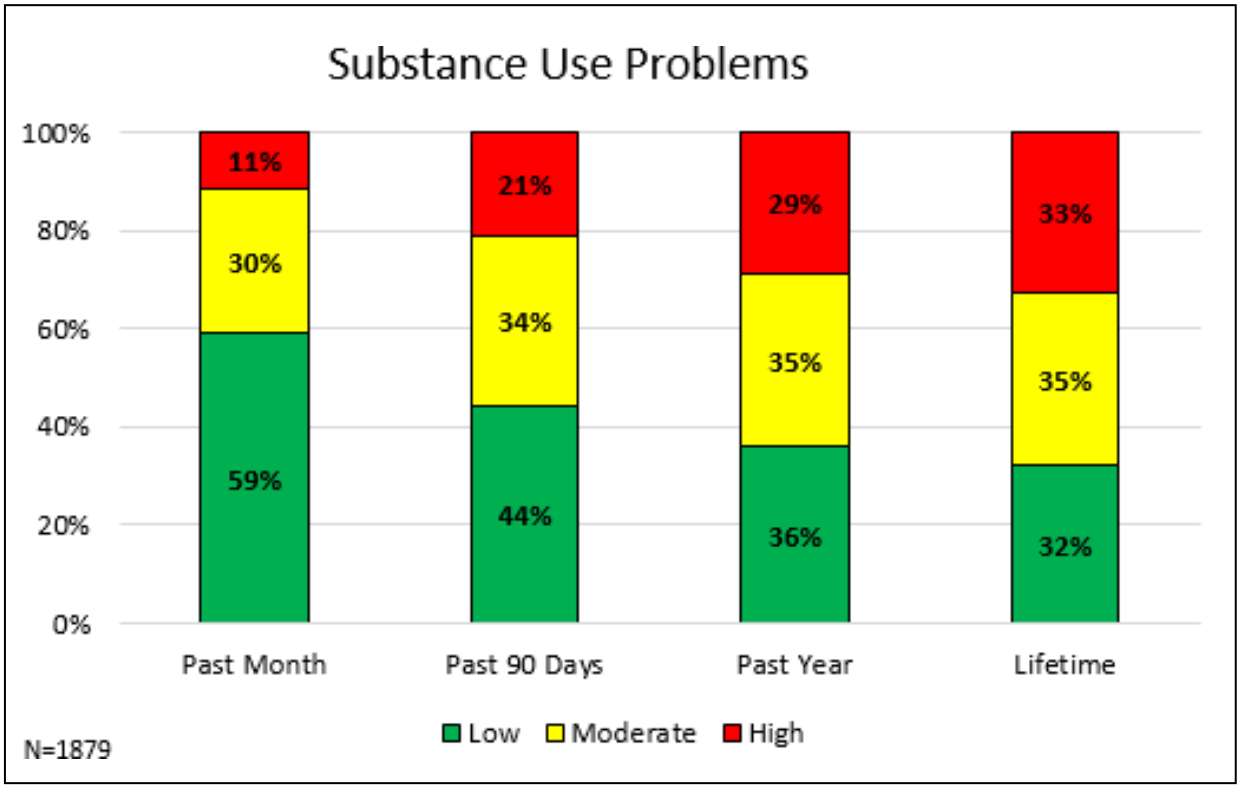


*Youth may have been served by multiple programs during the reporting period. ACRA-ACC is the youth clinic-based service included. MDFT, MST and MST-EA are the included home-based services for youth. Caregiver services reported the number of unique families served.

Adolescent Substance Use Services

Substance use disorder is a disorder that begins in adolescence. Most adults who develop a substance use disorder report starting substance use in their adolescence[2]. Youth who initiate substance use earlier have among the poorest life outcomes including higher rates of substance use disorders, physical health problems, and mental health problems contributing to shorter life expectancies. In Connecticut, the average age at entry to substance use treatment is 15 years. Already at treatment entry nearly two out of three (64%) Connecticut youth report experiencing moderate to high severity substance use problems in the year prior to admission signaling that the state can improve on identifying youth substance use earlier (Figure 3). These symptoms include problems at home, work or school, giving up important hobbies or activities, continued substance use despite problems, inability to cut down or stop using, and withdrawal problems or sickness if they try to stop or reduce their substance use.

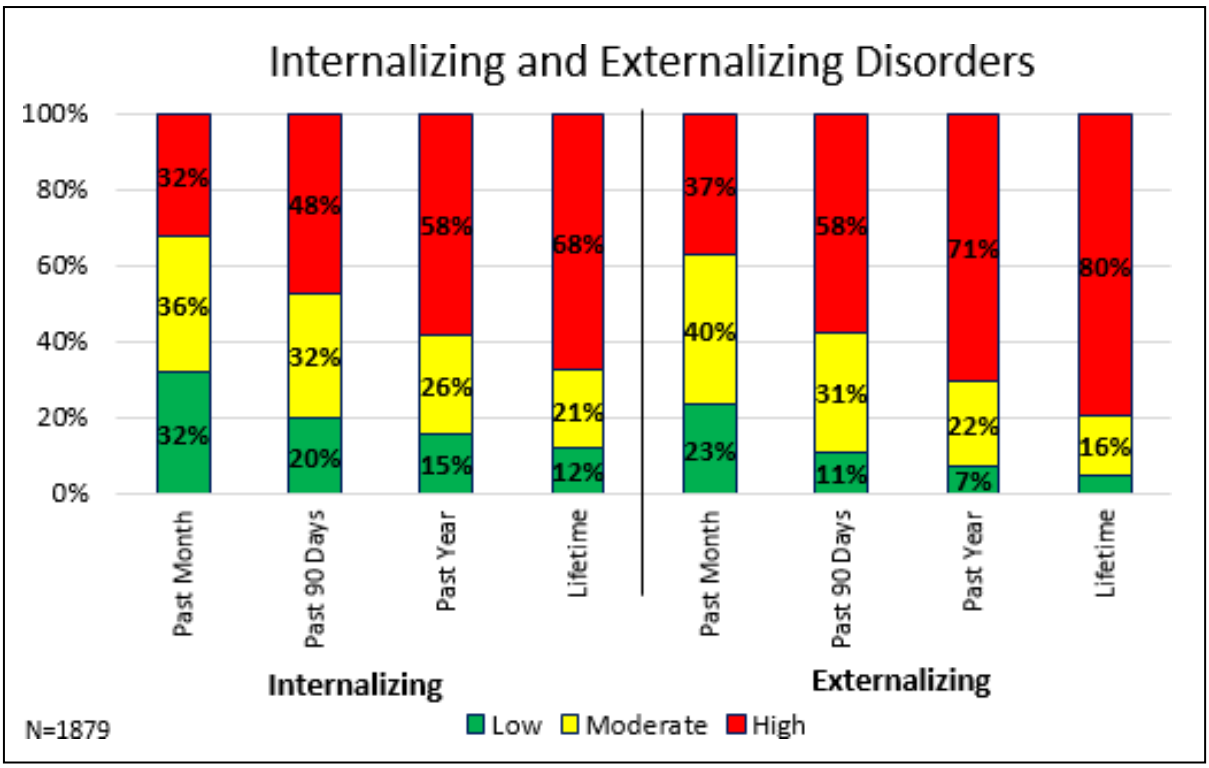
Figure 3. Severity of Substance Use Problems Among Adolescents Entering Publicly Funded Treatment, GAIN Data, FY2018-FY2021.



[2] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS*, November 2016.

Drug use also is associated with other risky behaviors and adverse experiences including risky sexual behavior, experiences of violence, mental health problems and suicide risk.[3] In fact, Connecticut youth overwhelmingly report mental health problems at intake to substance use disorder treatment underscoring the complexity of their needs and the importance of integrated co-occurring treatment (Figure 4). **More than 9 out of 10 (93%) youth entering SUD treatment reported moderate to high severity symptoms related to externalizing disorders** suggesting the need for treatment related to ADHD, conduct disorder, gambling or other impulse control disorders. **Greater than 8 out of 10 (85%) of youth reported moderate to high severity symptoms related to internalizing disorders** suggesting the need for mental health treatment related to depression, anxiety, trauma, psychosis and suicide. In rarer cases, treatment for serious mental illness like psychosis may be necessary.

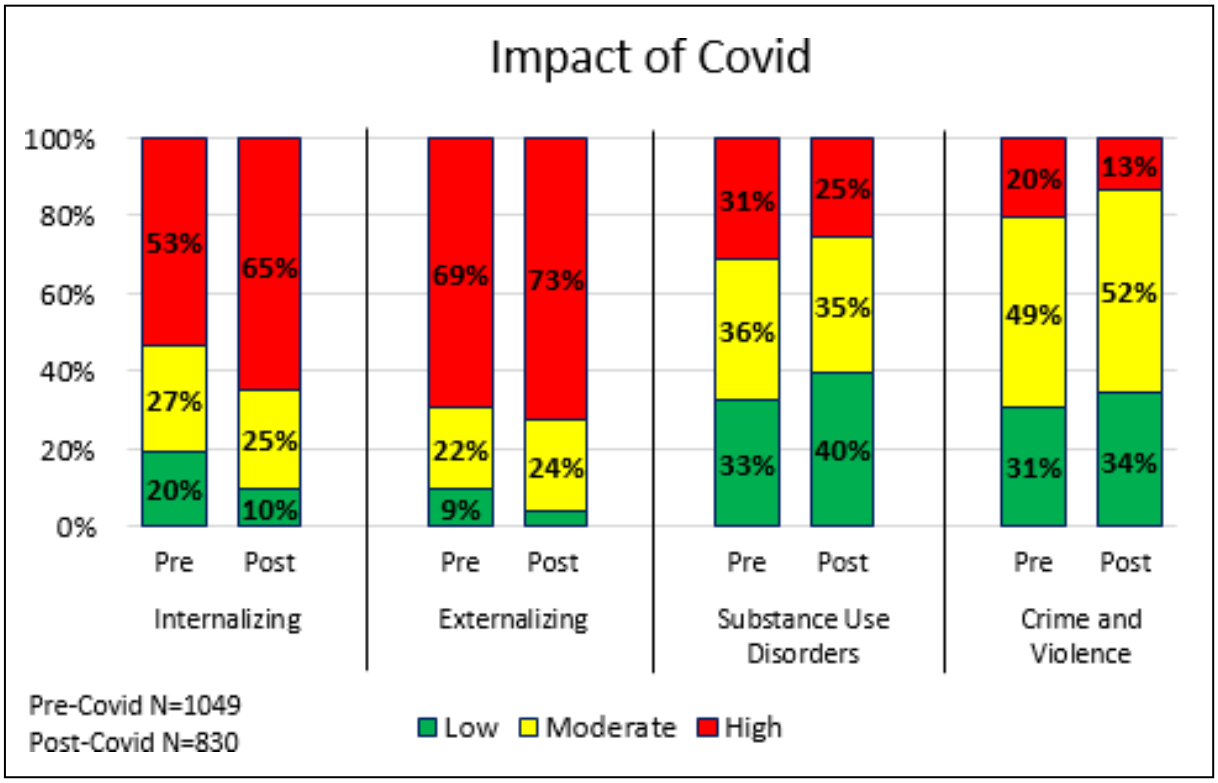
Figure 4. Severity of Mental Health Problems Among Adolescents Entering Publicly Funded Treatment, GAIN Data, SFY2018-2021



[3] CDC, Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report, 2009–2019* pdf icon[PDF – 31 MB]. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Infectious Diseases, NCHHSTP; 2020.

Impact of COVID-19. COVID-19 exacerbated the mental health needs of youth entering publicly funded substance use treatment. Comparisons of DCF GAIN data from 1049 youth entering treatment before the start of the COVID-19 health emergency with data from 830 youth entering treatment after the start of COVID-19 showed a **12% increase post-COVID in youth reportedly experiencing high severity internalizing disorder problems** (e.g., depression, anxiety, trauma, suicide) during the year prior to treatment admission (Figure 5).

Figure 5. Impact of COVID-19 on Adolescents Entering Publicly Funded Treatment, GAIN Data, SFY2018-2021



Screening and early identification, access to a full continuum of integrated treatment services, and ongoing peer support and recovery services are key components of a comprehensive and responsive substance use service system. DCF uses data collected by providers from youth entering services, feedback from youth and families, and input from advocates, experts and other stakeholders as part of an ongoing continuous quality improvement processes to develop and refine such a system for Connecticut's youth. DCFs network of substance use treatment and recovery support services are entirely evidence-based and family-focused. Table 2 describes adolescent substance use services supported by DCF. The table at the end of this section provides detailed information about where each service is available throughout the state.

Table 2. Description of DCF-funded Adolescent Substance Use Services

Program Type: Name	Target Population & Descriptions	Catchment Area
Clinic-based outpatient: Adolescent Community Reinforcement Approach / Assertive Continuing Care	Adolescents age 12-17 years, who have an identified substance use issue and meet American Society of Addiction Medicine (ASAM) criteria for outpatient level of care.	14 clinic sites across 6 teams with statewide coverage
Intensive in-home: ASSERT Treatment Model (ATM) for youth opioid use	Comprehensive treatment and recovery program for adolescents and young adults up to age 21 years inclusive, with opioid use and related behavioral and emotional problems. ATM provides MDFT treatment, access to Medication Assisted Treatment (MAT) and up to 12 months of continuing care after MDFT discharge using the Recovery Management and Supports model.	Four (4) teams serving DCF regions 3, 4, 5, 6
Intensive in-home: Multidimensional Family Therapy (MDFT)	Family-based comprehensive treatment for children and adolescents age 9-18 years old with substance use, or are at risk of substance use, and have related behavioral and emotional problems.	18 teams across 7 providers; with 4 of these providers also offering a specialty protocol for youth and young adults with opioid use disorders
Intensive in-home: Multi-Systemic Therapy (MST)	Adolescents age 12-17 with a DSM-5 diagnosis who exhibit antisocial, acting out, substance using, and/or delinquent behaviors.	DCF and CSSD jointly fund 12 teams across 4 providers covering the entire state
Intensive in-home: MST Emerging Adult (MST-EA)	Emerging adults age 17-21 with serious mental illness and/or substance use, with or without a trauma history. The young adult must be aging out of foster care or involved in the child welfare system; have stable housing or a plan to achieve stable housing; and co-referred to DMHAS behavioral health services.	DCF Area Offices served include Milford, Bridgeport, Waterbury, New Britain, Hartford and Manchester
Residential for males: Rushford Academy	Six-month residential program for adolescent males. Individual and group therapy is offered using the Seven Challenges curriculum.	Six (6) beds at Rushford in Durham
Residential for males: MDFT Residential Program	Four-month residential program for committed delinquent males ages 14-18 with mild to moderate substance use treatment needs. MDFT offers integrated mental health and substance use treatment to improve educational and emotional functioning, and to promote community and family re-engagement.	Eight (8) beds at Connecticut Junior Republic in Litchfield
Recovery Support: Youth Recovery CT	Curriculum-based virtual and in-person recovery support groups to youth and their families	49 groups available statewide

Outpatient Substance Use Services

The Department funds four evidence-based substance use treatment programs at the American Society of Addiction Medicine (ASAM) outpatient level of care. These programs include:

- Adolescent Community Reinforcement Approach with Assertive Continuing Care (A-CRA/ACC)
- ASSERT Treatment Model (ATM) - funded with both state and federal dollars
- Multidimensional Family Therapy (MDFT)
- Multi-Systemic Therapy (MST)
- Multi-Systemic Therapy for Emerging Adults (MST-EA)

These services are offered either in clinics or in the homes of youth and their families one to three times weekly. All services treat substance use and co-occurring mental health problems, and address other life areas such as family, school, work, and peers. A-CRA/ACC uses behavioral interventions with youth to promote pro-social activities and build recovery through a combination of clinic- and home-based sessions. MDFT and MST are home-based services that offer more frequent treatment sessions. MDFT uses family therapy as the primary strategy to address substance use and other problems including delinquency. MST uses an "environmental systems" approach working primarily with parents to address youth substance use and delinquency. MST-EA uses the MST approach to address the unique needs of older adolescents transitioning to young adulthood including building skills for independent living. Outcomes for clients who discharged from these services in FY2021 are in Table 3.

Table 3. Performance Outcomes for Adolescent Outpatient Substance Use Services, PIE Data, FY2021

METRIC	ACRA-ACC % (N)	MDFT % (N)	MST % (N)	MST-EA % (N)
Number Admitted/Served in FY2021	176	715	222	45
Outcomes for Clients who Discharged in FY2021:	133	367	107	25
Abstinence/Reduction in Substance Use	73% (52)	83% (303)	92% (89)	61% (15)
Living at Home at Discharge	96% (128)	99% (363)	100% (107)	92% (23)*
Improvements in School Attendance	87% (62)	91% (332)	95% (102)	^
No New Arrests	93% (66)	92% (336)	98% (105)	96% (24)

*includes transitional living home for MST-EA
^Not applicable - data not captured for this service

ASSERT Treatment Model (ATM). In 2017 DCF received a grant from the Center for Substance Abuse Treatment (CSAT) to implement evidence-based treatment for youth. In response to growing concern about the opioid crisis, and the potential for the crisis to spread among adolescents, particularly transition age youth, DCF launched a treatment program specifically to address opioid use known locally as the ASSERT Treatment Model (ATM). ATM launched in four existing MDFT teams that received specialized training related to opioid use pharmacokinetics, symptoms, and risks, and additional staffing to deliver the continuing care service. ATM combined three evidence-based services into a single program model to deliver MDFT treatment, medication assisted treatment (MAT) to reduce withdrawal symptoms and cravings, and continuing care for up to 12 months after MDFT discharge using the Recovery Monitoring and Support (RMS) approach. ATM is the first program of its kind in the country for youth. It demonstrated that integration of multiple evidence-based practices to treat youth opioid use is possible and early results are promising.

According to the final ATM report for the ASSERT grant, 16 youth diagnosed with Opioid Use Disorder (OUD) were discharged from ATM and had data entered into the MDFT portal for analysis. These data include all youth with an OUD diagnosis who started ATM regardless of whether they completed the program. Thus, the information provided is in keeping within the spirit of the rigorous "intent-to-treat" research design. These 16 youth were primarily male (88%) and White Non-Hispanic (82%). Their ages ranged from 15 – 19, with 51% being 17 years or older. More than half (57%) of the youth came from families with annual incomes of $50,000 or less, 21% with less than $25,000. Youth in ATM are more male (82% vs. 54%), White Non-Hispanic (88% vs. 48%), and older (51% vs. 16% being 17 or older) than the general MDFT treatment population in Connecticut. Family income was similar between the two groups. At intake to ATM, all youth reported polydrug use with regular use of three or more substances including opioids, on average (Table 6).

Table 4. ATM Final Report, Substance Use Reported at Intake, MDFT portal data, February 2022

Substance Use at Intake	ATM (n=16)
Polysubstance Use	100%
Opioids & Marijuana Use	100%
Opioids & Benzodiazepines	62%
Opioids & Alcohol	56%
Opioids & Cocaine	25%
Opioids & Methamphetamine	4%
Average number of substances used at intake (including opioids)	3.7

The ATM service model also showed promising results when compared to MDFT as usual (Table 5). This effect is especially notable given that ATM targeted youth with opioid use disorder who were older, and had longer and more complex substance use.

Table 5. ATM final report, Performance Outcomes, MDFT portal data, February 2022

OUTCOME	ALL MDFT (N=207)	ATM ONLY (n=16)
Youth living at home/not in placement	91%	94%
Youth in school/working	81%	75%
Youth with no new arrests	86%	88%
Families with no new child abuse/neglect reports	89%	75%
Youth with no drug use other than marijuana or alcohol	88%	63%
Youth who never or rarely engage in illegal activities other than drug/alcohol use, shoplifting, trespassing, loitering, truancy, etc.	82%	50%
Youth who never or rarely engage in violent behavior	62%	63%
Youth with stable mental health functioning	82%	69%
Youth who do not affiliate mostly or exclusively with anti-social peers	94%	81%

All ATM youth with OUD at intake showed meaningful improvements at discharge. Overall, 88% of youth showed a reduction in opioid and other "hard drug" use (e.g., benzodiazepines, cocaine, and methamphetamine). At discharge, 63% of youth with OUD were abstinent from opioids and all other hard drugs and nearly all (94%) were living in a home setting. Youth also showed significant improvements in their mental health (69%) and school or vocational functioning (75%); and reductions in aggression and violence (63%) and involvement with anti-social peers (81%).

DCF Adolescent Residential Substance Use Treatment Programs

Multi-Dimensional Family Therapy Residential program at CT Junior Republic is an 8-bed, short-term (4-6 months), family-centered Multidimensional Family Therapy (MDFT) residential program for males, ages 14-18, who are committed to DCF and who are experiencing substance use problems. This program integrates the MDFT model into all aspects of residential and clinical programming and provides an expansive array of educational, vocational, clinical, and residential programming. State funding of this service ends on March 31, 2022.

Rushford Academy is a 6-bed, short-term substance use residential treatment program for adolescent males ages 12-17 years who are committed to DCF. Rushford Academy uses the evidence-based Seven Challenges treatment approach during counseling sessions, to help youth build better decision-making skills, improve emotional literacy, and develop individualized relapse prevention plans.

In addition to these residential programs, DCF has rate agreements with other residential programs throughout the state to meet the heterogeneous treatment needs of youth requiring this level of care.

Caregiver Substance Use Services

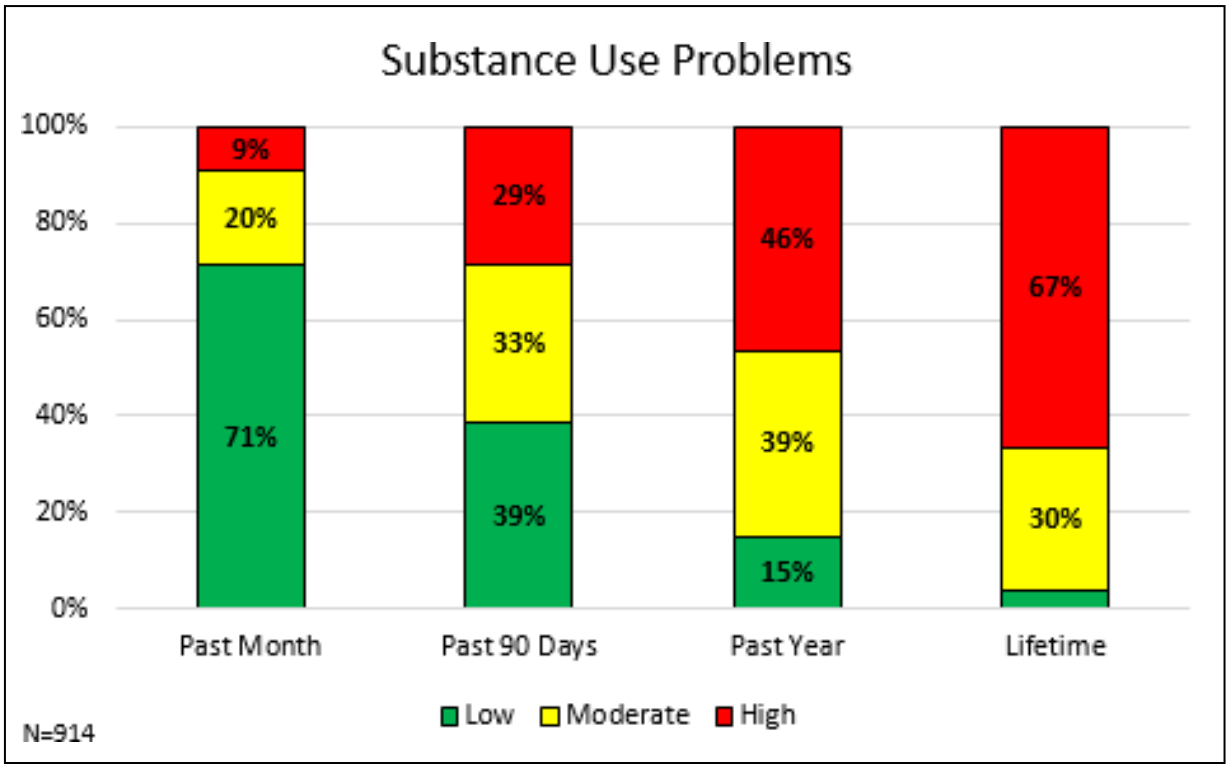
There is strong recognition statewide and nationally that parental substance use problems are a key factor adversely affecting children's immediate and future health and development. This is particularly true for children in the child welfare system. Over the past decade, DCF has continued to enhance and grow evidence-based services designed to mitigate the impacts of parental substance use on children to increase their safety, well-being, and permanency. These services target the state's most vulnerable children and families including families with very young children, families who have had their children removed because of problems related to substance use, or families whose children are at high risk for removal related to caregiver substance use. Many of these services are intensive and available in homes, often preventing child removal or the need for more restrictive care for caregivers such as residential treatment. More recently, the Department has launched a suite of non-clinical services designed to bookend clinical services. These services identify treatment needs, connect caregivers to care and help them to stay in treatment, and provide support when treatment ends. A brief description of these services is in Table 6.

Table 6. Description of Substance Use Services for DCF-involved Caregivers

Program Type: Name	Target Population & Descriptions	Catchment Area
Family Based Recovery	DCF-involved families with a child ages 0-5 years at risk of removal, and where caregiver substance use is a factor. In-home services provided three times per week for six to nine months.	Statewide: 12 teams across seven providers
Multi-Systemic Therapy Building Stronger Families (MST-BSF)	DCF-involved families with children between the ages of 6-17 years. MST-BSF addresses the needs of each family member, including any trauma issues and case management services. In-home services provided three times per week for six to nine months.	DCF Regions 4 and 6, and the following Area Offices: Bridgeport, Norwich, Waterbury. Seven teams across five providers.
SAFE Family Recovery (SAFE-FR)	DCF-involved caregivers with minor children of any age. SAFE-FR offers three evidence-based services: substance use screening (SBIRT), treatment engagement (MDFR), and recovery support (RMS).	Statewide: 6 teams across five providers.

Data from the GAIN show that 85% of caregivers receiving DCF–funded treatment report moderate to high severity substance use problems in the year prior to entering treatment (Figure 6). Just over one-third (38%) admitted to at least weekly use of any drug in the 90 days prior to admission.

Figure 6. Substance Use Severity of Caregivers Entering DCF Funded Treatment, GAIN Data, SFY2018-2021



At entry to DCF-funded services, GAIN data reveals that most (60%) caregivers reported prior substance use treatment such as counseling, medication, case management or aftercare services. Nearly all (93%) reported having moderate or high substance use disorder at some point in their lifetime.

The needs of DCF-involved caregivers who have substance use problems often are complex involving substance use in combination with mental health and physical health conditions, and other social or legal problems. According to DCFs GAIN data, the vast majority of caregivers in DCF funded substance use services reported moderate to high severity physical health problems (86%), stress problems (91%), and risk behaviors (94%) in the year prior to treatment entry. These problems include worrying about their health, not meeting responsibilities due to health problems, and problems accessing health care. Caregiver sources of stress included death or health problem of a family member, fights with others, or major changes in relationships. Moderate to high risk factors include unprotected sex, needle use, and physical, sexual or emotional abuse. Problems related to crime and violence are not uncommon among these caregivers with nearly half (45%) reporting a history of interpersonal violence, drug-related crime or property crime.

Consistent with the high value DCF places on children remaining at home in their communities, caregiver substance use treatment services are intended to help vulnerable families remain home together while receiving intensive care and supports to address child safety concerns. The

Department holds providers of these services to a high standard of care and data shows these services are effective at addressing substance use and keeping children with their families (Table 7).

Table 7. Performance Outcomes for Caregiver Substance Use Treatment Services, PIE Data, FY2021

METRIC	FBR % (N)	MST-BSF % (N)
Total Number Admitted/Served in FY2021	314	147
Outcomes for Clients who Discharged in FY2021:	86	70
Abstinent in Last 30 Days of Treatment	94% (81)	77% (54)
No New DCF Careline Reports During Treatment	92% (79)	87% (61)
Child(ren) Living at Home at Program Discharge	91% (78)	86% (60)

FEDERAL AND OTHER SPONSORED SUBSTANCE USE INITIATIVES & PROJECTS

AccesS, Screening and Engagement, and Referral to Treatment (ASSERT)

During this reporting period, DCF successfully completed the federally-funded Improving Access Continuing Care and Treatment (IMPACCT) strategic planning project referenced in the previous triennial report. IMPACCT positioned DCF to secure additional funding from SAMHSA/Center for Substance Abuse Treatment (CSAT) to implement the follow-up grant known locally as ASSERT. The ASSERT project implemented the ATM treatment program described earlier in this report, as well as substance use system and infrastructure improvements for youth. The four-year project period ended September 29, 2021. ASSERT is currently in a one-year no cost extension to complete key project goals.

ASSERT completed several policy and planning activities to inform policymakers and improve the public's awareness of substance use and available services. These activities including producing an integrated behavioral health financial map in collaboration with Beacon Health services. The financial map compiles Medicaid claims data for substance use and mental health services by level of care, member demographics, and diagnosis. The map highlights opportunities for the state and providers to maximize third party reimbursement for substance use services, document prevalence of substance use identification among youth, and identify service utilization patterns. ASSERT established the LiveLOUD Families website as an online resource for information about teen opioid and other substance use. LiveLOUD Families hosted live and pre-recorded education and anti-stigma sessions for parents and caregivers and disseminated information to the public about youth substance use treatment and support services – particularly the ATM service.

Child Abuse Prevention and Treatment Act (CAPTA)

Federal Legislation. CAPTA is the key federal legislation that guides child protective services programming nationwide. The most recent reauthorization of CAPTA requires hospitals to notify state child welfare agencies when an infant is born prenatally exposed to substances. Recent CAPTA amendments also focused attention on the important role Plans of Safe Care (POSC) play to support access to a broad range of social, medical, developmental and behavioral health services and supports for these vulnerable infants and their families. The federal legislation leaves it up to states to decide how to implement CAPTA. As a result, CAPTA implementation has taken different forms across the country. At the extreme, every infant born prenatally substance exposed (PSE) is reported to child welfare for child abuse and neglect concerns.

Connecticut's Approach to CAPTA Compliance. Led by DCF and in partnership with other state agencies, hospitals and other community stakeholders, Connecticut took a unique approach to complying with CAPTA. Unlike other states, Connecticut does not require a CPS report to be completed on every infant born substance exposed unless other child safety factors are present. Connecticut also added additional data elements to its CAPTA notification system to inform DCFs racial justice and substance exposed infant (SEI) initiatives, and the Department's anticipated Families First planning efforts.

In preparation for the state's launch of its CAPTA compliance efforts, DCF and DMHAS linked and embedded CAPTA within the existing SEI initiative coordinated by Wheeler Health. This assertive connection between the two efforts ensures that CAPTA data on infants born prenatally exposed informs statewide SEI policy and planning efforts.

Beginning on March 14, 2019, Connecticut required hospitals to notify DCF when an infant is born substance exposed using an independent online CAPTA notification system. Prophetically, Connecticut's novel implementation of CAPTA has positioned the state to comply with proposed amendments to CAPTA currently under review and expected to go into effect in 2022. If promulgated, these amendments would require states to maintain separate child welfare information (CWIS) and CAPTA notification systems. The separation of CWIS and CAPTA means that notifications are not captured in DCFs case management system and cannot be reported in the department's National Child Abuse and Neglect Data System (**NCANDS**) Child File. This issue is being addressed as part of the upgrades to CWIS (also known as CT-KIND) so the state can come into full compliance with federal CAPTA regulations.

DCF also launched a CAPTA website dedicated to providing stakeholders and the public information on the state's efforts to comply with the federal legislation. The site includes detailed information about Connecticut's CAPTA implementation. Several unique features and important goals worth noting here include the state's commitment to:

1. ensure CAPTA notifications are separate from the DCF Careline child abuse reporting system by building a distinct CAPTA notification system;

2. keep notifications "blind" – the department does not receive identifying information other than what is necessary to plan prevention efforts and services for this population; and

3. divert referrals to child protective services when the notification does not also include child safety concerns.

DCF shares data from the CAPTA notification system with state stakeholders and community partners directly, and through the SEI initiative. Table 8 below summarizes key CAPTA data collected during this triennial reporting period.

Table 8. Summary of CAPTA Notification Data, March 14, 2019 – June 30, 2021

CAPTA DATA	Percent %	Number (N)
Total CAPTA Notifications to DCF	100%	4623
CAPTA Notifications Diverted from a DCF Careline Report	51%	2371
Plan of Safe Care (POSC) was Created for Birthing Person and Infant	67%	3087
Birthing Person Race and Ethnicity		
Non-hispanic Black/African American	22%	1022
Non-hispanic White	45%	2062
Non-hispanic Multi-race or Other	1%	55
Non-hispanic Undisclosed/Declined Race	12%	555
Hispanic Any Race	20%	929
Infant Exposures Indicated in CAPTA Notification*		
Marijuana	77%	3536
Any Type of Opioid – Prescribed or Non-Prescribed	20%	942
Any Type of Medication Assisted Treatment (MAT, Buprenorphine or Methadone)	14%	660
Cocaine	8%	372
Alcohol	3%	126

*Infants may have been born exposed to multiple substances.

Plans of Safe Care (POSC) are required by federal law and have an important role in Connecticut's CAPTA implementation. In Connecticut, reporters who submit CAPTA notifications without a POSC are guided to make a DCF referral to ensure the birthing person and infant are able to access needed services and supports to prevent or mitigate child well-being concerns. DCF and DMHAS jointly developed training and technical assistance materials and workshops to educate the medical community and women's service providers on how to assist pregnant or birthing persons with completing a POSC to avoid unnecessary child welfare referrals. The Departments also jointly funded a United Way POSC website targeting the general public. In addition to general information about CAPTA, the United Way site includes a feature that allows birthing persons to create an electronic POSC on a smartphone, tablet or other electronic device.

The Comprehensive Addiction Recovery Act (CARA) 2016 amendment to CAPTA further requires states to collect data and monitor their implementation. In order for the state to continue receiving CAPTA grants from the federal government, Connecticut must collect specified data on infants with PSE and provide an annual report on the number of infants: 1) identified; 2) for whom a POSC was developed; and 3) for whom a referral was made for appropriate services, including for the affected family or caregiver. To help the state monitor its CAPTA implementation, DCF contracted with a CAPTA expert at the University of Connecticut School of Social Work (UCONN SW). During this triennial report period, DCF and UCONN SW collaborated to obtain the necessary Institutional Review Board/Human Subjects and Department approvals and set in place data sharing agreements for the evaluation to commence.

Families First Prevention and Services Act (FFPSA)

On February 9, 2018, the Family First Prevention Services Act (FFPSA) was signed into law as part of the Bipartisan Budget Act. The Act reforms federal child welfare financing to allow federal reimbursement to states for mental health, substance use, and in-home parent skill training services to families at risk of entering the child welfare system. It also seeks to improve the well-being of children already in foster care by incentivizing states to reduce placement of children in congregate care.

DCF launched a rigorous stakeholder process that involved more than 400 community partners in developing Connecticut's Family First Prevention Plan during this reporting period. These partners included model developers, sister state agencies, providers, advocates, and families with lived expertise. Connecticut's Family First Plan is a tool DCF will use over the next triennial as part of the overall strategy to shift from a system solely focused on child protection, where the action is taken after harm to a child has occurred, to a collaborative child well-being system focused on prevention and early intervention. The Plan reimagines DCF to serve those families who come to the attention of child protective services and provide services and supports for families "upstream" before there is any child welfare involvement. This vision is guided by a dedicated staff who will lead the state from Families First planning to implementation.

Family Stability Project (FSP); a randomized controlled trial of Family Based Recovery (FBR)

DCF and its partners continue to work on the final phase of the Family Stability Project (FSP) to evaluate the impacts of FBR as compared to “services as usual.” FSP is a Social Impact Bond (SIB) project between DCF, Social Finance, Inc., UConn Health, and the Kennedy School at Harvard. FSP used a randomized controlled trial methodology to evaluate FBR using outcomes data collected through an 18-month follow-up period after caregiver enrollment into services. From October 2016 through June 2020, FSP enrolled a total of 714 caregivers. Of those 371 received FBR services. The final enrollment data and outcome report will be submitted to DCF in Spring of 2022.

Randomized Controlled Trial of recidivism in MST-TAY services

Through SFY2018, DCF continued to collaborate with Drs. Maryann Davis (University of Massachusetts Medical School), Ashli Sheidow (Oregon Social Learning Center), and Mike McCart (Oregon Social Learning Center), on a grant from the National Institute of Mental Health (NIMH; #R01MH108793) to conduct a randomized controlled trial of Multisystemic Therapy for Emerging Adults (MST-EA) through 2020. MST-EA, referred to in Connecticut as MST-Transition Age Youth (MST-TAY) is being evaluated for recidivism reduction and mental illness outcomes, as well as other functional outcomes. The 4-year trial currently is enrolling participants. In SFY19, the program transferred from DCF to Judicial Branch, Court Support Services Division (JB-CSSD). This is the first randomized controlled trial ever conducted in the U.S. or internationally that focuses on reducing recidivism in emerging adults.

Substance Exposed Infant (CT SEI) Initiative

The CT SEI initiative is a collaboration between DCF, DMHAS and Wheeler Health (the project coordinating center) to establish a SEI State Coordinator and develop statewide collaborations to inform SEI policy and practice at state and local levels. DCF and DMHAS jointly fund and manage this initiative with Wheeler Health. During this reporting period, CT SEI completing work from the 2016-2021 SEI Strategic Plan and created a new 5-year Plan which commences in 2022. The new Strategic Plan includes action steps to continue the work of identifying and addressing gaps in SEI prevention, screening, early intervention, treatment, and data collection efforts for affected infants and their families.

CT SEI uses topic-focused workgroups comprised of local experts and key stakeholders that meet regularly to discuss data and emerging issues, and provide recommendations for practice and policy reform, and ideas to improve the state's CAPTA implementation. Key activities and recommendations from these workgroups during this triennial reporting period included:

- CAPTA: targeted notification education for birthing hospitals, ongoing data monitoring and sharing, and individualized POSC support
- SEI awareness and marketing: created monthly electronic campaigns addressing various topics affecting birthing people and families impacted by substance use. Topics included SUD/recovery and the intersection with intimate partner violence, pregnancy and infant loss, breastfeeding, and stress management.
- Virtual Conference: "From Stigma to Empowerment: Supporting Women & Families Impacted by Trauma and Addiction" conference reaching 240 professionals live.

The new Strategic Plan focuses on promoting policies intended to reduce bias, disparities and inequalities in access to SEI care and needed support services. The Plan also emphasizes coordinating responses to SEI among health care providers, and identifying the

necessary continuum of services for vulnerable families, including prevention, early intervention and intensive intervention services. Over the next triennial reporting period, CT SEI will move forward the recommendations contained in the new plan.

Youth Recovery CT (formerly Connecticut Recovery Oriented Support System (CROSS) for Youth)

CROSS was established by DCF in October 2017 with SAMHSA State Targeted Response (STR) funding from DCF and DMHAS. The name has since transitioned to Youth Recovery CT. Wheeler Health administers the Youth Recovery CT initiative which establishes and supports a network of agencies across Connecticut that provide evidence-based SMART Recovery groups for youth ages 16-18 or 18-24, SMART Recovery Family & Friends groups, and pro-social Alternative Peer Group (APG) activities for youth and young adults. Since its inception, Wheeler has awarded 49 mini-grants to 31 organizations across the state to establish SMART Recovery, SMART Recovery Friends & Family, and alternative peer groups. Agencies in the Youth Recovery CT network include schools, universities, youth service bureaus, treatment providers, correctional institutes, and other youth and young adult serving organizations. The Youth Recovery CT Coordinator at Wheeler develops, promotes and maintains the SMART Recovery network of facilitators. Additional information of this initiative can be found at www.youthrecoveryct.org.

Integrated Treatments for Behavioral Health and General Substance Use

In addition to services for primary substance use problems already described, the Department funds other services that treat behavioral health conditions with co-occurring substance use. These integrated services are equipped to address commonly co-occurring mental health and general substance use problems among youth and adult caregivers.

Caregiver Intimate Partner Violence and Substance Use

In 2012, recognizing the impact and prevalence of co-occurring family violence and substance use on child safety, DCF set forth a vision for a comprehensive system to address intimate partner violence (IPV) that was rooted in the literature and informed by best practices. Beginning in 2014 DCF launched its first IPV service, Intimate Partner Violence – Family Assessment Intervention Response (IPV-FAIR). Multisystemic Therapy – Intimate Partner Violence (MST-IPV) soon followed in 2017. Together, these services provide a tiered approach to IPV services to DCF-involved families at low- to moderate-risk of violence and child safety. These services are available only to families with child protective services involvement. Descriptions of these services are in Table 9 below.

Table 9. Description of IPV services as of June 30, 2021

Program Type: Name	Target Population & Descriptions	Catchment Area
Intimate Partner Violence – Family Assessment Intervention Response (IPV-FAIR)	DCF-involved families providing care to a minor child who have had an IPV incident within the previous 180 days. Children may reside in the home, or if placed out of home, reunification must be part of the permanency plan. The severity of IPV must be appropriate for family-based treatment services. Services occur 1-3 times per week primarily in the family's home. Clinic appointments are available when needed.	DCF Middletown Area Office
Multi-Systemic Therapy Intimate Partner Violence (MST-IPV)	DCF-involved families providing care to a minor child who have had a report to DCF within the previous 180 days that included IPV. Children may reside in the home, or if placed out of home, reunification must be part of the permanency plan. The severity of IPV must be appropriate for family-based treatment services. Services occur at least 3 times per week in the family's home. The clinical approach uses evidence-based interventions to address risk factors contributing to IPV. MST-IPV builds on the family's strengths to improve parent management practices, minimize family conflict, increase child safety, and sustain the family's progress made during treatment.	Statewide: 6 providers operating from 6 sites.

Both IPV-FAIR and MST-BSF offer substance use treatment as part of an integrated approach to address multiple factors that contribute to IPV and child abuse or neglect. Substance use treatment is not the primary focus of these services and not all families receiving IPV services require substance use treatment. When families could benefit from substance use treatment and receive them as part of their IPV services the results are positive (Table 10).

Table 10. Performance Outcomes for Intimate Partner Violence Services, PIE Data, FY2021

METRIC	IPV-FAIR % (N)	MST-IPV % (N)
Number of Individuals Served in FY2021	450	14
Number of Families Served in FY2021	316	^
Outcomes on Families/Individuals Discharged in FY2021	314 families	10 individuals
Abstinent or Reduction in Substance Use in Last 30 Days of Treatment*	71% (29)	67% (6)
No New DCF Careline Reports During Treatment	85% (268)	90% (9)
Families with Child(ren) Living at Home	^	93% (13)

^Data not reported by this program.
*For IPV-FAIR, this includes 29 out of 41 discharges with documented substance use at intake and where decrease in substance use was identified as a treatment goal. For MST-IPV this includes 6 out of 9 individuals with available discharge data.

Discharge data from DCFs PIE system show that IPV-FAIR and MST-BSF clients have reductions in substance use from intake to treatment discharge (71% and 67% respectively), and the vast

majority have not had new reports made to DCFs Careline during treatment (85% and 90% respectively).

Functional Family Therapy

FFT is an evidence-based intervention for families offering intensive clinical services and support to youth ages 11-18 returning from out-of-home care, or who are at risk of requiring out-of-home care, due to psychiatric, emotional, or behavioral difficulties. FFT specializes in working with youth who are at risk for delinquency, violence, general substance use, or other behavioral problems such as Conduct Disorder or Oppositional Defiant Disorder. Connecticut data from the FFT model developers show positive outcomes across a wide range of problems (Table 11).

Table 11. Performance Outcomes for the Functional Family Therapy Service, Model Data, FY2021

METRIC	FFT N or %
Number of Total Youth Served in FY2021	415
No Intensification of Referral Problems	92%
Youth Attending School	93%
No Law Violations for Youth	96%
No Safety Incidents for Family	96%
Number of Youth with Substance Use Served in FY2021	12
Average Rating of reduction in Alcohol Use (Scale 1-4) *	2
Average Rating of Reduction in Drug Use (Scale 1-4)*	2.4

*Therapist rating scale: 1 “Not Better” 2 “Little Better” 3 “Some better” 4 “A Lot Better”

Treatment for Youth with Problem Sexual Behavior

Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB) is a specialty integrated service for youth who have committed sexual offenses and demonstrated other problem behaviors including substance use. The goals of MST-PSB are to decrease antisocial behaviors and out-of-home placements using evidence-based interventions directed at youth and their families, and other community-based resources and professionals connected to them. In randomized controlled clinical trials MST-PSB has shown effectively increases in youth social connectedness, school achievement, and family cohesion, and decrease general substance use, mental health symptoms, and disruptive and criminal behaviors. Data from DCFs PIE system show similar improvements in youth and family functioning (Table 12).

Table 12. Performance Outcomes for the MST-Problem Sexual Behavior Service, PIE Data, FY2021

METRIC	MST-PSB % (N)
Number of Individuals Served in FY2021	59
Outcomes for Individuals Discharged in FY2021	43
Abstinent or Reduction in Substance Use in Last 30 Days of Treatment	72% (31)
No New Arrests During Treatment	95% (41)
Youth Living at Home at Program Discharge	98% (42)

Distribution of DCF Substance Use Services

DCF is committed to supporting high-quality substance use services that are accessible to youth and families throughout Connecticut. The majority of the Department's funded services are available across the state. Among services that do not have statewide coverage, some are demonstration projects to establish if a service could be beneficial (e.g., ATM), or serve small specialty populations and are located in high need areas (e.g., MST-PSB), while other services are relatively new and still scaling up to statewide access (e.g., MST-BSF). Table 13 illustrates the availability of DCFs substance use services throughout the state as of June 30, 2021.

Table 13: Statewide Distribution of Substance Use-Focused and Integrated Substance Use Services by DCF Region and Area Office as of June 30, 2021

R	Area Office	SUBSTANCE USE-FOCUSED SERVICES										BEHAVIORAL HEALTH & GENERAL SUD			
		A-CRA /ACC	ATM	FBR	MDFT	MST	MST-BSF	MST-EA	MST-PSB	Youth Recovery CT	SAFE-FR	IPV-FAIR	MST-IPV	MST PSB	FFT
1	Bridgeport	X		X	X	X	X	X	X	X	X	X			X
	Norwalk	X		X	X	X		X	X	X	X	X			X
2	New Haven	X		X	X	X	X	X	X	X	X	X			X
	Milford	X		X	X	X		X	X	X	X	X			X
3	Middletown	X	X	X	X	X		X	X	X	X	X	X	X	X
	Norwich	X	X	X	X	X	X	X	X	X	X	X		X	X
	Willimantic	X	X	X	X	X			X	X	X	X		X	X
4	Hartford	X	X	X	X	X	X	X	X	X	X	X			X
	Manchester	X	X	X	X	X	X	X	X	X	X	X		X	X
5	Waterbury	X	X	X	X	X	X	X	X	X	X	X			X
	Danbury	X	X	X	X	X			X	X	X	X			X
	Torrington	X	X	X	X	X			X	X	X	X			X
6	New Britain	X	X	X	X	X	X	X	X	X	X	X			
	Meriden	X	X	X	X	X	X	X	X	X	X	X			X

➢ Judicial Branch Court Support Services Division

Beginning on the following page is the substance use service grid created by the Judicial Branch's Court Support Services Division (JB-CSSD).

Program	Adult or Juvenile	SA Prevention and/or Treatment	SA Funding State and Program Income (PI)	Description of Services
Multi-Systemic Therapy (MST)	Juvenile	Treatment	$4,233,626	Intensive, evidence-, family- and community-based treatment program for serious, chronic, and violent juvenile offenders. It blends clinical treatments including cognitive behavioral therapy, behavior management training, family therapies and community psychology. The overriding goal of MST is to keep adolescents who have exhibited serious clinical problems—drug abuse, violence, severe emotional disturbance—at home, in school and arrest free.
MST-EA (Emerging Adults) previously MST - TAY	Juvenile	Treatment	$1,667,484	MST-EA is an adaptation of the MST model designed for transition-aged youth and young adults involved with the justice system who have mental illness or engage in substance use. A home-based therapist delivers services to treat mental illness, reduce substance use (when present) and reduce recidivism. Coaches also work with young adults to increase school, work and prepare for independent living.
Linking Youth to Natural Communities (LYNC)	Juvenile	Prevention & Treatment	$7,261,724	The Linking Youth to Natural Communities (LYNC) programs are multi-modal centers focusing on a scope of targeted services for court-involved youth ages 12-17 and their families. The program conducts intakes & assessments, provide cognitive-behavioral interventions and case management services to address basic needs and pro-social activities, and discharge planning that are gender-specific, evidence-/research- based, culturally comp
REGIONS - Secure for Adolescent Males (Contracted)	Juvenile	Prevention & Treatment	$5,727,950	This program model is an individually-focused therapeutic residential program for adolescent males with a disposition of "Probation Supervision with Residential Placement" which is being integrated with Dialectical Behavior Therapy (DBT) on an individual and milieu level. The trauma informed program is designed to decrease recidivism and increase skills, decrease substance misuse, improve educational functioning, improve mental health and increase stability and overall functioning. The program will accept referrals from all of Connecticut's juvenile courts/probation.
REGIONS LIMITED - Secure for Adolescent Females (aka Journey House)	Juvenile	Prevention & Treatment	$4,031,235	This program model is an individually-focused therapeutic residential program for adolescent females with either (1) a disposition of "Probation Supervision with Residential Placement" or (2) an Order to Detain. The program model is being integrated with Dialectical Behavior Therapy (DBT) on an individual and milieu level. The trauma informed program is designed to decrease recidivism and increase skills, decrease substance misuse, improve educational functioning, improve mental health and increase stability and overall functioning. The program will accept referrals from all of Connecticut's juvenile courts/probation.
Juvenile Staff Secure Residential Facility (JSSRF)	Juvenile	Prevention & Treatment	$7,889,200	Individually-focused therapeutic residential program for adolescent males with a disposition of "Probation Supervision with Residential Placement" which is being integrated with Dialectical Behavior Therapy (DBT) on an

				individual and milieu level. The program is designed to decrease recidivism and increase skills, decrease substance misuse, improve educational functioning, improve mental health and increase stability and overall functioning.
Intermediate Residential (IR)	Juvenile	Prevention & Treatment	$3,412,970	Brief (4 month) out-of-home Treatment service targeting youth with substance abuse, behavioral health or co-occurring needs. MDFT is clinical model, and is provided to the client in the program and to the family as well. MDFT is also offered following discharge from the program in the home community. There is a boys' programs and a girls' programs.
Court Based Assessment (CBA)	Juvenile	Prevention & Treatment	$75,000	Psychological and substance abuse evaluations as ordered by the court to determine service that best match treatment needs of child and family.
Adolescent Community Reinforcement Approach (A-CRA)	Juvenile	Prevention & Treatment	$333,269	Evidence-based behavior therapy for substance using adolescents and caregivers; identified population is 12-17 years old with substance use and meet ASAM criteria for outpatient level of care

Total spending for CSSD in FY 21 totaled **$34,632,458**

➢ Department of Public Health

PRACTITIONER LICENSING AND INVESTIGATIONS SECTION (PLIS)

- The Department of Public Health is responsible for investigating complaints against licensed health and routinely investigates licensed prescribers who are alleged to have inappropriately prescribed medications. If violations of the standard of care related to prescribing are identified, prescribing practitioners are subject to licensure discipline by their respective board. Discipline may include, but is not limited to a license reprimand, civil penalties, requirements for additional education related to prescribing, probation with a monitor to review prescribing practices, and reports to the Department.

- The Department of Public Health investigates complaints regarding licensed health care practitioners who may be impaired due to substance use disorder. These practitioners may be removed from practice until they are deemed safe to practice. Once a practitioner is deemed safe to practice, they may return to work under a consent order with terms that include but are not limited to: restrictions on practice settings, no access to narcotics, random urine screens reported to the Department, requirements to participate in therapy, requirements to attend 12-step meetings, and employer reports. The Department monitors the licensee adherence to terms and may further restrict the licensees practice if terms are violated. The penalty for violating terms of a consent order may lead to license revocation or surrender. These efforts are to protect public safety while supporting the licensee's recovery.

- The Department works closely with the HAVEN program, a confidential alternative to public discipline, for licensees who meet specific criteria for participation. The Department may refer individuals with substance use disorder to the HAVEN program. The HAVEN program may refer individuals ineligible for its program to the Department. Eligibility for HAVEN includes no prior licensure discipline, no patient harm caused, and no felony convictions. The HAVEN program monitors its participants similarly to the Department.

- Hospitals and other licensed practitioners are mandated to report potentially impaired practitioners to the HAVEN program or DPH pursuant to 19a-12e of the Connecticut General Statutes. The Department and the HAVEN program have seen significant increases in reports of impaired practitioners since the law was enacted in 2015.

TOBACCO CONTROL PROGRAM

- **Prevention Activities**

  DPH implements evidence-based programs that incorporate interventions through policy, systems, and environmental changes. This encourages long term changes towards reducing tobacco use and increasing tobacco free living as a social norm. Changes that affect youth

are also successful at reducing other youth substance use and decrease adult tobacco use, which in turn reduces youth visibility of tobacco use.

- **Tobacco Use Cessation Activities**

  The tobacco use cessation telephone Quitline is operated 24 hours a day, 7 days a week under a contract with DPH that includes both text messaging and web registration options as well as starter packs of nicotine replacement therapies. Through Public Health and Health Services (PHHS) Block Grant Funds, DPH also offers a few face-to-face tobacco use cessation programs at certain locations free of charge. Although tobacco use cessation services are covered under health insurance policies pursuant to the Affordable Care Act, there are still select insurance policies that do not yet cover these services, so these programs try to fill in the gap in policy coverage.

- **Training Institute**

  DPH provides training for community partners based on needs and updated research and develops and shares resource materials to assist with various community initiatives. During the past three years, most trainings provided have been for tobacco treatment specialists, in order to make services more readily available to anyone that needs it. Building this cessation infrastructure has helped more youth-serving organizations to help youth quit vaping and support people with their cessation efforts.

- These initiatives are supported by the CDC funding for tobacco control program with $824,868 funding annually.

CANNABIS SURVEILLANCE

In accordance with Public Act 21-1, Sections 65 and 146, the Department of Public Health has updated its web site to include information on Cannabis and is enhancing the following surveillance systems to monitor cannabis use and adverse events:

- **Behavioral Risk Factor Surveillance System (BRFSS)**

  The CT BRFSS, sponsored and designed by the CDC, is an ongoing statewide health survey conducted by phone to Connecticut adults and include measures of risk factors, health behaviors, and social determinants of health (SDOH). Data from the CT BRFSS data is used as a tool for targeting and building health promotion activities. Data from the CT BRFSS helps programs fill gaps in their surveillance and data to better inform their prevention programs. The survey routinely collects data on tobacco use, vaping and, in accordance with Public Act 21-1, the BRFSS will collect data annually on adult cannabis use. The CDC-designed cannabis/marijuana use questions will be enhanced with state-added questions and with the passage of House Bill 5243 in the 2022 legislative session, participation is now mandatory, and the collection sample will be larger. The BRFSS is supported by a CDC Cooperative Agreement, along with numerous other federal and state funding sources which

sponsor specific topics on the BRFSS or support an oversample to improve data reliability and detection of health disparities. The annual administration of the BRFSS costs between $850,000 to $1,000,000.

- **Connecticut School Health Survey (CSHS)/Youth Risk Behavior Survey (YRBS)**

  The CSHS is nationally known as the YRBS and is a CDC sponsored statewide health survey conducted in a school-based setting in public Connecticut high schools every other year. The CSHS is a comprehensive health questionnaire used to compare the prevalence of health-risk behaviors among subpopulations of students; assess trends in health-risk behaviors over time; and help develop and evaluate school and community policies, programs, and practices designed to decrease health-risk behaviors, and improve health and educational outcomes among youth. The results of this survey continue to support the strong link between healthy behaviors and positive educational outcomes. The survey routinely collects data on alcohol, tobacco, vaping and illicit drug use. In accordance with Public Act 21-1, the CDC designed questions on marijuana use will be enhanced with state-added questions and included in every biennial survey. The CSHS is supported by a CDC Cooperative Agreement, along with federal tobacco prevention funds and state-funded cannabis funding. The annual administration of the YRBS costs between $95,000 to $116,000.

- **Syndromic Surveillance System/EpiCenter**

  The Syndromic Surveillance System or EpiCenter is a system used for reporting emergency illnesses and health conditions by emergency departments and hospital-affiliated urgent care centers. DPH is building a new functionality within EpiCenter to help identify and track injuries and adverse events linked with cannabis use or addiction. This includes verifying accuracy of current classification for marijuana/tetrahydrocannabinol (THC) use; creating a new classification for cannabis poisoning; building a new dashboard to track emergency room visits with cannabis use; and, creating a new cannabis publication for DPH and local health departments.

- **Pregnancy Risk Assessment Monitoring System (PRAMS)**

  The Connecticut PRAMS is a surveillance project of the DPH and the CDC. PRAMS collects information on maternal health, attitudes, and experiences before, during, and shortly after pregnancy from a sample of postpartum women in Connecticut. CT PRAMS developed a survey supplement in consultation with CDC and Gillian Schauer, Governor Lamont's consultant, around marijuana/cannabis use, and the use of Cannabidiol (CBD) products before, during, and after pregnancy; how (e.g., smoked, dabbed, vaped, etc.) and why (e.g., relieve nausea, relieve stress or anxiety, etc.) women used marijuana products during pregnancy; conversations around marijuana use or recommendations during prenatal care; perceptions of how long someone should wait after using marijuana before breastfeeding or pumping milk for their baby; and if they think the use of marijuana products during pregnancy could be harmful to a baby's health. This supplement is being implemented during the 2022

surveillance year. Beginning with the 2023 surveillance year, the new PRAMS Phase 9 survey will be implemented, and we plan to retain 1-2 questions on the survey for long-term surveillance.

HIV AND HEPATITIS C (HCV) PREVENTION PROGRAM ACTIVITIES

- **Program Description**

  The Connecticut Department of Public Health (CT DPH) HIV/HCV Prevention Program receives funding from the CDC to support a high impact, comprehensive HIV/HCV Surveillance and Prevention Program focused on activities to reduce new HIV/HCV infections, achieve viral load suppression and improve health outcomes for persons living with HIV/HCV. The Program received funding from the Centers for Disease Control and Prevention (CDC) through a Cooperative Agreement grant for both Integrated HIV and Viral Hepatitis Surveillance and Prevention Programs for Health Departments. State funds are used for HIV testing supplies, Syringe Services Program (SSP) supplies, Integrated Community Planning, Community Distributions Center (condom distribution and health education materials) and social media related initiatives.

  The HIV/HCV Prevention Program is also located in the TB, HIV, STD and Viral Hepatitis Section within the Infectious Disease Division.

- **Core Programs**

  - HIV/HCV Prevention Program focuses efforts on communities where HIV/HCV is most heavily concentrated by supporting increased HIV/HCV testing, access to pre-exposure prophylaxis (PrEP) for HIV prevention, and the expansion of prevention services for person who use drugs and to populations most likely to be impacted by health disparities.

  CT DPH's HIV/HCV Prevention Program is the state's leader in the provision of funding for HIV/HCV testing within clinical settings (Routine Testing Services) and non-clinical settings that provide Outreach, Testing and Linkage (OTL) services in communities most impacted by HIV/HCV. PrEP Navigation Services is integrated into HIV testing services. Since 1990, CT DPH has been the sole resource for Harm Reduction Services in CT and coordinates the Syringe Service Programs (SSPs) and Drug User Health Services, such as Overdose Prevention and Access to Narcan.

  The program oversees the Community Distribution Center which operates the statewide education materials/resource warehouse, in addition to the required CDC component, Condom Distribution Program for persons living with HIV and those at highest risk of infection for HIV, HCV, Substance Use Disorder (SUD), and STIs.

- **Collaborative Activities**

  - Community Naloxone Distribution Activities – Created first was the community naloxone distribution program known as, *Overdose Prevention Education and Naloxone (OPEN) Access CT Program*. OPEN Access CT Program continues to be a successful addition to current syringe services programs (SSPs) that are under contract with DPH. Programs offer free HIV/HCV screening, harm reduction education, substance use treatment referrals, overdose prevention training and overdose (OD) kits. The funding source is state AIDS funding and currently provides funds to purchase HIV/HCV kits, overdose (OD) kits and syringes services supplies. Participants will be trained on overdose prevention, harm reduction strategies, and how to access substance treatment referral services.

    The DMHAS funded initiative State Opioid Response (SOR) grant with DPH that provided support to purchase Narcan ended in 2020. This initiative covered three regions in CT that were most impacted by injection drug use and opioid related deaths. The initiative was a great success and allowed for the expansion of harm reduction services across CT.

    DPH continues to collaborate with various state partners and local health providers, and community-based organizations across the state to provide access to overdose prevention trainings, resources, and OD kits. In 2021, the Department of Consumer Protection (DCP) in collaboration with the DPH, passed key legislation on the approval of the use of Syringe Service Vending Machines. The legislation allows for SSP sites to expand access to syringes via vending machines across CT. The new legislation will be effective in July 2022.

  - **Narcan Distribution and Training Activities** – In 2020, the HIV Prevention Program's OPEN Access Program conducted 3,123 individual-level OD trainings for clients participating in syringe services programs and distributed 3,292 naloxone kits. In 2021, the OPEN Access Program conducted 4,303 individual trainings and distributed 5,759 naloxone kits. For the OPEN Access Program community naloxone distribution component, in 2020 due to COVID-19, there were only 4 group-level community trainings conducted with 26 participants and 6 naloxone kits distributed. In 2021, there were 154 group-level community trainings conducted with 783 participants and 908 naloxone kits distributed. The community-level trainings target a variety of providers (i.e., first responders, department of corrections staff, substance treatment staff, emergency medical staff, overdose survivors and their family members). As of today, the department has expanded SSPs from 3 in 2017, to 8 programs in 2021. These are contracted sites, the DPH also supports five satellite/mobile sites with harm reduction sites with supplies, for a total of 13 programs. In exchange, these sites provide data to DPH on the number of clients provided with harm reduction supplies, the number of overdoses (fatal and non-fatal), and the numbers of referrals to prevention and treatments services. DPH will continue to expand harm reduction services throughout

the State via SSPs' home delivery, secondary distribution methods, and SSP vending machines in the future. In addition, DPH encourages funded SSPs to partner with other organizations located in rural and suburban geographical areas in order to continue to expand our harm reductions services as needed.

- **Fentanyl Testing Initiative** – In 2020, 4,700 fentanyl testing strips were distributed to over 5,700 SSP participants. In 2021, 15,680 fentanyl testing strips were distributed to over 6,300 SSP participants. In collaboration with SPPs and community partners, the initiative provides free fentanyl testing strips to SSPs in CT. A fact sheet was developed to better educate providers and the community on the risks of overdose due to fentanyl.

- **Integrated Planning for HIV/HCV/SUD/STIs**- In 2020, the DPH began work to develop the State's Integrated Plan for HIV, HCV, SUD, and STIs. The new plan will include elimination plans for each these focus areas, also known as a syndemic. DMHAS and other State agencies that work with populations across the syndemic, will be key partners and will be participating in the planning process. The final plan is due 12/31/22 and will be submitted to the CDC and the Health Resources Services Administration (HRSA).

- **Accomplishments for the last year**
  - Expanded SSPs from 9 to 13 programs.
  - Coordinated CT's Northeast SSP Institute Trainings. Since 2020, there have been 3 trainings focusing on harm reduction for persons who use drugs.
  - Maintains the CDC Determination of Need (DON) which allows CT DPH to use federal funds for SSP activities.
  - Collaborated with the Department of Consumer Protection (DCP) on the legislative policy which allows for CT SSPs to operate vending machines for the provision of harm reduction supplies in regions of CT where there are no or limited harm reduction services.
  - Secured additional CDC funding for Viral Hepatitis Surveillance and Prevention for Health Departments. CT DPH received $315,000 for surveillance and prevention activities. Prevention efforts will focus on increased viral hepatitis testing, treatment, and vaccination for persons at risk for HCV, HAV/HBV, especially persons who use injection drugs.

- **Current & Projected projects and initiatives**
  - Collaborating with DMHAS on Annual Harm Reduction Conference to take place on May 20, 2022.

- Collaborating with programs: Office of Injury Prevention, the Immunization Program, and DMHAS to increase HIV/HCV screening and HAB/HBV vaccination among persons who use drugs.

OFFICE OF EMERGENCY MEDICAL SERVICES (OEMS)

- In June of 2019 the SWORD (Statewide Opioid Reporting Directive) program was launched. Following legislation chapter 368v of the general statutes as defined in section 20-206jj, all who treat a patient for an overdose of an opioid drug, must report the overdose to the Department of Public Health, in a form and manner prescribed by the Commissioner of Public Health. The SWORD program requires all reports be made by EMS providers directly to the Connecticut Poison Control Center via a phone call to (800) 222-1222.

- Between June 2019 and April of 2022, thirty-four issues of the monthly SWORD newsletter have been published to the OEMS website. The SWORD newsletter shares opioid overdose data trends, which are gleaned directly from ODMAP and Connecticut Poison Control data.

- Between June 2019 and April of 2022, just over 13,000 suspected opioid overdoses have been reported to the Connecticut Poison Control Center by Connecticut EMS providers as part of the SWORD program.

- Two annual reports for the SWORD program are available on the website. The first spans June 2019-May 2020, and the second spans June 2020-May 2021. The year three report will be posted mid-summer 2022.

- A wallet foldable card was developed, mass produced, and distributed to EMS providers and agencies, outlining a series of questions, which EMS providers need to answer when they make their mandated call to Connecticut Poison Control, as part of the SWORD program. When an EMS Provider places a call to the Connecticut Poison Control Center, via (800) 222-1222, the Poison Control Center Specialist asks eleven questions, which are then entered into the State's poison tracking system, and ODMAP (Overdose Detection Mapping Application Program). The ODMAP system allows local public health, law enforcement, and EMS partners to track overdoses in near real time. These approved entities also share trends with local harm reduction providers.

- OEMS is utilizing Federal grant money, provided by a Bureau of Justice Assistance, and Office of Justice Programs, COSSAP (Comprehensive Opioid, Stimulant, and Substance Abuse Program) toward the creation of an API (Application Programming Interface), which will create a data bridge between ImageTrend, which serves as the EMS data repository for the State, and ODMAP (Overdose Detection Mapping Application Program), which is the federal opioid overdose tracking system, maintained by Washington/Baltimore HIDTA (High Intensity Drug Trafficking Area). The API will allow for automation of reporting within the SWORD Program. The initial development and testing phase has begun, and implementation will take place late Fall 2022. This program should save EMS providers time and provide more accurate reporting to the ODMAP system.

- The Naloxone Leave-behind Protocol is a new EMS protocol, released 4/5/2022, and it can be located on page 156 of the Statewide Emergency Medical Services Protocols document. The protocol allows EMS providers to dispense overdose kits, containing Naloxone, to patients, family member or other bystanders at the scene of opioid overdoses.

- OEMS program staff manage local public health relationships with COSSAP sub-award recipients in the New Haven Health Dept., Hartford Health & Human Services, the Torrington Area Health District, and the Uncas Health District. Monthly meetings are held where local public health partners report on the opioid response activities and harm reduction efforts, which are related to the grant.

- OEMS program staff manage an opioid resources networking group known as the SWORD working group, which convenes monthly. These meetings are attended by Connecticut Poison Control, the UCONN Medical Center, the Office of the Chief Medical Examiner, HIDTA (High Intensity Drug Trafficking Area) for Connecticut, and DPH's Injury and Violence Surveillance unit. This group convenes to discuss trends in fatal and non-fatal overdoses, and has been instrumental in collaborating on public health notifications, which are often based on trends identified in various data sets.

➢ Department of Consumer Protection (DCP)

The Department is tasked with promoting access to safe and effective pharmaceutical care services in Connecticut and protecting consumers against fraud, deception, and unsafe practices in the distribution, handling, and use of pharmaceuticals and medical devices. The Program has a statutory responsibility to set standards for the control of prescribing, dispensing, and administration of pharmaceuticals by health care providers as well as distribution of pharmaceuticals by health care facilities (e.g. hospitals, clinics, long-term care) and other entities (e.g. manufacturers, distributors, community-based programs.

MAJOR SUBSTANCE USE INITIATIVES AND ACCOMPLISHMENTS

The DCP's substance initiatives fall into 4 major categories: the Connecticut Prescription Monitoring Program (PMP), increasing access to Naloxone, safe storage, disposal of over the counter and prescription medications, and the implementation of Connecticut's Medical Marijuana Program. In addition, DCP provides educational programs to support each of these efforts.

PRESCRIPTION MONITORING PROGRAM (PMP)

The Connecticut Prescription Monitoring and Reporting System (CPMRS) was designed to collect prescription data for Schedule II through V drugs into a central database that can be used by medical providers and pharmacists in the active treatment of their patients. The CPMRS also collects dispensation of insulin drugs, glucagon drugs, diabetic devices, diabetic ketoacidosis devices, gabapentin, and naloxone. On October 1, 2015, legislation was passed requiring health care professionals to check the CPMRS before prescribing controlled substances for greater than 72 hours of treatment. Additional provisions require that pharmacists enter controlled substance prescription data after July 1, 2016, immediately or no later than 24 hours. Connecticut now shares data with 39 states, Washington DC, Puerto Rico, and the Military Health Systems.

DCP works in partnership with other state agencies targeting both prescribers and pharmacists on drug-seeking behavior and how to use the CPMRS effectively. The program and partners have focused their efforts on educating the general public on safe storage and proper disposal of over the counter and prescription drugs. DCP routinely analyzes and published statistical information obtained from CPMRS to support the activities of DCP and sister agencies concerning prescription drug misuse and abuse and for use in research. The statistics information can be found on our website https://portal.ct.gov/DCP/Prescription-Monitoring-Program/CTPMP-Statistics.

In addition, the PMP has trained over 112 law enforcement agencies on how to use the CPMRS to conduct prescription drug fraud investigations. As part of those efforts, the program periodically promotes law enforcement educational campaigns that to increase awareness of the CPMRS and the prescription fraud problem in Connecticut.

COMMUNITY DRUG TAKE BACK PROGRAMS

Another important initiative of DCP has been the establishment of a prescription drop box program that recently added pharmacies. There are now over 116 boxes in operation between the state police, municipal police, and local pharmacies which have collected over 268,750 pounds of unwanted medications since 2012. DCP has been involved with Community Drug Take-Back Days and provided documentation on the DCP website on how to set up such an event. DCP also conducts educational campaigns for the general public about prescription drug abuse and the safe storage and disposal of over-the-counter and prescription medications. Dropbox locations can be found using the interactive map on our website https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Local-Drug-Collection-Boxes.

MEDICAL MARIJUANA PROGRAM

DCP has established and implemented Connecticut's Medical Marijuana Program. The Program utilizes a pharmaceutical model for the manufacturing and dispensing of medical marijuana and marijuana products. Dispensary facilities are also required to upload dispensing information into the Connecticut Prescription Monitoring and Reporting System (CPMRS) at least once per day.

ACCESS TO NALOXONE

DCP passed legislation allowing pharmacists to prescribe and dispense Naloxone after completing a certifying training course. DCP implemented an online continuing education training course last summer and has also collaborated with major chains regarding an existing training tool they use for the same purpose. To date, almost 600 pharmacies have at least one pharmacist certified and can now prescribe Naloxone in the state. Pharmacies that have at least one pharmacist that can prescribe naloxone can be found on our interactive map https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Naloxone-Prescribing-By-Pharmacists. DCP also allowed pharmacies that have a trained pharmacist to hold naloxone prescribing events away from the pharmacy thereby improving access to naloxone. Over 13,000 dispensations of naloxone products were reported to the PMP for 2021, which is the first year we started collecting that information

➢ Department of Corrections

System of Care

The Department of Correction (DOC) provides comprehensive treatment services utilizing a graduated system of Substance Use Treatment Programs. The Agency's Addiction Treatment Unit (ATU) screens, assesses, and provides treatment to greater than 80% of the individuals who enter the Correctional System. A range of treatment options are available to meet the offenders' treatment needs. Programs range from brief treatment focusing on Re-entry and Reintegration; Intensive Outpatient (IOP) utilizing Cognitive Behavioral Therapy Curriculum to Residential Substance Use Treatment in a modified Therapeutic Community setting. The Addiction Treatment Unit provides Aftercare programming designed to provide a continuum of care and recovery maintenance. The Addiction Treatment Unit also provides services to the specialized population to include the Young Adult Offenders, Youthful Offenders, Women, Driving Under the Influence (DUI) Offenders, Medications for Opioid Use Disorder (MOUD), and temporary violation as an incremental sanction in Time Out Program (TOP) for Parolees at risk for Violation of Parole.

Major Initiatives and Accomplishments

In-prison Addiction Treatment

The DOC Addiction Treatment Unit provides in-prison treatment services to several thousand Offenders annually. These services include brief treatment, Intensive Outpatient, Therapeutic Community Treatment, youth specific Intensive Outpatient treatment, gender specific treatment, DUI specific treatment, Time Out Program (TOP) for at risk Parolees and Medication for Opioid Use Disorder (MOUD). Recent TOP improvements include MOUD induction and maintenance, curriculum enhancements and process facilitation.

DUI Offenders

Connecticut General Statute, CGS 18-100h permits the Department of Correction to offer provisional release. This discretion allows eligible offenders convicted of Driving Under the Influence and related convictions to be released on Home Confinement (HC). Offenders are screened upon admission by Addiction Treatment staff to determine eligibility. Following the initial screening, eligible Offenders are then given an in-depth DUI assessment to determine treatment need. The DUI treatment programs offer an elevated range depending on the level of care needed for the offender. Offenders are required to complete the treatment program prior to being released on DUI Home Confinement. DOC Community Release Unit (CRU) renders decisions for all DUI HC releases. Cases approved for Home Confinement are transferred to the DOC Division of Parole and Community Services DUI Unit, a specialty parole unit to begin the release process. In addition, DMHAS funding has supported Telehealth equipment for the DUI population for linkage of care in the community. This has provided the DUI population with faster access to treatment in the community.

COMMUNITY AFTERCARE

DOC is the sub-grant recipient of the Residential Substance Abuse Treatment (RSAT) grant from OPM. DOC has enhanced its ability to provide continuity of care from in-prison to community care for Offenders following their participation in Residential Substance Use Treatment Programs. These services include Behavioral Health Treatment in addition to recovery supports such as employment and housing assistance, transportation and other services.

In 2022, the Addiction Treatment Unit began a new initiative. The Residential Substance Abuse Treatment (RSAT) grant has funded two CCAR Recovery Coach positions. The Recovery Coaches in this position will work alongside the Addiction staff in the residential Tier 4 Programs at Osborn CI, Robinson CI, and York CI. The facility assigned Recovery Coaches will provide support and serve as a motivator, resource broker, mentor and liaison to the individuals in the residential programs.

MEDICATION ASSISTED TREATMENT/MEDICATION FOR OPIOID USE DISORDER (MOUD)

The DOC currently serves approximately 615 inmates daily with Opioid Use Disorder Medications and Psycho-Behavioral Counseling. There are currently MOUD programs in 9 Correctional facilities. These programs are vendor based, except for York Correctional Institution, which is an internally Licensed and Accredited Opioid Treatment Program (OTP). During the expansion to include 9 facilities, there have been significant achievements made to offer all three FDA approved medications: Methadone, Buprenorphine, and Extended-Release Naltrexone. Methadone and Extended-Release Naltrexone are available at all 9 locations and Buprenorphine in 2 locations with the remaining 7 facilities offering Suboxone strips as the roll-out continues in 2022. The DOC fully supports the expansion to include all medications, however, there has been a slower roll-out of Buprenorphine due to Covid challenges. The Agency will use Suboxone strips instead of the previous formulation, Subutex, as Suboxone strips have proven to be beneficial to the safety and security of the DOC. The National Commission on Correctional Healthcare (NCCHC) continues the work with the DOC and community partners to obtain full Accreditation for the OTP programs. A satellite location has begun at Garner CI in Newtown, CT which will be vendor-operated to include all three medications. The expansion to add a satellite location at this facility will allow MOUD treatment to individuals that have significant mental health needs.

NALOXONE (NARCAN)

In a continued effort to respond to the growing Opioid Epidemic, NARCAN distribution and overdose education continue with DOC staff, the Inmate population, the Community Supervised Parole population, Halfway House providers, and recently expanded to the families of the Offender population. Overdose education and how to respond to an overdose emergency training is ongoing and is completed during CPR recertification for all staff. Every facility has NARCAN strategically placed throughout the facilities for easy access for any staff member to respond to an overdose emergency. The Addiction Treatment Unit in the jails are now training every new intake during facility orientation about the signs of an overdose, how to respond to an overdose emergency, as well

as advising the individual that NARCAN is available to them upon their release. Recently, in a partnership with the Addiction Treatment Unit, the Parole and Community Services division adopted their own policy that gives Parole Officers the ability to distribute NARCAN to offenders on their caseload. Several of the contracted provider Halfway Houses have decided to also distribute NARCAN to offenders completing their stays in the Halfway Houses. There is a new effort to increase access to NARCAN in the Halfway Houses to decrease the response time to an overdose emergency. The DOC will be purchasing alarm style boxes that hold NARCAN. When the box is opened to access the NARCAN it will trigger an alarm to alert staff that there is an overdose occurring in the house. This will decrease the response time and allow staff to respond to the emergency faster in some of the larger Halfway Houses. NARCAN training and education are now also offered to the sponsors of our offenders. All sponsors of DOC releases or offender community placements are offered this service. If the sponsor is interested, the NARCAN coordinator will connect with the sponsor and provide training and education to them as well as inform them of how to access NARCAN.

TOBACCO CESSATION AND PREVENTION

Over the past several years, the Tobacco and Health Trust Fund Board provided funding to the DOC to develop tobacco education and cessation support programs in several jails. In 2016, DOC expanded this program to provide similar programs in the DOC funded Halfway Houses. Smoking prevalence data was collected as part of this project. The results show that Correctional populations have 4 to 5 times higher smoking prevalence rates than the general population, and female prisoner rates were even higher. This indicates that the Criminal Justice population has not benefitted from the national public health efforts to reduce the health consequences of tobacco, as has the general population. In 2022 tobacco cessation efforts have been integrated into the Addiction Treatment portfolio to include mindfulness and meditation to address smoking cessation and daily care, as well as care in Halfway Houses.

RECOVERY COACHING

The Recovery Coaching initiative with Connecticut Community for Addiction Recovery (CCAR) has expanded to our Community Parole District Offices as well as our Halfway House contracted providers. The Addiction Treatment Unit Staff and CCAR provide training and education about peer recovery support and how to refer offenders for these services to support them in their recovery journey in the community. In 2021, there were 282 Peer Recovery support referrals to CCAR. These individuals have received support on navigating treatment, have been referred for MAT, and are engaged members of the CCAR recovery community. The Addiction staff inside of the Correctional facilities, continue to refer and have individuals engage with coaches before their release from custody. In addition to the in-reach in the Correctional facilities, the Addiction Staff are providing the Recovery Coach Academy inside of the prisons. This Academy gives newly released individuals an opportunity to begin the process to become a Recovery Coach in the community.

➢ State Department of Education

The Connecticut State Department of Education (CSDE) offers several substance use prevention supports through programs that address the issue directly and through meeting the social- emotional, developmental and behavioral health needs of students.

The following programs have been implemented throughout the 3-year reporting period (fiscal years 2019-2021) and will continue to be administered by CSDE pending available appropriations. The funding levels listed are from fiscal year 2021:

AFTER-SCHOOL GRANT PROGRAM: $5,636,281

The After-School Grant Program was established by the Connecticut General Assembly for creating high quality after-school programs. After-school programs are defined as programs that take place when school is not in session and provide recreational activities, parent involvement, wellness components and educational enrichment designed to complement academic programs for students in Grades K-12. These programs, located in elementary or secondary schools or community-based facilities, provide a range of high-quality services to support student learning and development. In addition to tutoring, mentoring, homework help and academic enrichment initiatives, programs also provide youth development activities, violence and pregnancy prevention programming, substance use prevention, counseling, project-based learning, art, music, and technology education programs, service learning and character education. Between 28 and 32 programs are funded annually.

FAMILY RESOURCE CENTERS: $5,802,710

Family Resource Centers (FRCs) provide access, within a community, to a broad continuum of early childhood and family support services that foster optimal development of children and families. FRCs offer parent education and training, family support, preschool and school age childcare, teen pregnancy prevention, substance use prevention, positive youth development services and family day-care provider training. School-based FRCs collaborate with many resources in their communities, including child-care providers, School Readiness Councils, local United Way chapters and service providers of the Departments of Social Services and Children and Families. There are currently 58 FRCs funded through the CSDE annually.

LEADERSHIP, EDUCATION, ATHLETICS IN PARTNERSHIP (LEAP): $280,990

The LEAP Program implements year-round community and school-based programming with a multi-tiered mentoring model designed to achieve positive academic and social outcomes for children living in high poverty urban neighborhoods. Since 1992, LEAP has led the movement to provide children and youth with opportunities to thrive in all areas of their lives. LEAP programming addresses the whole-child, with activities in reading, math, arts, health, athletics and interpersonal skill building.

NEIGHBORHOOD YOUTH CENTERS: $552,479

Exclusively served through Boys and Girls Clubs, the Neighborhood Youth Center (NYC) Grant Program focuses on character development as the cornerstone of positive youth growth. Boys and Girls Clubs focus on capturing the interests of young people, improving their behavior and increasing their personal expectations and goals. The CSDE supports 17 sites through the Connecticut Alliance for Boys and Girls Clubs and one individual community-based club (Bridgeport).

PRIMARY MENTAL HEALTH PROGRAM: $345,288

The Primary Mental Health Program is an evidence-based program that helps children in pre-k through third grade adjust to school, gain confidence and social skills, and focus on learning.

Through play, the Primary Mental Health Program addresses children's school adjustment difficulties and increases their chances for success. Through a competitive bidding process, the CSDE currently supports 18 Primary Mental Health Program sites throughout the state.

SCHOOL-BASED DIVERSION INITIATIVE (SBDI): $900,000

In collaboration with the Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS) and the Child Health and Development Institute (CHDI), the CSDE implements SBDI in school districts with high incidences of student arrest and disciplinary sanctions. SBDI is a school-level initiative that engages teachers, staff, administrators, and school resource officers through consultation, expert training, and capacity building activities. SBDI is an effective strategy to increase access for students and families to mental health prevention supports and treatment services in the school and local community. Thirty-seven schools and thirteen districts have implemented SBDI to date.

PROJECT ADVANCING WELLNESS AND RESILIENCY IN EDUCATION (AWARE): $1,774,332

In October 2018, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a five-year grant to the CSDE to improve capacity within three school districts to improve services and supports for students with mental and behavioral health needs. In partnership with the Department of Children and Families (DCF), Project AWARE will

serve the communities of Middletown, Naugatuck and Windham by increasing staff knowledge of indications of student distress; skills to engage with the student; and knowledge of appropriate services for those students who will benefit from structured supports.

Furthermore, the school districts will develop improved formal and reciprocal relationships with community service providers for their region. District staff will receive training on and implementation of the Adolescent Brief Intervention and Referral to Treatment (A-SBIRT) tool and other cognitive-behavioral intervention practices.

- **Total Annual Funding for Fiscal Years 2021: $15,292,080**

➢ Department of Social Services

The Department of Social Services, the State Medicaid Agency, covers a wide vareity of substance use disorder treatment and medication to treat substance use disorders for the Medicaid population. Recently, the Department submitted and received authorization from the Center for Medicare and Medicaid Services (CMS) to cover substance use residential treatment through an 1115 Demonstration Waiver. The following represents the Medicaid population with substance use disorders.

Medicaid 1115 Demonstration Waiver for Substance Use Disorders:
The Department of Social Services (DSS) as the state Medicaid Agency submitted an 1115 Demonstration Waiver application to the Centers for Medicare and Medicaid Services (CMS) in an effort to transform the Medicaid reimbursed substance use disorder treatment system. The demonstration waiver, which went into effect on May 1, 2022 with CMS approval, allowed Medicaid to reimburse substance use disorder residential treatment program. Prior to the CMS approval of the demonstration waiver, all substance use disorder residential treatment services were fully state funded. As a result of the demonstration waiver and the coverage of residential treatment, the state is in a position to receive federal financial participation (FFP) or federal match on expenditures related to residential treatment services. The federal match on expenditures allowed DSS to establish new and enhanced rates for residential treatment programs so they can comply with the most recent edition of the American Society of Addiction Medicine (ASAM) treatment criteria.

More information may be found on the DSS website on the SUD Demonstration Waiver using the following link:

Substance Use Disorder Demonstration Project

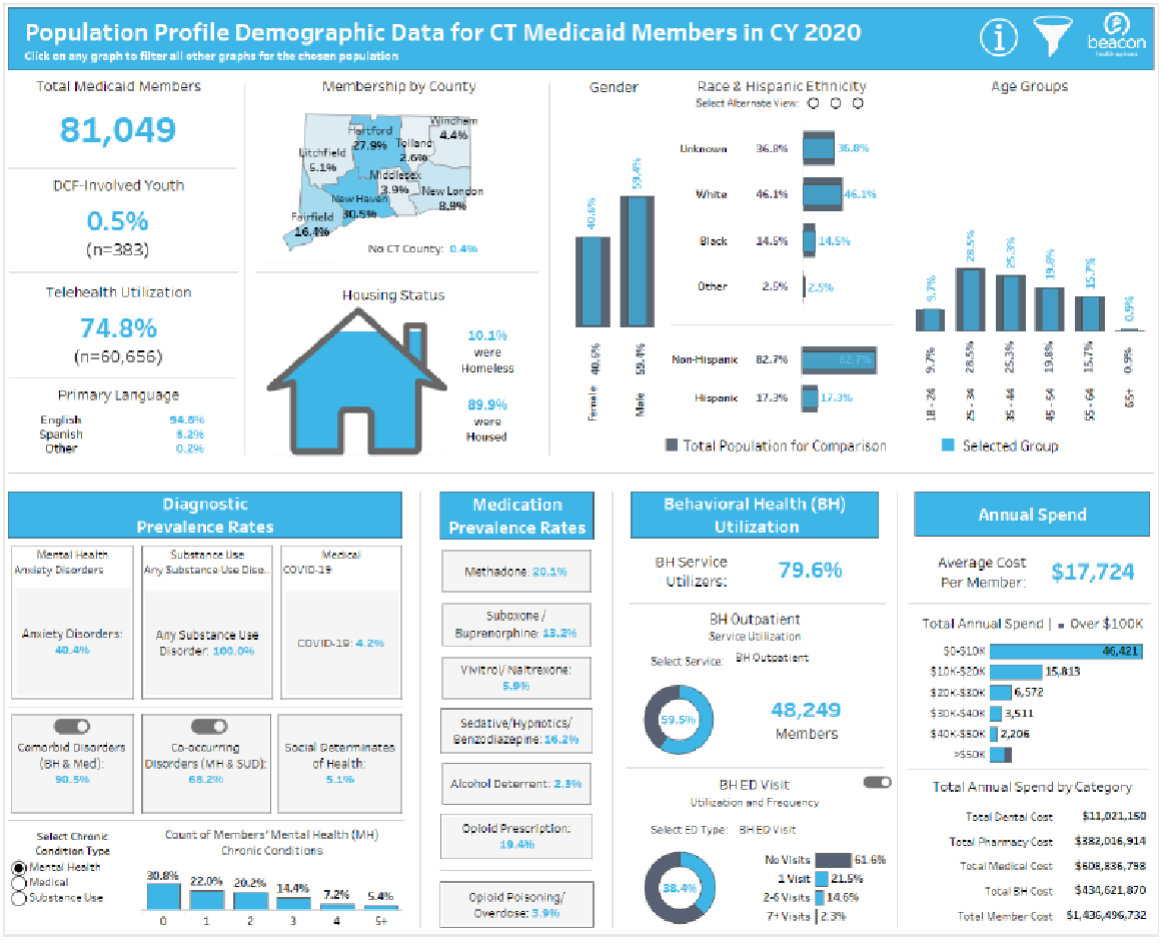
Population Profile of Medicaid Members with Substance Use Disorder (SUD)

The following dashboard highlights data in the adult Medicaid populations with SUD for Calendar Year 2020. There were 81,049 adult Medicaid members with SUD. The statistics for this population include:

- Primarily English speaking (94.6%)
- New Haven and Hartford Counties are the highest counties of residence (30.5% and 27.9%, respectively)
- Most were housed (89.9%) versus being homeless
- Most frequent pattern of member demographics include:
- Race: white (46.1%)
- Ethnicity: Non-hispanic (82.7%)
- Age group: 25 – 34 years old
- Ninety percent had comorbid disorders (presence of behavioral and medical health issues)
- Sixty-eight percent had co-occurring disorders (presence of mental health disorder in addition to the SUD diagnosis)
- Almost 40% of this member population were on a form of Medication for Addiction Treatment (MAT) which includes Methadone, Suboxone/Buprenorphine, Vivitrol/Naltrexone.
- Eighty percent of this population utilized a behavioral health service in the year

Population profile CY 2020

Entire adult population with and SUD

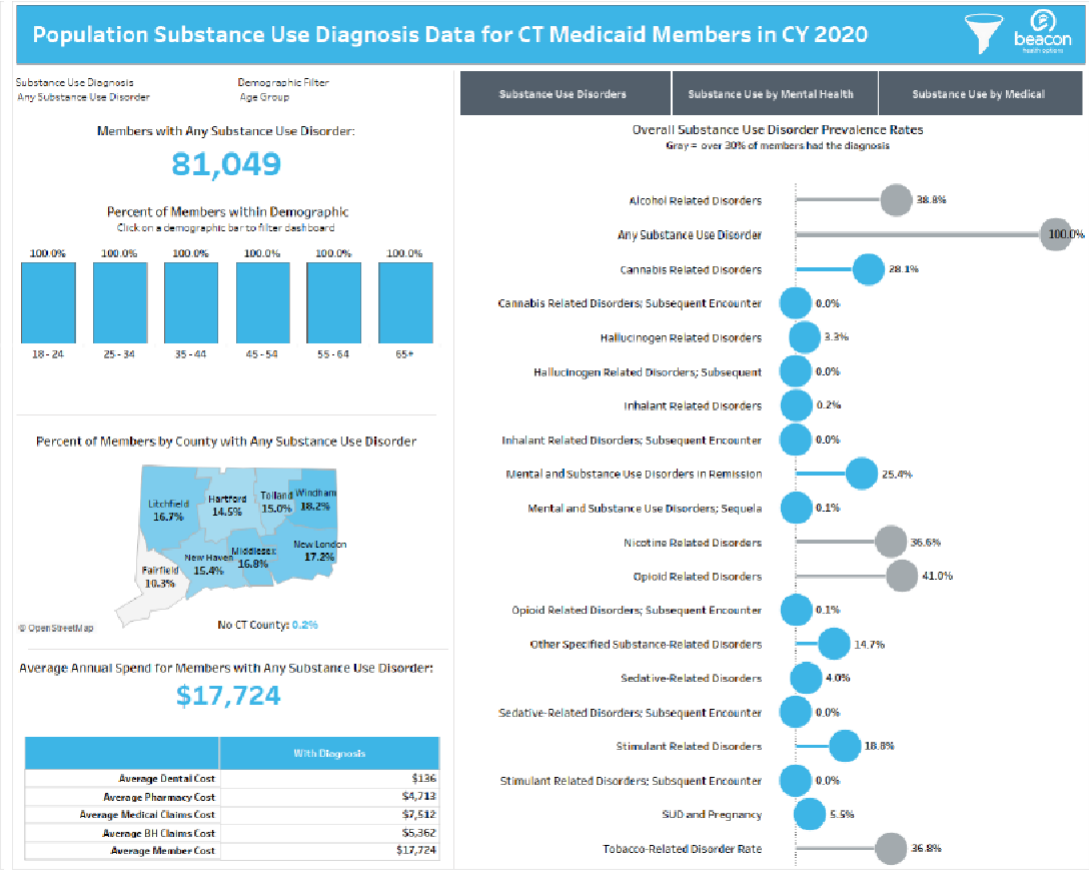


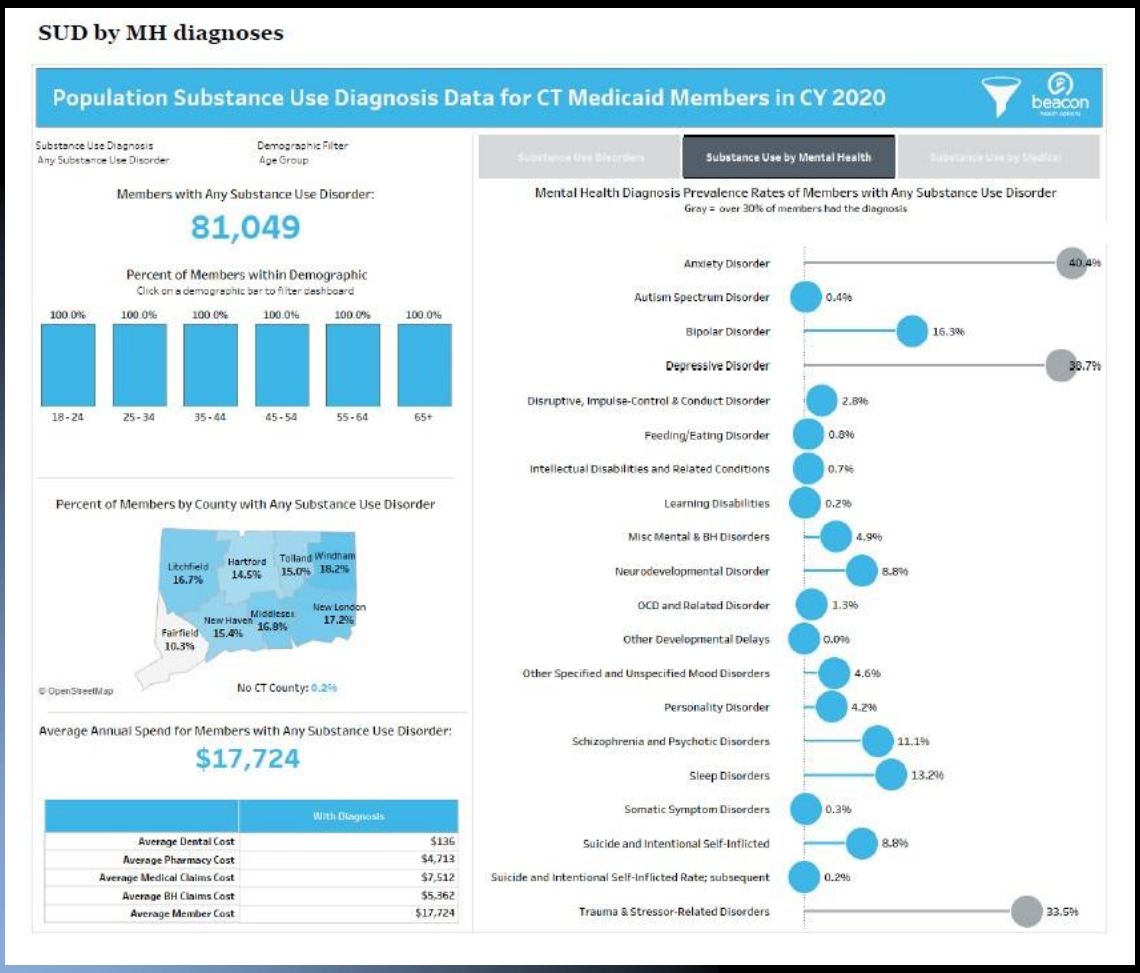
Substance Use Disorder Diagnoses

The following dashboard highlights the specific types of Substance Use Disorders (SUD) of the entire adult Medicaid population with SUD in Calendar Year 2020. Of the 81,049 adult Medicaid members with an SUD in CY2020, the following are the top five SUD categories:

- Opioid Related Disorders: 41.0%
- Alcohol Related Disorders: 38.9%
- Tobacco Related Disorders: 36.9%
- Nicotine Related Disorders: 36.6%
- Cannabis Related Disorders: 28.1%

SUD by SUD diagnoses





Mental Health Disorder Diagnoses

The dashboard above highlights the specific types of Mental Health Disorders of the entire adult Medicaid population with SUD in Calendar Year 2020. Of the 81,049 adult Medicaid members with an SUD in CY2020, the following are the top five Mental Health Disorder categories:

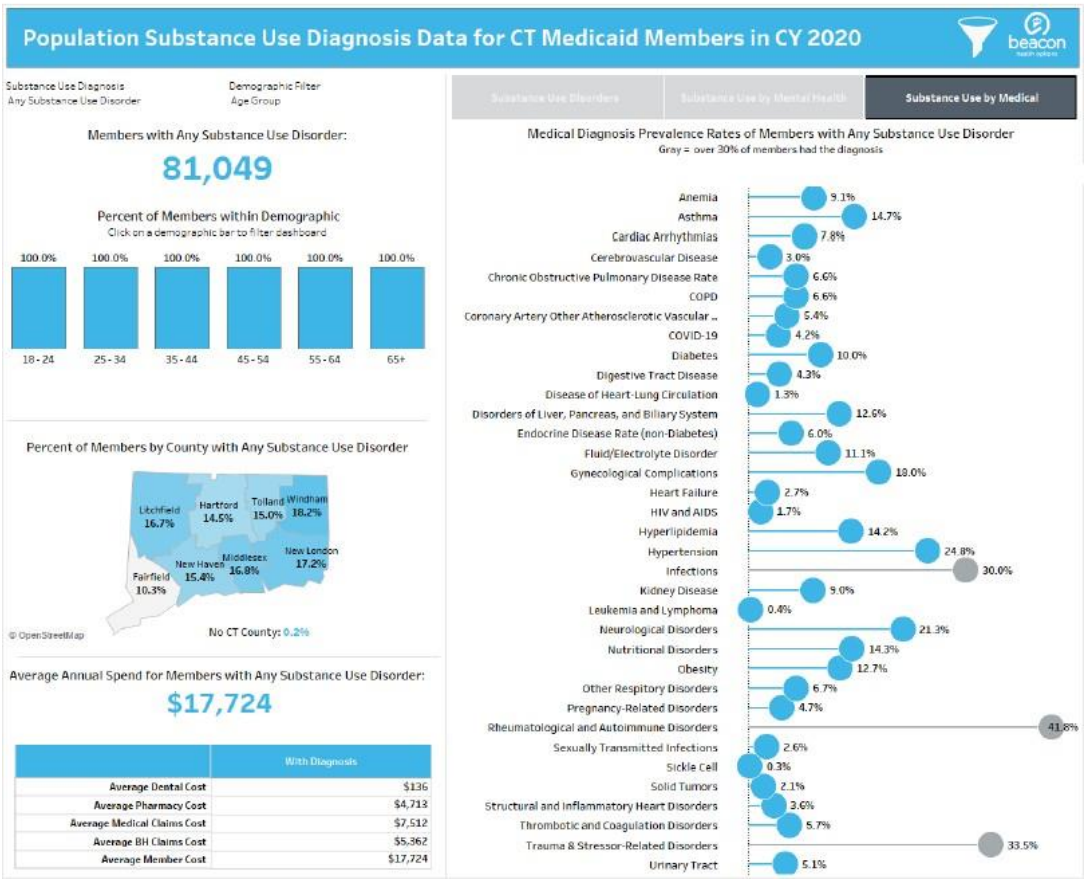
- Anxiety Disorders: 40.4%
- Depressive Disorders: 30.7%
- Bipolar Disorders: 16.3%
- Sleep Disorders: 13.2%
- Scizophrenia and Psychotic Disorders: 11.1%

Medical Diagnoses

The following dashboard highlights the specific types of Medical Diagnoses of the entire adult Medicaid population with SUD in Calendar Year 2020. Of the 81,049 adult Medicaid members with an SUD in CY2020, the following are the top five medical diagnosis categories:

- Rheumatological and Autoimmune Disorders: 41.8%
- Trauma and Stressor Related Disorders: 33.5%
- Infections: 30.0%
- Hypertension: 24.8%
- Nuerological Disorders: 21.3%

SUD by medical diagnoses



Medicaid Substance Use Disorder (SUD) Benefits and Services

The following are currently Medicaid covered SUD behavioral health benefits and services:

- Screening and brief intervention
- Outpatient services
- Methadone Maintenance
- Medication for Addiction Treatment (MAT)
- Intensive Outpatient Services (IOP)

- Partial Hospitalization Program (PHP)
- Ambulatory Withdrawal Management
- Inpatient Hospital Withdrawal Management
- Residential Treatment
- Targeted Case Management (TCM) for members aged 19 and under
- Targeted Case Management (TCM) for adults with Serious Mental Illness and Co-occurring disorders (substance use and mental health disorders)

Opioid Prescription Utilization

The Department of Social Services has been tracking the opioid prescription utilization for several years in effort to advance policies and practices that reduce accidental overdoses. The following data represents opioid prescription practices over the last five years. The data reflects that the trend over the last five years is a significant decrease in all of the following categories: counts of opioid prescriptions written, quantity of opioids being dispensed, number of unique recipients filling opioid prescriptions, total spend on pharmacy spend for opioid prescriptions.

Connecticut Medical Assistance Program
Annual Opioid Prescription Utilization Report
2017 - 2021

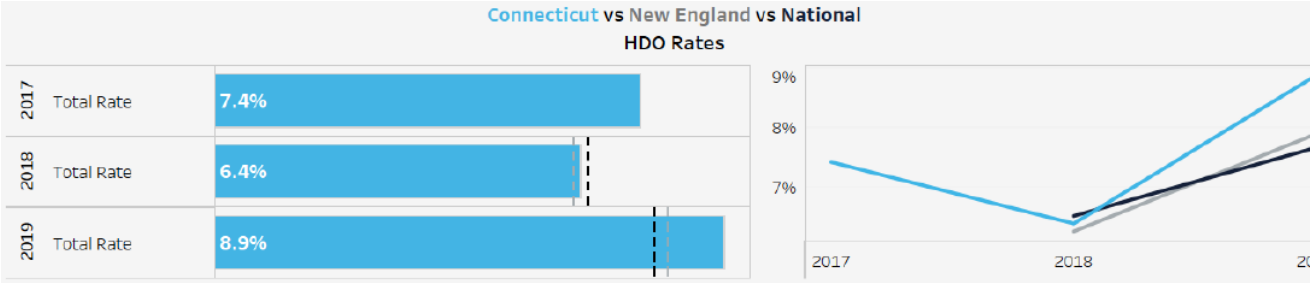
Connecticut Medical Assistance Program Opioid Prescription Utilization								
Year	Opioid Prescription Count	Percent change from 2017	Opioid Quantity Dispensed	Percent change from 2017	Unique Recipient Count Filling Opioid Prescriptions	Percent change from 2017	Total Paid Amount to Pharmacies for Opioid Prescriptions	Percent change from 2017
2017	412,773		22,030,822		122,779		$16,617,066	
2018	342,201	-17.10%	18,510,115	-15.98%	102,741	-16.32%	$13,297,971	-19.97%
2019	300,881	-27.11%	16,328,636	-25.88%	90,596	-26.21%	$11,541,766	-30.54%
2020	260,685	-36.85%	14,282,086	-35.17%	75,151	-38.79%	$10,246,689	-38.34%
2021	258,021	-37.49%	13,454,057	-38.93%	78,754	-35.86%	$9,732,593	-41.43%

High Dose Opioid (HDO)

There are several nationally recognized and validated measures to opioid prescriptions, one of which is High Dose Opioid. High dose opioid prescribing may identify a very high risk practice or pattern of prescribing.

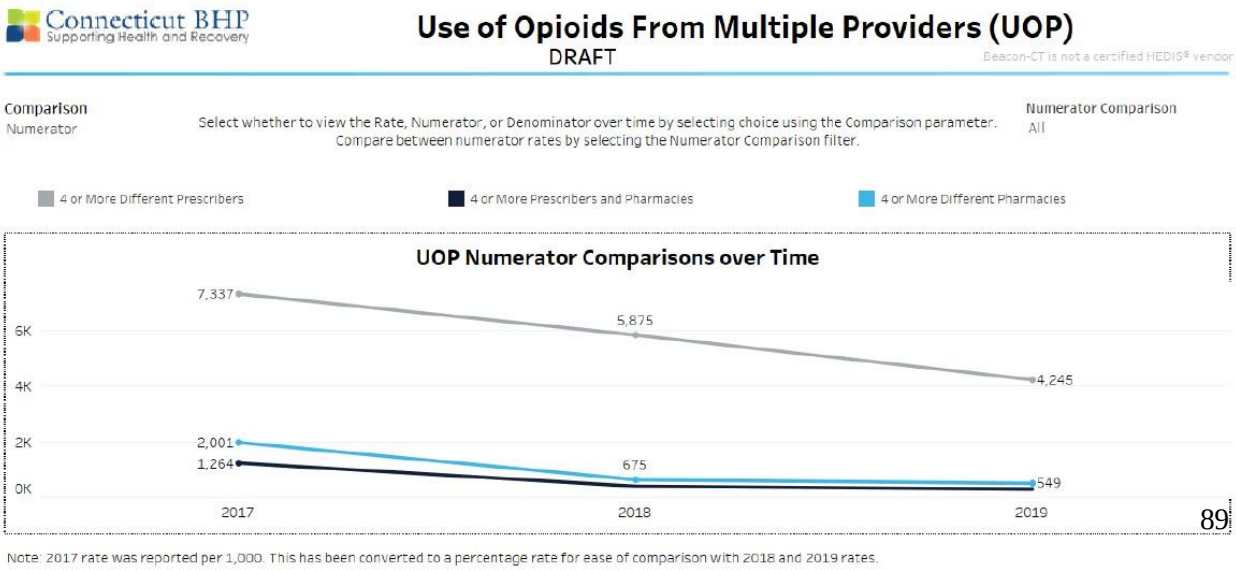
Opioids at High Dosage (HDO) HEDIS® measure is important to help identify patients at high risk by focusing on providers who prescribe opioids in doses exceeding 90 morphine milligram equivalents (MME). There are four steps to calculate the average daily morphine milligram equivalents (MME). First, for each opioid dispensing event, the number of opioid dosage units per day is calculated by dividing the opioid quantity dispensed by the days' supply for that medication.

Second, the MME daily dose is calculated by multiplying the number of opioid dosage units per day with the dose strength (mcg or mg) by the MME conversion factor. The MME conversion factor converts the opioid medication to the comparable analgesic strength of oral morphine (Table HDO-A)42. Third, the MME daily doses are summed for all dispensing units. Finally, the average MME for all opioid dispensing events is calculated for the treatment period. It is important to note that for this measure, a lower rate indicates better performance. The following graph compares Connecticut rates for prescribing HDO to that of all to the average for New England states and for the nation. In CY2018, Connecticut had a higher HDO rate than New England states and lower HDO rate than the national average. In CY2019, Connecticut had a higher HDO rate than both the averages for New England state and the nation.

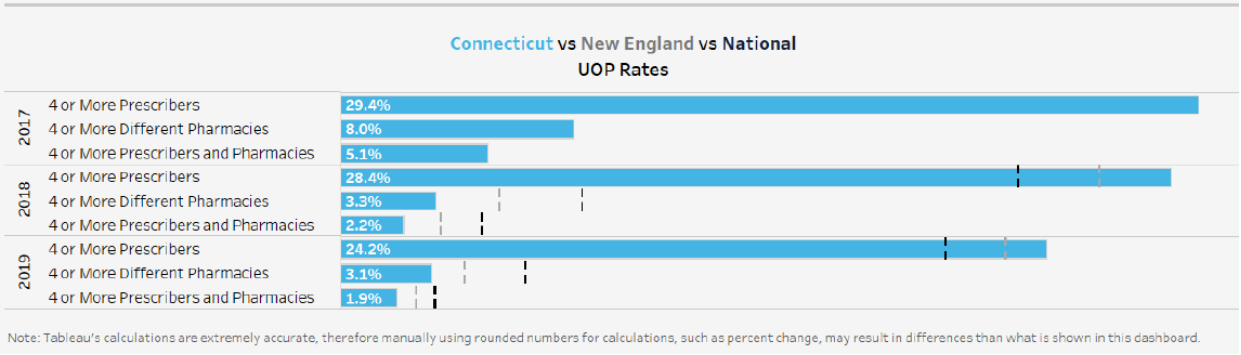


Use of Opioids from Multiple Providers

Another national measure that is potentially very dangerous and could lead to accidental overdoses is when a member received an opioid prescription from more than one provider. The following data represents the rates and number of people who are prescribed an opioid from more than one provider. The following graph depicts that Connecticut had shown a decrease from Calendar Years 2017 through 2019 in the number of members who obtained a prescription from more than one provider / pharmacy.

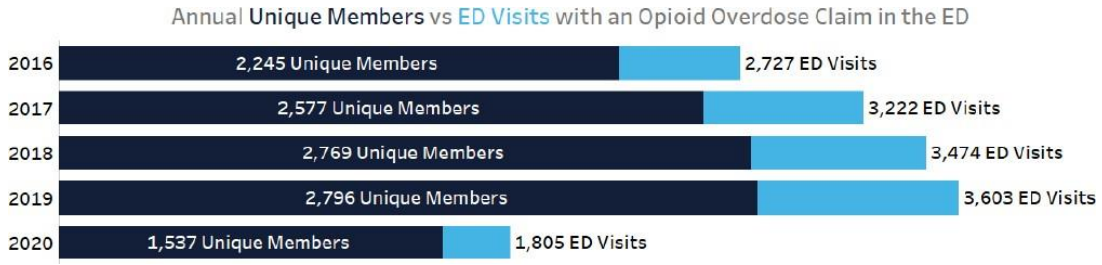


In the following graph, Connecticut is compared against New England states average and national average for instances of members having multiple opioid prescriptions at once. In Calendar Years 2018 and 2019, Connecticut outpaced both the New England and national averages in the categories of "4 or more prescribers" but displayed lower averages in both years compared to both New England and the nation in the categories of "4 or more different pharmacies" and "4 or more prescribers and pharmacies".



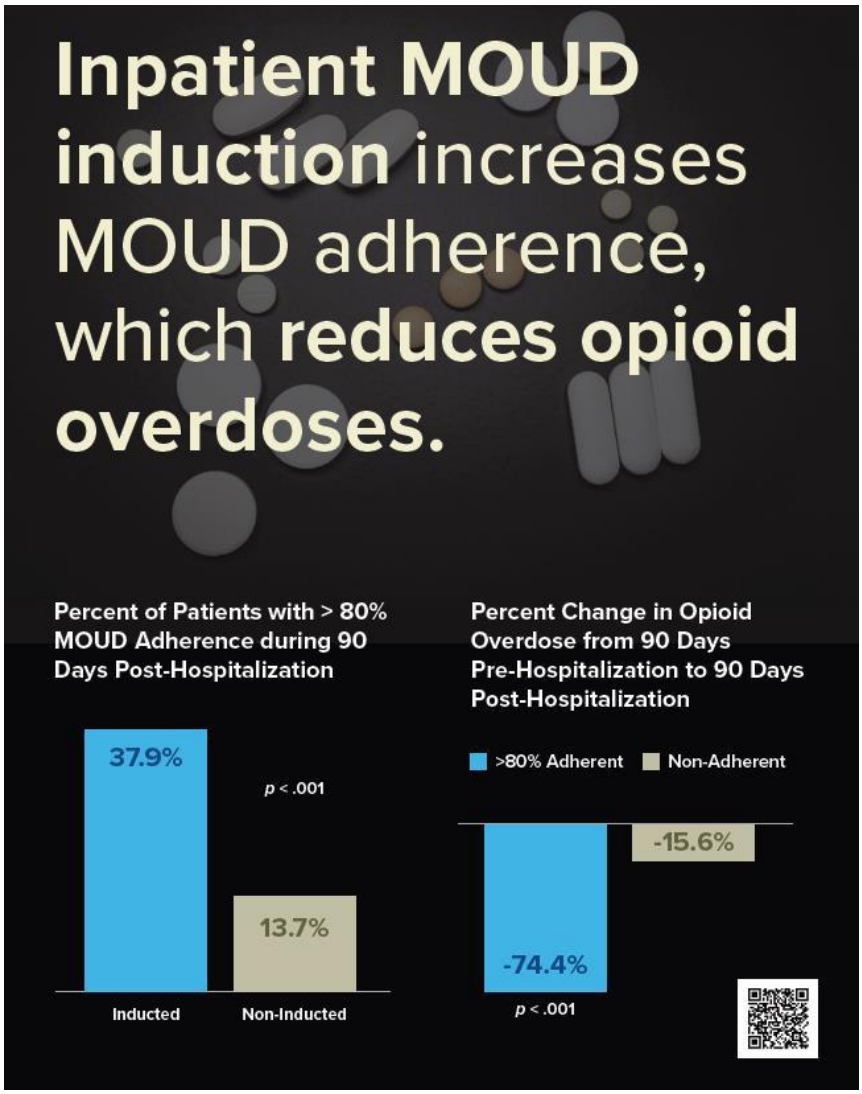
Opioid Poisoning in the Emergency Department

Accidental overdoses frequently result in an individual being transported to the emergency department. In such cases, the emergency department may indicate an opioid poisoning. The following data represents opioid poisoning in the emergency department. The data illustrates that the number of both unique members and ED visits increased from 2016 - -2019, but decreased in 2020.



Medication for Opioid Use Disorder

Medicaid covers several medications for the treatment of opioid use disorder. The following represents efforts to make those medications more accessible for individuals eligible for Medicaid and which medications are being used. The data below reflects that those inducted on MOUD while inpatient have a greater chance at remaining adherent to this treatment post-discharge than those who were not inducted during inpatient stay.

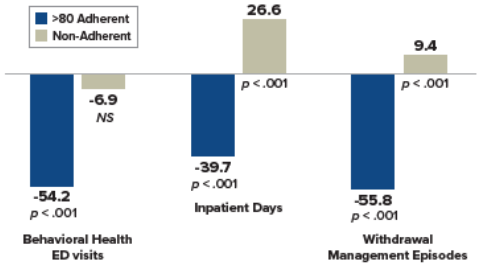


RESULTS: Of the 3,143 patients admitted for withdrawal management (73.5% male, 47.4% White, 22.6% Hispanic), 733 were inducted on MOUD (23.3%) and 2,410 were not inducted (76.7%).

MOUD adherent individuals saw a greater drop in opioid overdose in the post- period (from 8.2% to 2.1%) compared to non-adherent members (from 7.7% to 6.5%).

MOUD adherent adults also saw a significant decrease in their average number of BH ED visits (from 0.7 to 0.3), average number of inpatient days (2.4 to 1.4), and in the mean number of withdrawal management episodes (0.5 to 0.2).

Percent Change in Service Use 90 Days Pre and 90 Days Post Hospitalization



CONCLUSIONS: MOUD induction during inpatient care is associated with higher likelihood of post-discharge adherence, which in turn is associated with reduced service utilization and opioid overdose. Various implementation supports, such as peer support services, are crucial to success.

Additional Authors
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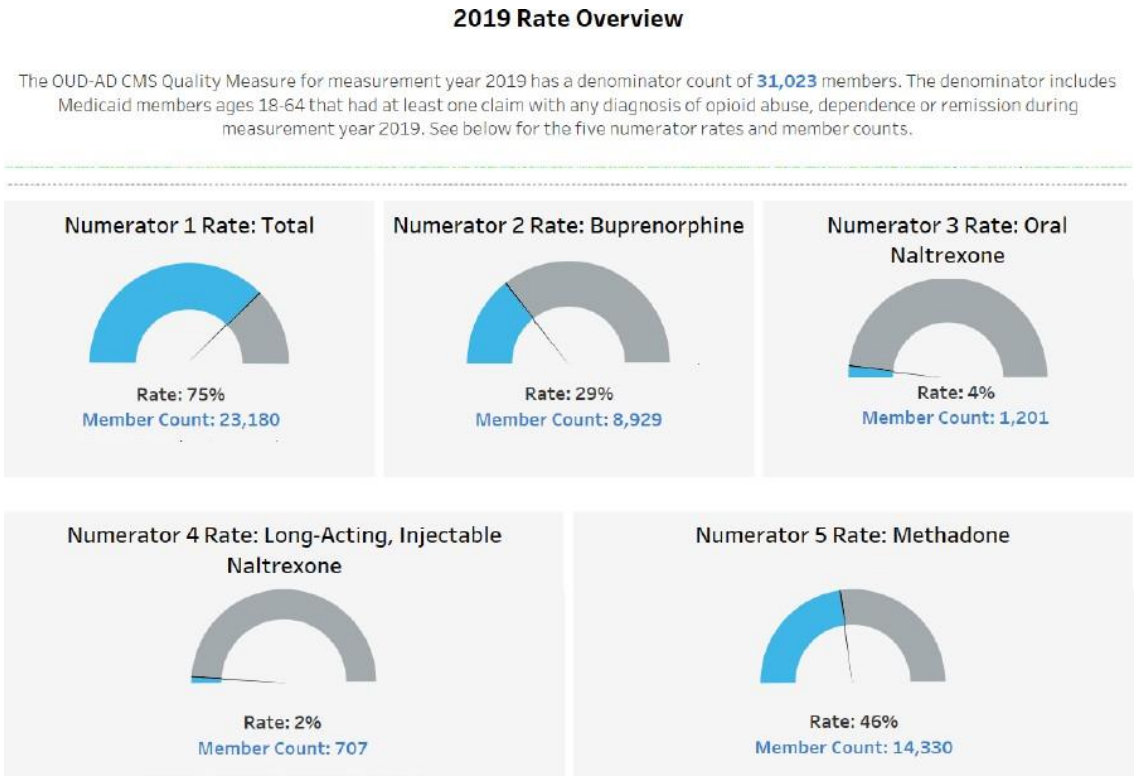
Pharmacotherapy for Opioid Use Disorder (CMS measure)

This measure includes five distinct rates

- Group 1: A total rate that captures any FDA approved MOUD
- Group 2: Separate rate representing the FDA approved drug buprenorphine
- Group 3: Separate rate representing the FDA approved drug oral naltrexone
- Group 4: Separate rate representing the FDA approved drug long-acting, injectable naltrexone
- Group 5: Separate rate representing the FDA approved drug methadone

The data below shows that of Connecticut Medicaid members in Calendar Year 2019, 75% of members with an Opioid Use Disorder (31,023), 75% were on any type of MOUD. Of those on MOUD:

- 46% were utilizing Methadone
- 29% were utilizing Buprenorphine
- 4% were utilizing Oral Naltrexone
- 2% were utilizing Long-acting, Injectable Naltrexone



Department of Mental Health and Addiction Services

Triennial Report 2022 Opioid Annex

DMHAS Triennial Report Subsection Responding to the Opioid Epidemic

Introduction

Connecticut, like all of the other New England states and indeed, most states in the country began to see a significant increase in opioid use in fiscal year 2011. The surge in heroin and other opioid use has been described by the Centers for Disease Control and Prevention (CDC) as an epidemic (CDC, 2018). This is reflected in growing numbers of overdose deaths attributable to opioid use; it is also echoed in increases in admissions, specifically related to opioid use, to Connecticut's treatment system. Many of these overdose deaths involve the use of multiple substances. Since our last Triennial Report Overdose deaths have continued to rise.

Overdose deaths are rising, fueled largely by expanded use of fentanyl. In the past fentanyl was mixed or cut with heroin but in the past three years, fentanyl is being used to manufacture counterfeit drugs in pill form. The DEA has cautioned that these pills are made to look like prescription opioid drugs but increasingly are being manufactured to mimic stimulant and other drugs. This use is killing unsuspecting users at alarming rates. These counterfeit pills are often being manufactured in China and distributed by Mexican drug cartels in the United States. The DEA has cautioned that they are increasingly seeing counterfeit pills with over 2 milligrams of fentanyl, a dose that is considered deadly.

Connecticut has responded to this crisis with comprehensive, multi-agency strategies that include treatment, prevention, education and training, new legislation and policy initiatives. Additionally, the state has applied for and received private and federal funding targeting the opioid crisis. These strategies continue but more needs to be done to address the use of fentanyl. Without reductions in the trafficking of fentanyl, it is likely that overdose deaths will continue to rise.

Connecticut's Opioid Epidemic

Overdose deaths have continued to rise. Calendar year 2020 accounted for 1,378 fatal drug overdoses in Connecticut, an increase of 14.3% from CY19. Calendar year 2021 accounted for 1,531 fatal drug overdoses, an increase of 11.1% from CY20.

The disturbing trend that was described above regarding the impact of fentanyl is demonstrated in an analysis of the drugs involved in overdose deaths. In CY18, fentanyl was involved in 75% of all overdose deaths. Fentanyl-involved overdose deaths increased in CY19 to 82%. In 2020, the average percentage of fentanyl involved deaths further increased to 85%. The percentage of fentanyl-involved deaths in CY21 was 86%.

The continued problem with opioids in the state can be observed in trends compiled from DMHAS' data collection system. Data for FY21 demonstrates that heroin and opioids account for approximately 42% of all substance use treatment admissions while alcohol is reported to be the primary drug involved in approximately 37% of these admissions. Admissions related to marijuana comprise about 8% of substance use treatment admissions in FY21. In the last Triennial Report, it was observed that cocaine and crack admissions accounted for almost 7.5% of admissions to the substance use treatment system. This was seen as a disturbing trend because that had been a significant increase over prior years. This has not increased and cocaine and crack accounted for approximately 5.8% of admissions to the substance use service system in FY 21.

Connecticut's Opioid Epidemic and Related Data

Fentanyl is the primary substance involved in Connecticut's opioid crisis, although heroin and prescription opioids such as hydrocodone, oxycodone, codeine, morphine, and diverted methadone are also present. Fentanyl, a synthetic opioid, is 50 to 100 times the strength of heroin and is increasingly being mixed with or substituted for heroin (CDC, 2018). This practice places both users and others in close proximity at greater risk due to the greater strength and toxicity of the drug. Overdose deaths related to opioids escalated over the 2019 – 2021 time period and now account for over 92% of all accidental overdose deaths in Connecticut.

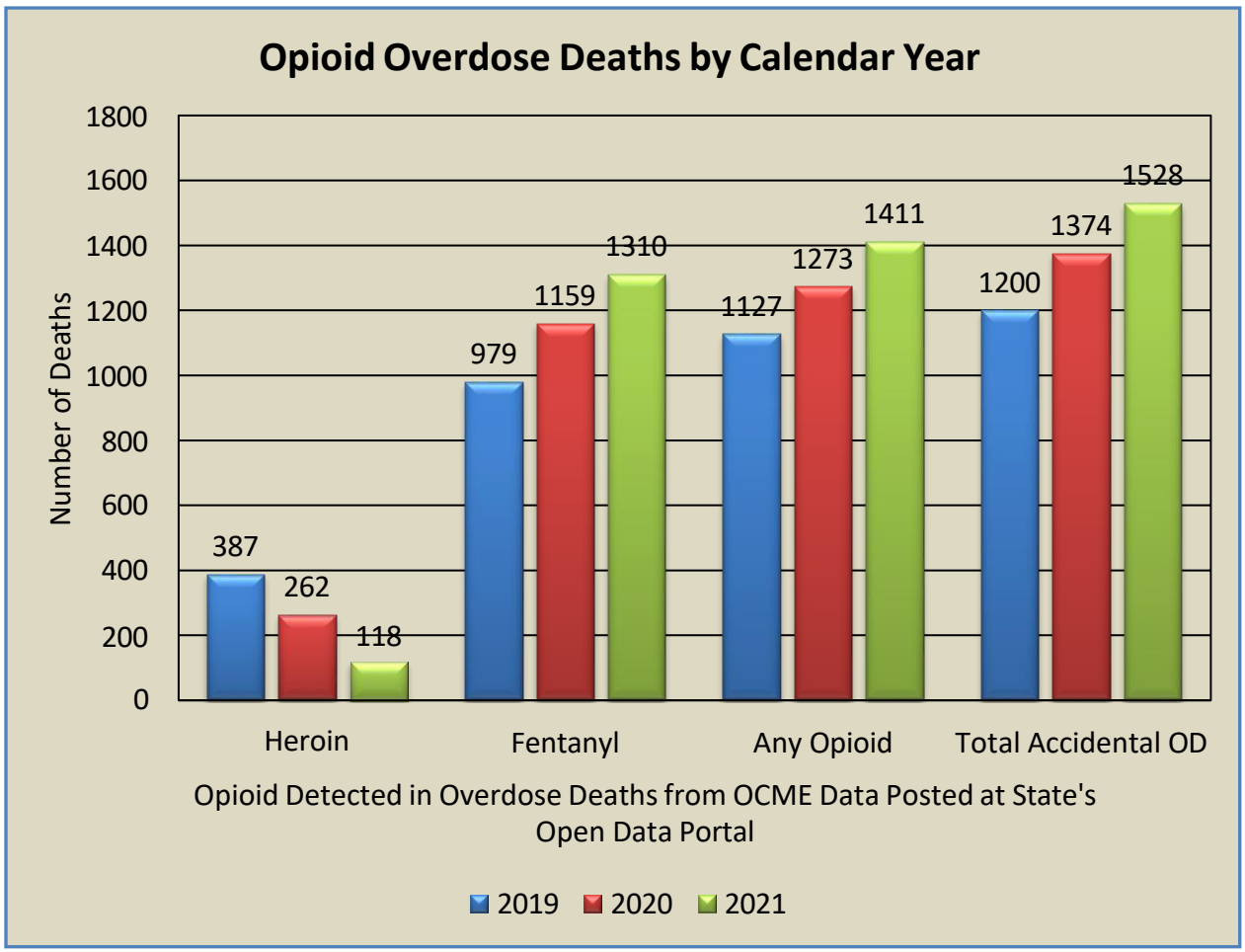


Figure 1

Overdose deaths have been steadily rising in Connecticut; there was a 27% increase in total accidental overdose deaths from CY19 to CY21. Office of the Chief Medical Examiner (OCME) data documents significant poly-substance involvement (OCME, 2021), but opioids are involved in the majority of overdose deaths. Opioids were detected in 92% to 94% of the overdose deaths reported in each of the last three calendar years. Figure 1 shows a sharp rise (34% increase) in fentanyl-related deaths between 2019 and 2021, while the share of heroin deaths declined by 70% during the same time. In CY 2018, 74% of all overdose deaths involved fentanyl and its analogues and now, over the past three years, 82%-85% of deaths involved fentanyl. The COVID-19 pandemic encompassed some of FY20 and all of FY21 and impacted the number of admissions to and individuals served by DMHAS programs. Total admissions to DMHAS programs dropped by 8% from FY19 to FY20 and were down 19% from FY20 to FY21. Admissions to Addiction programs decreased by 1% from FY19 to FY20, but were down by 29% from FY20 to FY21.

The Connecticut treatment system has seen a decline in opioid-related admissions since its peak in FY17. Heroin and other opioid-related admissions have been in a slow decline from 2017 through 2021. The larger drops in opioid-related admissions were between FY19 and FY20 (-15%) and also between FY20 and FY21 (-16%), which encompassed the COVID pandemic. To account

for the general COVID-related decline in admissions, the figure below includes information about opioid admissions as a percentage of admissions to Addiction programs. This green line illustrates that although the total number of admissions has declined, the percent of admissions that are opioid-related hit a low of 43% in FY20 and increased to 51% of admissions in FY21. The average number of admissions per client remained steady at 2.0 per client from FY17 to FY20. However, this ratio decreased slightly to 1.90 in FY21, likely due to the challenges of serving clients during the pandemic. See Figure 2 for more detail on the number of unduplicated clients and opioid-related admissions to the DMHAS treatment system.

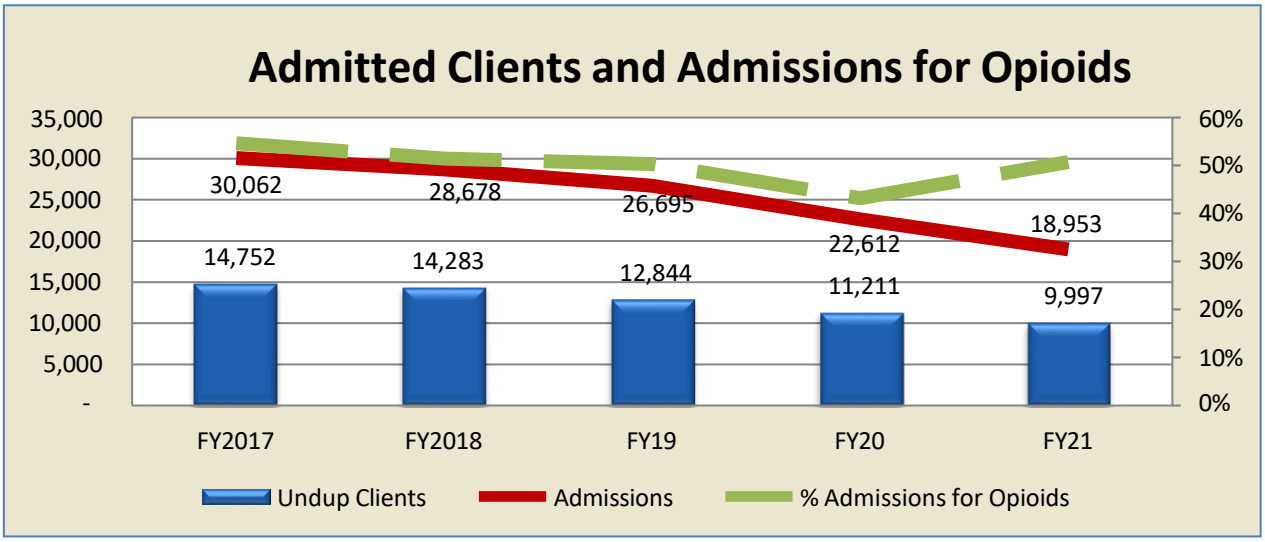
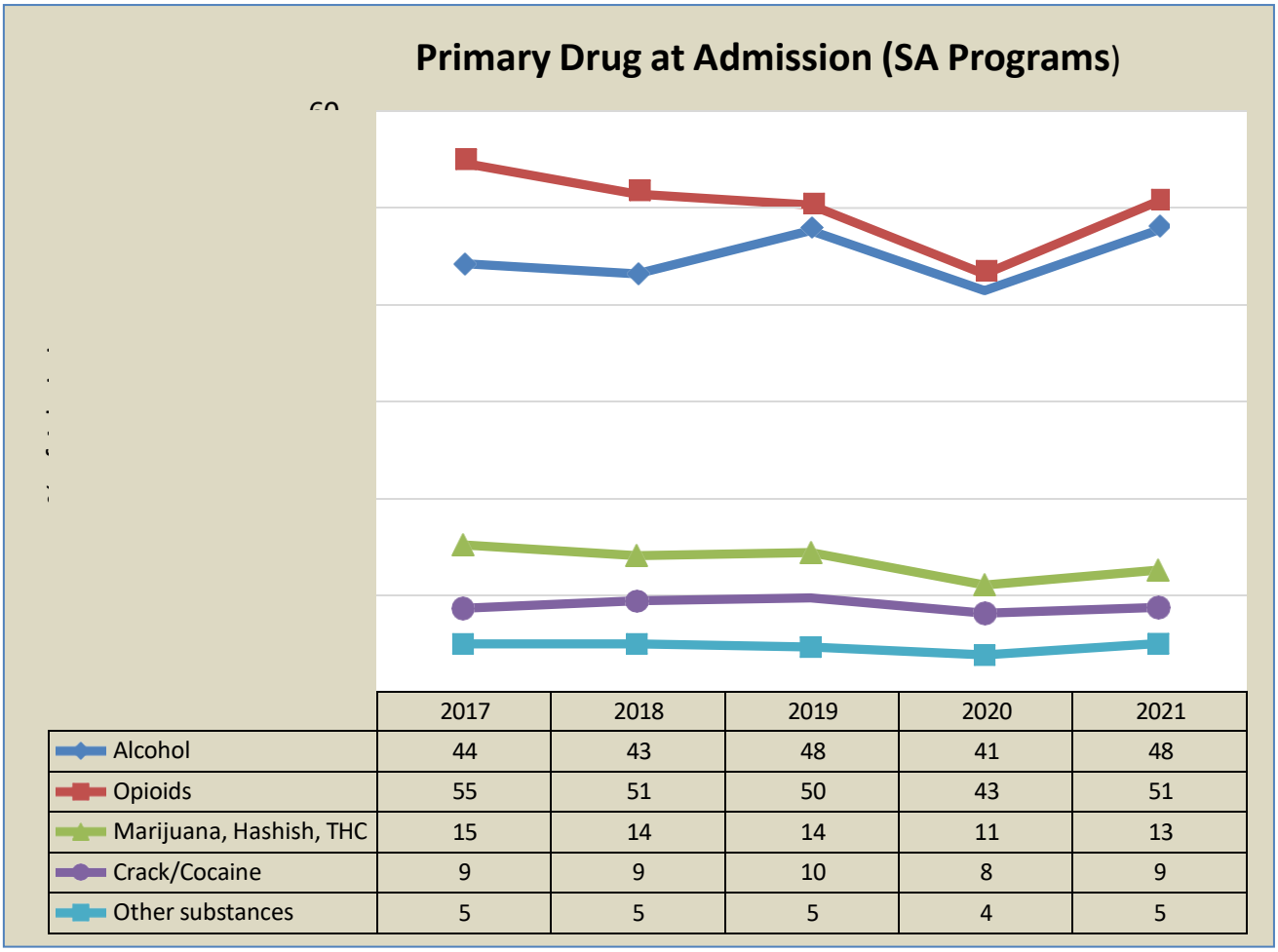


Figure 2: Admitted Clients and Admissions for Opioids, FY17-FY21 (*Data from DMHAS EDW; All funding sources)



	2017	2018	2019	2020	2021
Alcohol	44	43	48	41	48
Opioids	55	51	50	43	51
Marijuana, Hashish, THC	15	14	14	11	13
Crack/Cocaine	9	9	10	8	9
Other substances	5	5	5	4	5

Figure 3: Primary Drug at Admission, FY17-FY21 (*Data from DMHAS EDW; includes all funding sources)

When individuals are admitted to DMHAS substance use services, they report their "primary drug" of use. For a number of years, alcohol had been the most frequently reported primary drug at admission. Since FY15, opioids have replaced alcohol as the primary drug reported at admission within the SA treatment system. With the exception of FY20, heroin, along with prescription opioids, accounted for over 50% of all SA treatment admissions. Figure 3 (below) illustrates the constancy with which opioids were most frequently reported as the primary drug of choice over the past five years.

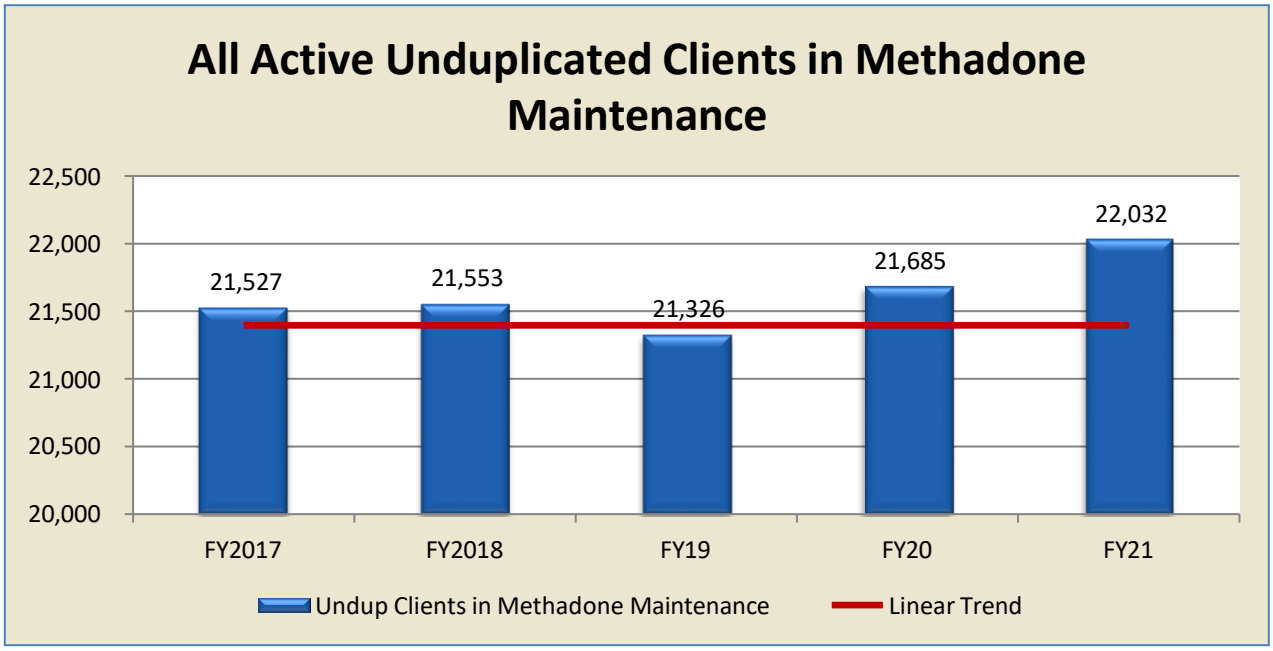


Figure 4: Unduplicated Clients in Opioid Treatment Programs/ Methadone Maintenance, FY17-FY21 (*Data from DMHAS EDW; includes all funding sources)

The impact of the opioid crisis has been evident in certain treatment levels of care. In FY 17, DMHAS served 21,527 clients in OTP's and that number grew to 22,032 in FY 21, a 2% increase. Even through the challenging FY20-FY21 timeframe, Figure 4 illustrates the retention and actual increase in the number of clients served in OTP's/methadone maintenance programs.

New admissions to OTP's were impacted by the complexities associated with the COVID 19 pandemic and declined over the last few years with a 17% decline from FY19 to FY21. The number of unduplicated clients dropped by only 13% during this same timeframe. Even though the total numbers of admissions and clients decreased, Figure 5 indicates that the percentage of overall admissions to OTP's was at an all-time high of 21% in FY21. The use of mobile MAT is widely supported and is being executed as a way of reaching clients in remote areas, and was also emphasized during the pandemic to provide outreach to people largely staying at home.

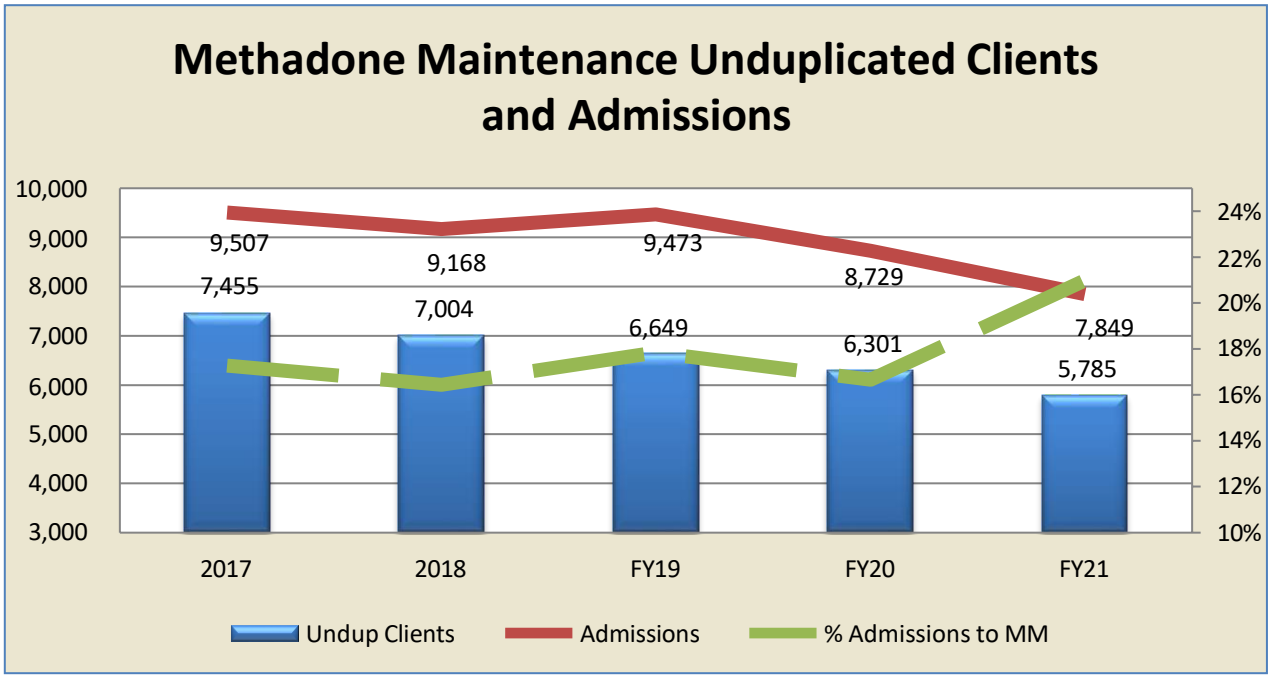


Figure 5: Yearly Admissions and Clients in Methadone Maintenance, FY17-FY21
(*Data from DMHAS EDW; includes all funding sources)

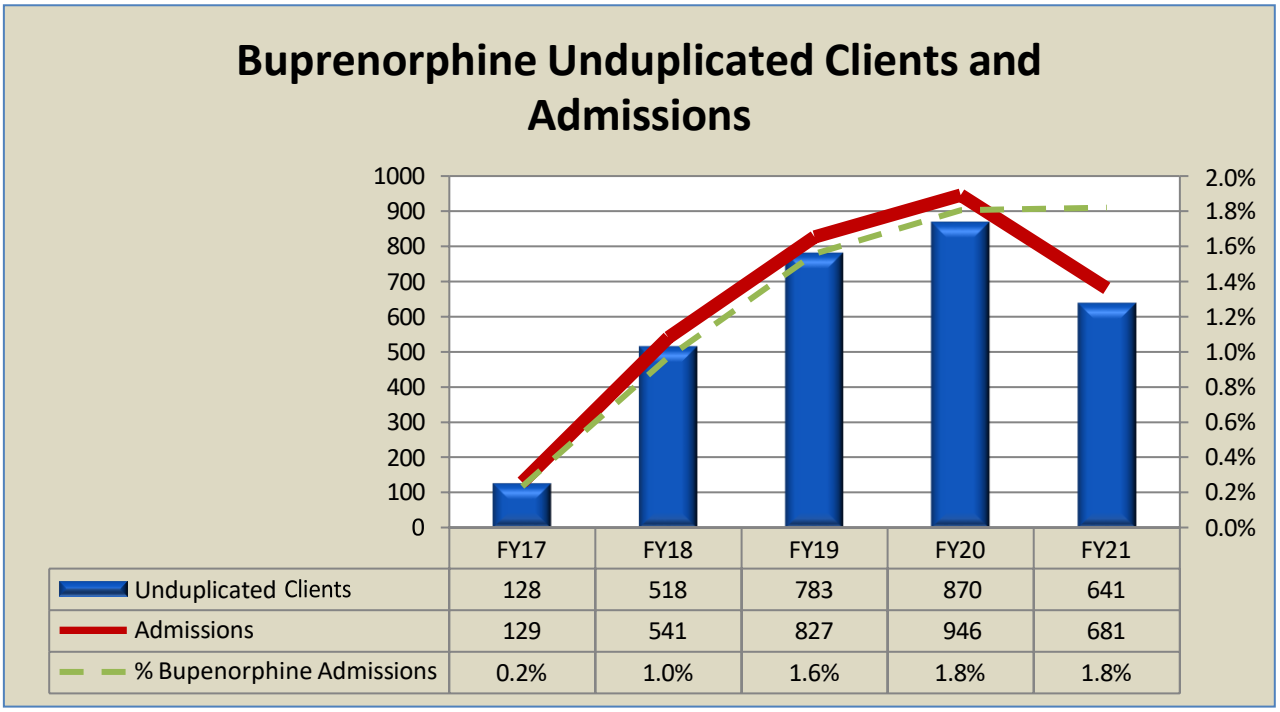


Figure 6: Yearly Admissions and Clients in Buprenorphine Programs, FY17-FY21
(*Data from DMHAS EDW; includes federally funded MAT programs)

Admissions to buprenorphine programs have generally increased steadily over the past five years with a peak in FY20. The number of unduplicated clients served in FY21 increased by 400% since FY17 and the number of admissions has increased 428%. At its peak in FY20, there were 633% more admissions and 580% more clients served in buprenorphine programs compared to FY17. With examination of the percentage of total admissions to buprenorphine programs rather than the raw number of admissions, it is evident that the percentage of buprenorphine related admissions has remained steady at approximately 2% of all admissions to substance use program over the last three years. Unlike methadone which must be provided in highly structured clinics, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed in physician's offices. These programs provide persons with opioid disorders an additional evidence-based option for the treatment of opioid dependency, significantly increasing treatment access (SAMHSA). The increase in buprenorphine clients may explain some of the FY19 decrease in the number of clients utilizing Methadone Maintenance programs (Figure 5); more clients are using alternative treatment options to Methadone Maintenance. Figure 6 provides more specific information regarding the number of admissions and clients served in buprenorphine programs.

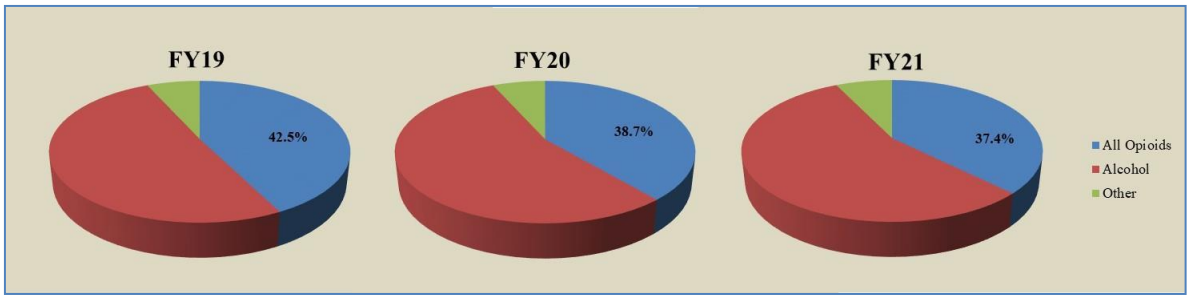


Figure 7: Primary Drug at Admission in Withdrawal Management/Detoxification Programs, FY19-21 (*Data from DMHAS EDW; includes all funding sources)

Approximately 43% of all admissions to withdrawal management programs in FY19 were related to heroin or other opioids. In FY21, this percentage was 37%. Greater emphasis is being focused on connecting these clients to medication-assisted treatment. This is shown in Figure 7 above.

The demographics associated with opioid users have remained fairly stable over the last three years. While the largest number of admissions continues to originate in our most populated cities, most cities in Connecticut are represented in opioid related admissions to our treatment programs.

The percentage of female opioid users declined by 2% while the percentage of males increased by 2%. The composite of race categories for clients who used opioids generally remained stable; there was a slight decrease (-3.3%) in the number of White/Caucasian users over the three years and a slight increase (+1.5%) in the number of Black/African American users. The number of non-Hispanic clients decreased by 3.8%, while the number of Hispanic clients remained about the same (+0.3%) over time. Over the three years, there was a modest trend of more opioid users in

both younger age groups (18-25 years and 26-34 years) and fewer users in the older age groups. Overall, the number of younger users (under the age of 35) increased by 3.3% while the number of older users (35 years and older) declined by 3.3%. Figure 8 below illustrates this trend.

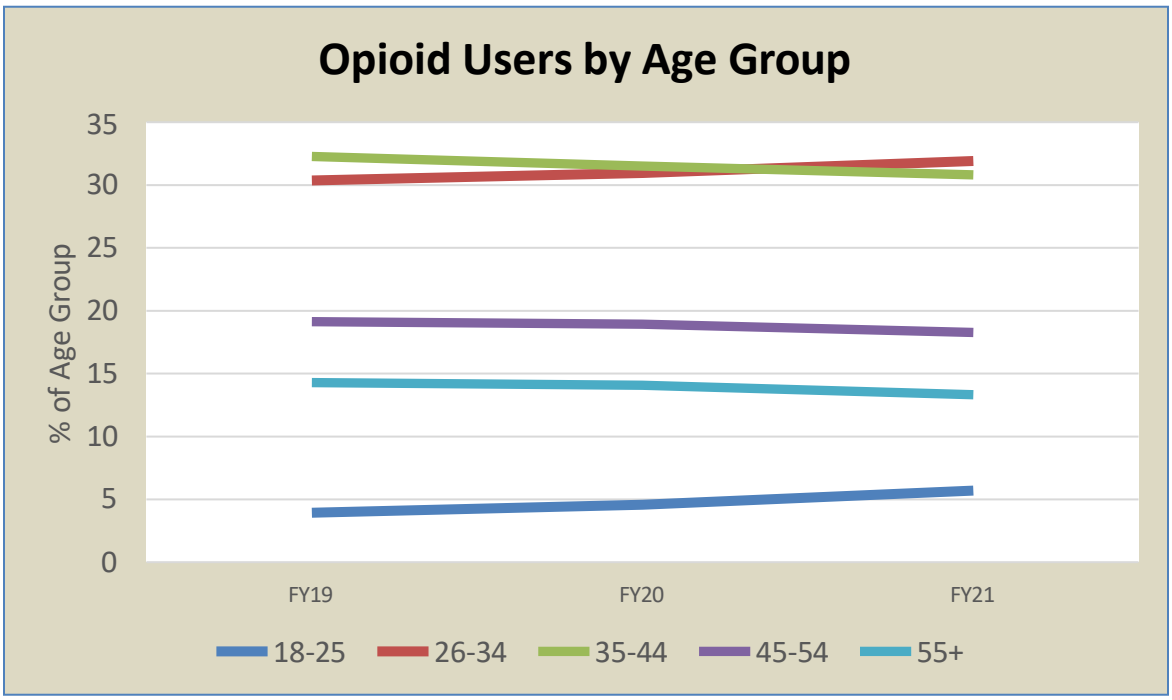


Figure 8: Opioid Users by Age Group: FY19-FY21

Connecticut Opioid Legislation and Policy Initiatives

Connecticut over the past 10 years has proactively introduced and revised legislation focused on addressing the opioid crisis. Legislative initiatives have focused on making Naloxone more accessible, placed limits on the prescribing of opioids, increased monitoring of opioid prescriptions through the CT Prescription Drug Monitoring and Reporting System, and increasing the availability of the lifesaving drug Narcan. In addition, funding was made available to increase outreach and engagement to persons who survive an opioid overdose. Connecticut has been fortunate that our legislative bodies have heavily focused on the opioid epidemic.

A comprehensive report of all legislative initiatives focused on Connecticut's Opioid Drug Abuse Laws can be found at the following link: https://www.cga.ct.gov/2021/rpt/pdf/2021-R-0197.pdf . This report was prepared by the Connecticut Office of Legislative Research and was issued in November, 2021. It examines legislative and policy initiatives in the following areas: Patient Care and Treatment, Access to Opioid Agonists, Prescription Drug Monitoring, Opioid and Controlled Substance Monitoring, Health Insurance and Drug Disposal.

6 Key Strategies for a Comprehensive and Coordinated Response to the Opioid Epidemic

1 STRATEGIES RELATED TO RESCUE

- Reduce overdose deaths by expanding the availability of naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives

2 STRATEGIES RELATED TO PREVENTION AND EDUCATION

- Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals.

3 STRATEGIES RELATED TO TREATMENT

- Expand engagement and access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine and naltrexone.

4 STRATEGIES RELATED TO CRIMINAL JUSTICE

- Implement criminal justice reforms that will increase the availability of MAT in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution.

5 STRATEGIES RELATED TO LAW INFORCEMENT

- Foster improved coordination between law enforcement and Connecticut's treatment system in order to divert individuals arrested for opioid related crimes into treatment.
- Enforce laws related to trafficking of heroin and other opioids.

6 ACCOUNTABILITY AND QUALITY CARE

- Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need.

Adapted from the Addiction Policy Forum-Key Elements of a Comprehensive Response to the Heroin Epidemic

Strategy 1: Strategies Related to Rescue

➢ Reduce overdose deaths by expanding the availability of Naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives.	
Action Step: Continue to expand the statewide network of pharmacists that are trained and willing to prescribe and dispense naloxone	**Action Step:** Widely disseminate the names and locations of pharmacists that have completed the Dept. of Consumer Protection training program and are willing to prescribe and dispense Narcan.
Action Step: Provide in-person training to law enforcement, first responders, treatment providers, community organizations and families regarding proper use of Narcan.	**Action Step**: Continue to expand the numbers of Emergency Medical Technicians and other first responders that carry Narcan
Action Step: Continue to make online training regarding Narcan available to the general public.	**Action Step:** Continue to educate opioid users, family members, and the general public about Narcan.
Action Step: Distribute Narcan through syringe exchange programs.	**Action Step**: Ensure that all insurance carriers reimburse pharmacists for prescribing Narcan.
Action Step: Apply for federal funding being made available to expand overdose prevention training.	**Action Step:** Continue to ensure Narcan is available in schools and universities in CT
Action Step: Continue to distribute fentanyl testing strips in order to prevent overdoses.	

Strategy 2: Strategies Related to Prevention and Education

➢ Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals	
Action Step: Use the state's network of Regional Behavioral Health Advocacy Organizations (RBHAO's) to distribute Narcan and educate the community about how to access it, and community resources available for the treatment of opioid use.	**Action Step**: Apply for federal funds being made available to prevent opioid use and overdose deaths associated with heroin and other prescription opioids.
Action Step: Continue to Inform the public about risks of opioid use and prescription drug use through videos, social media, websites, PSA's, and posters and billboards	**Action Step**: Continue efforts through the state's prevention and treatment network to de-stigmatize addiction which is often a barrier to help-seeking.
Action Step: Continue to disseminate educational materials regarding opioids for students, parents, and school personnel.	**Action Step**: Expand community disposal sites for unused and expired prescription medications.

Strategy 3: Strategies Related to Treatment

➢ Expand access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine, and naltrexone. ➢ Rapidly link opioid users to treatment	
Action Step: Create a statewide network of walk-in assessment centers to rapidly assist opioid users to find appropriate treatment.	**Action Step**: Establish and implement protocols to attempt to rapidly engage into treatment those individuals that were rescued from an overdose
Action Step: Continue the statewide toll free call line to connect callers to treatment options and make transportation available for individuals seeking treatment.	**Action Step:** Maintain and expand as necessary the statewide network of methadone maintenance programs.
Action Step: Increase capacity for outpatient programs to prescribe buprenorphine and naltrexone through clinic-based MAT.	**Action Step**: Improve linkages from withdrawal management services to MAT
Action Step: Continue to apply for federal funding being made available to expand access to MAT.	

Strategy 4: Strategies Related to Criminal Justice

➢ Implement criminal justice reforms that will increase the availability of MAT in jails and prisons. ➢ Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution

Action Step: Continue the Law Enforcement Assisted Diversion (LEAD) programs in Hartford and Bridgeport and seek additional funds to expand the program.	**Action Step:** Continue to maintain and expand methadone services in the correctional system.
Action Step: Continue to transition offenders with drug convictions to community substance use programs.	**Action Step:** Continue diversionary services for individuals arrested for crimes related to opioid use. Expand where possible.
Action Step: Increase employment training and job opportunities for ex-offenders.	

Strategy 5: Strategies Related to Law Enforcement

➢ Foster improved coordination between law enforcement and Connecticut's treatment system in order to divert individuals arrested for opioid related crimes.

Acton Step: Provide DMHAS access line number to state and local police departments.	**Action Step:** Ensure law enforcement personnel have access to Narcan and are trained to administer the drug

Strategy 6: Accountability and Patient Care

▪ Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need	
Action Step: Provide continuing education training to medical professionals regarding risks involved in using painkillers and dangers associated with co-prescribing (i.e. opioids and benzodiazepines).	**Action Step:** Continue to require medical professionals to query the state's Prescription Monitoring Program when initially prescribing opioids and at regular intervals for patients receiving pain medications for chronic conditions.
Action Step: Continue to Require pharmacies to enter data into the State's PMP as prescriptions are filled (real time data entry) in order to ensure PMP is complete and up-to-date.	**Action Step:** Increase efforts to identify mechanisms for sharing data across state agencies

CONNECTICUT ALCOHOL AND DRUG POLICY COUNCIL

The CT Alcohol and Drug Policy Council (ADPC), co-chaired by the DMHAS and DCF Commissioners were legislatively mandated in 1997. It was charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens -- across the lifespan and from all regions of the state and included representatives from all three branches of State government (Executive, Judicial, Legislative), individuals in recovery and family members, and private service providers. It has four working sub-committee which include prevention, treatment, recovery and criminal justice sub-committees. In 2015 Governor Malloy charged the ADPC with coordinating Connecticut's efforts related to substance use in light of the opioid crisis. The ADPC current recommendations and progress to date can be found in the table below:

CT Alcohol and Drug Policy Council Recommendations and Progress Update 2021

Prevention Subcommittee Goals	Progress to date	Status
Identify **core competencies for Continuing Medical Education** around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff). Measures: • Number of individuals attending the Scope of Pain trainings • Decrease in the number of opioids prescribed	• A list of core competencies was developed by Dr. Daniel Tobin, Assistant Prof. of Medicine, Yale Univ. School of Medicine and Medical Director of the Adult Primary Care Center at Yale New Haven Hospital. These competencies are the objectives of the lectures he delivers to both prescribers and non-prescribing medical staff and is suggested for use in measuring current pain management programs for medical trainees and providers. • To date, six Scope of Pain trainings have been delivered to prescribers and non-prescribers across the state including the most recent on November 29th in Hartford. Additional trainings are being planned throughout the state. • The next SOP training is planned in Enfield for December 4, 2019	Original goal Completed. Trainings are ongoing with 527 individuals trained to date.
Create a **Statewide Prevention and Education Communication Strategy** which will: • Raise awareness of and provide education on the dangers of opioids and reduces stigma and other barriers for individuals and family members seeking help.	• The 6 health districts awarded a PDO grant are receiving quarterly report cards with data on age, gender, race ethnicity, residence and where overdose deaths have occurred in order to target their interventions. • The drugfreect.org website continues to be utilized approximately 1,800 times/day, and is in the process of being redesigned. • National Prevention Week is scheduled for May 12-18, 2019. The planning committee is coordinating an educational forum at the New Britain Museum of American Art, a Health & Wellness Fair at the State Capitol, a prevention video conference and numerous local community events.	Goal is Completed and activities are ongoing
• Provide education and resources regarding dispensing, safe storage and disposal of prescription medications.	• There are a total of four completed Remembrance Quilts that are available for display. Additional quilt square making events are being planned.	Goal is Completed, activities are ongoing
• Inform prescribers by developing and adopting Fact Sheets; support the	• 4 health districts from across the state have been trained to implement comprehensive prescriber, school and community social marketing education	Completed

dissemination process of such Fact Sheets to prescribers Promote ADPC adoption of one or more of the Public Service Announcements that have been developed by DMHAS and other currently available educational materials for distribution. Assist with the identification of necessary resources to do so. <u>Measures:</u> • # of website hits • Increase in calls to the toll free number • Increased number of individuals being trained • Increase in the volume of unused prescription medication collected Number of quilting events	campaigns which will include medication storage and disposal information. • The Subcommittee reviewed a series of CDC-produced factsheets and posters directed at patients and families. Identified materials were mailed to more than 1,000 healthcare agencies. • On November 21, 2017 a press release was issued jointly by the DCP and DMHAS encouraging the public to check their medicine cabinets and dispose of and/or secure medications for the safety of their guests. • The DCP has: created a new "How to dispose of your medications" for Youtube; licensed additional law enforcement drop boxes; drafted language for drop boxes in pharmacies; provided brochures for distribution including "Secure Your Meds" and "Safe Storage and Disposal of Prescription Medication." • Brochures, posters, print ads, online ads, radio scripts, handbills, social media and on-line ads have been developed for the Change the Script campaign. A targeted campaign is being finalized for prescribers to increase their utilization of the CPMRS. Plans are for a statewide kickoff of the campaign in February 2018. • The "Change the Script" campaign materials continue to be broadly disseminated and evaluated statewide. New messaging for a variety of target audiences is being developed. The campaign will also be integrated with the statewide "One Word, One Voice, One Life" suicide prevention campaign since they share common risk factors.	Completed
Support **the integration of the Prescription Drug Monitoring Program (PDMP) with Electronic Medical Records (EMRs)** to improve access to patient data and reduce prescription drug misuse and overdose.	There have been ongoing functionality enhancements being made to the CPMRS. 40% of prescribers accessed the system between the time period of September 1st and August 31st. A total of 150,945 Clinical Alerts were distributed to all CPMRS prescribers during this time period.	Completed

Measures: • Number of institutions participating in integration • Number and types of campaign materials distributed • Increase in the number of CPMRS users	There have been 20 new additions to the integration of CPMRS and EHRs. They include: •Women's Health Specialty Care (DrFirst) •Stamford Dental Spa (DrFirst) •Orthopedic and Neurosurgery Specialists PC (Virence) •David Sasso MD LLC (DrFirst) •Perception Programs, Inc. (DrFirst) •Medical Specialists of Fairfield LLC (DrFirst) •Wilton Internal Medicine, LLC (DrFirst) •TCCF (DrFirst) •Bruce Rothschild, MD, PLLC (DrFirst) •Neurosurgery, Orthopedics and Spine Specialists PC (DrFirst) •Becky Kreuzer APRN, PMHNP, LLC (DrFirst) •The Children's Center of Hamden (DrFirst) •Mystic Medical Associates LLC (eClinicalWorks) •Micha Abeles, MD (NextGen) •Eastern Connecticut Hematology & Oncology (DrFirst) •Pain Management LLC (eClinicalWorks) •CareMedica (eClinicalWorks) •Jewish Family Services of Greater Hartford (DrFirst) •Marilyn Richard APRN (DrFirst) •Comprehensive Neurology and Pain Center of Connecticut (eClinicalWorks)	
Insure that **school administrators and/or nurses and college public safety personnel have naloxone available to them** and that the ADPC assists with obtaining funds, if necessary Measures • Increase in the number of school personnel who carry naloxone	SB 1057 proposes that each institution of higher learning (IHL) implement a policy covering the availability and use of opioid antagonists. It further requires that IHLs maintain a supply of opioid antagonists, make them available in a central location to students and employees, and notify authorities when used. A meeting of the campus members of the CT Healthy Campuses Initiative was convened to provide guidance on meeting the legislation requiring the development and posting of naloxone policies for all CT colleges s meeting. The DCP provided this guidance and will obtain a list of CT colleges and universities to track submission process. These policies must be submitted and approved by January 1, 2020. A naloxone survey was sent to school districts in November 2018. The results will be shared	Completed

	at a conference of School Nurse Supervisors on May 8th. A list of school nurses who indicated on the survey that they needed training on naloxone was sent for follow up.	
2/20/18 Make available age-appropriate, evidence-based opioid curricula in public schools K-12	Through the federal SOR grant DMHAS is contracting with SERC to bring awareness of the dangers of opioid use directly into the classroom for students in grades K-12. Torrington and Stratford school districts have been chosen to help develop and implement a guiding curriculum for OUD identification, prevention and supports. Plans are for the curriculum to be developed by July 1st and district training held by September 30th. A virtual 2-day conference was convened on August 118-19th to share the guiding curricula for selecting and implementing OUD programs. There were over 150 attendees from across the state. SERC will continue to work with school districts that are interested in more in-depth TA in utilizing the guidance.	Completed
2/20/18 Provide guidance and encourage the stocking of naloxone and reporting of naloxone use in schools.	The naloxone survey results were shared. RBHAOs will follow up with districts interested in training. The subcommittee is researching whether other states require naloxone in schools and whether there are other naloxone surveys being administered.	Completed
2/20/18 Expand naloxone education and availability for high risk populations	The RBHAOs have determined priority populations in each region and are working with some health districts to provide naloxone education and distribution. Additional opportunities to expand naloxone availability to the public have been met through the SOR federal grant. A total of 12,000 Narcan kits will be available for distribution in FY 2019 through the following: DMHAS, DOC, DPH, CT Hospital Association and the RBHAOs.	Completed

Tasks from HB7052 • One page fact sheet- Opioids :risks, symptoms, services and strategy for dissemination • Feasibility of Marketing campaign and monthly PSAs-Opioids: risks, symptoms, services (including opioid antagonists)	• A one-page fact sheet on the risks of OUD and resources available to address it is being finalized and reviewed for posting on the DMHAS website by October 1st. • A statewide media campaign called *Change The Script* targeting users, their families and friends, prescribers and the general public is being developed for deployment this fall. It is being designed for customization by local agencies to build on the growing awareness of the opioid misuse problem and move individuals and communities toward taking appropriate action.	Deliverable on or before October 1, 2017- <u>Completed</u> <u>Completed.</u> Deliverable on or before January 1, 2019 – Campaign development is completed. Soft launch in communities and across the state occurred January 2019. Official launch planned for the end of February 2018.
• Advise council of any recommendations for statutory or policy changes that would enable first responders or healthcare providers to safely dispose of a person's opioids upon death. • Led by DPH with DCP and DMHAS- develop a voluntary non-opioid directive form and post on DPH website	***HB-7052 Recommendation for Safe Disposal*** *A registered nurse employed by a home health care agency will be educated consistent with the information provided by the Department of Consumer Protection's website on approved disposal methods for all controlled substances. The home health care agency will retain documentation verifying that the registered nurse has received such education. Upon a patient's death, the RN will work proactively with the decedent's designated representative or responsible family member to destroy or remove all controlled substances belonging to the decedent from the dwelling.* • The VNOD form was developed by DPH and reviewed and approved by the DCP and DMHAS. It is currently being reviewed by their legal department in preparation for posting on the DPH website on October 1 2017	Deliverable on or before February 1, 2018 <u>Completed</u> <u>Completed</u>
6/18/19 Reduce addiction stigma in the workplace by supporting employers in the development of knowledge and practices that create a recovery-friendly workplace and policy guidelines that promote addiction recovery.	A scope of services for a consultant to put together a recovery friendly workplace toolkit with sample policies for human resources departments that addresses active users, individuals in recovery and family members of active users is being developed. The toolkit and accompanying webpage are completed and posted on the drugfreect.org website.	<u>Completed</u>
10/15/19 Institute a public health campaign to promote realistic pain expectations, while providing prescribers with resources to help patients	A subcommittee has been established and a campaign flyer and Personal Pain Management tool were developed and are being finalized in preparation for dissemination	<u>Completed</u>

moderate their expectations and manage their pain.	The Personal Pain Management flyer and tool were developed and made available for download on the drugfreect.org website.	
12/17/19 Work with established groups and initiatives to educate legislators, policy makers, medical and other professionals, families and community members on SEI/FASD, plans of safe care, and best practices for universal prenatal screening; and develop legislative and policy recommendations that support women and families.	Created 2 sub-groups: screening workgroup and marketing and training workgroup. • Recruiting for a POSC navigator through Wheeler • Group continues to update CAPTA data • CT Data Collaborative joined and we reviewed data profiles • 5 year strategic plan continues to be reviewed by state partners for updates and feedback. • Marketing and training workgroup meeting monthly. They created a charter for the group. • September Marketing campaign went out "tips for healthy pregnancy" and for October National pregnancy & infant loss awareness month"	Partial completion
8/2020 Work with news media outlets, journalism schools, and other organizations statewide to educate public information officers, editors, reporters, on-air professionals, and students on substance use disorders, recovery, and the importance of the use of non-stigmatizing language.	A successful "The Power of Media: Changing the Narrative on Substance Use" forum for media was held on December 10. The workgroup continues to meet and look for other opportunities to present the forum materials. Workgroup members have reached out to universities and colleges to offer the presentation to their journalism students and faculty members.	Partial completion
12/2021 Section 65 of PA 21-1 - CT's Adult Use Cannabis legislation requires the ADPC to make recommendations to the governor and legislature on efforts to promote certain public health initiatives and collection of data for certain reviews. In addition, DMHAS has received funding to develop and launch a public information and education campaign that delivers prevention messages and strategies to various populations. **Detail Recommendation:** Use the established Cannabis Workgroup of the Prevention Subcommittee to advise the public education campaign and the policy and program recommendations to prevent usage by individuals under age 21, which will be due to the Governor and General Assembly in January 2023.		NEW

Treatment Subcommittee Goals	Progress to date	Status
Promote screening, brief intervention and referral to treatment for opioid misuse (e.g. SBIRT) across the lifespan: • Implement Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) protocols according to national standards and/or as established by DCF, DMHAS and/or the UConn Health SBIRT Training Institute. • Expand professional trainings available on adult and adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT) to increase the frequency and number of individual screenings for opioid misuse, brief interventions, and referrals to treatment.	• Trainers, Kognito licenses and UCONN training institute available-ongoing • SAMHSA State Youth Treatment Implementation (SYT-I) proposal includes A-SBIRT trainings for various sectors. • DMHAS STR and DCF ASSERT Awards include resources for SBIRT implementation and expansion. Dollars going to Beacon Health Options and UConn. • SBIRT training offered at July 2017 opioid conference.	Completed. Maintain/Expand through DMHAS STR grant (A-SBIRT data infrastructure improvements and trainings) and DCF ASSERT grant (A-SBIRT training for a wide range of audiences)
Enhance early identification of substance use problems by **requiring children's Enhanced Care Clinics (ECC), for youth age 12-17 inclusive,** at intake to services to: • Conduct urine toxicology screening for common substances of abuse/misuse including opioids. Screening protocols should be trauma-informed and follow best practice standards of care for the populations served.	• Urine toxicology guidelines to be drafted by subcommittee for distribution to ECCs (can also be used beyond ECCs); please see October 2017 meeting packet for draft. • The original recommendation to "require" ECCs to use urine toxicology screening upon all admissions was explored by the committee and ultimately decided against because of the possible misuse of it and resulting alienation from treatment that could happen.	Completion Guideline document created and disseminated. Completed
Require the 13 DMHAS operated/funded Local Mental Health Authorities **(LMHA) to provide Buprenorphine** treatment on-site, including psychosocial and recovery support services. Psychosocial services require a comprehensive assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate. The assessment should include the individual's stage of readiness and receptivity to the recommendations.	• 12/16- One time DMHAS funding for LMHAs • 12/16-DMHAS Learning Collaborative begun including sharing of policies • Related-9/16 SAMHSA MATX funding expansion at 4 sites (2 LMHAs) • DMHAS Prevention-Treatment-Recovery Conference 7/17- 8 hrs FREE DATA training offered • Note: DCF ASSERT grant award includes expansion of MAT to youth aged 16-21	Completed. Maintain/Expand through involvement with Project ECHO opportunities and PCSS-MAT and NP/PA MAT MAT Learning Collaborative with 13 LMHAs and 7 STR sites is fully operational.

	• Sept 2017 DMHAS Prescriber MAT Learning Collaborative expanded to include all LMHA prescribers. ▪ DMHAS expands MAT Learning Collaborative to include 7 STR funded sites	
Establish a workgroup to identify and address regulatory barriers that limit access to care. Some examples include: LADC scope of practice; lack of integrated MH/SA program license; limits on which practitioner licenses can be used in outpatient hospital clinics; hiring regulations and practices regarding persons in recovery; and Medicaid eligibility interruptions given incarceration/ hospitalization. Note: <u>The Treatment Sub-committee will:</u> -Involve DPH in definition of limitations of existing regulation -Explore activities/workgroups in existence to limit duplication of efforts -Provide examples that are <u>specific to ADPC and governor's charge</u> -Involve DSS in discussion of Medicaid rules related to incarcerated individuals; clarify any mis-information regarding benefits	• Have explored multiple topics and invited speakers regarding the following topics: o children's behavioral health program licensing; o integrated mental health/substance abuse program license; o scope of practice for LADCs. o Mobile MAT o Increasing co-occurring capability of programs (e.g., licensing, funding, IMD rules)	Completed – DPH and other State agencies' membership on the subcommittee ensures this work moves forward when feasible and appropriate.
2/20/18 Increase access to substance use services (i.e. increasing access to lifespan MAT and co-occurring programming)	DCF has implemented a youth/young adult OUD treatment program through a SAMHSA Federal Grant (ATM program). The program combines MAT, family co-occurring treatment, and recovery checkups. Ongoing Waiver trainings to increase the number of MAT prescribers	Completed Completed – Three CT waiver trainings have been completed and are now available online free of charge.
Task from HB7052 Feasibility of establishing a publicly accessible electronic information portal-bed availability for withdrawal mgt., rehabilitation, outpatient MAT		Deliverable on or before January 1, 2019 <u>Completed</u> for withdrawal mgt., rehabilitation and certified/credentialed sober homes. Launched 11/20/17

8/18/20 General hospitals will start patients who are on their medical units, and who have an opioid use disorder, on a maintenance medication for their opioid use disorder and, when discharged from the hospital, have a discharge plan with a specialty provider for continuation of the medication.	1. Based upon the discussion at the 8/20 Council meeting, DPH will revise its guidance to reflect the patient needing "a history of one year of opioid use DISORDER" and disseminate to all hospitals. 2. SNF guidelines that were drafted by the joint DPH and DMHAS facilitated workgroup, were to have been rolled out at a training that was cancelled due to COVID. It will be suggested that DPH finalize the guidelines and disseminate them via BLAST Fax	**Not Complete** Update, 3/2021: The general hospitals, with the support of Beacon Health Options, continue to implement protocols for starting patients on medical units on medication for OUD. One barrier is the limited availability of SNF's that will admit someone on an MOUD. This discussion will continue with DCP, DMHAS and DPH.
2/2021 "The Alcohol and Drug Policy Council shall endorse a public health-oriented approach to the treatment of substance use disorder that is focused on harm reduction (as well as abstinence), and that the appropriate state agencies and their contractors implement such an approach." Action steps: • Conduct an informational session on harm reduction approaches for substance use disorder for the Alcohol and Drug Policy members • The sub-committee will examine existing guidance documents related to harm reduction approaches to treatment and DMHAS and DCF will disseminate, as appropriate. • Conduct one or two virtual 2 hour training events for treatment providers and hospitals encouraging the use of harm reduction/risk reduction strategies to keep substance users engaged in services.	Update, 9/2021: The sub-committee assisted Beacon Health Options to develop a forum for treatment providers addressing this topic that will be held in May or June, 2021.	**Completed** Beacon Health Options hosted a virtual two-hour Harm Reduction Forum on May 20, 2021
NEW 6/2021 A public health-oriented approach to the treatment of substance use disorder that is focused on harm reduction (as well as abstinence) is endorsed and will be implemented by state agencies and their contractors.		

Recovery and Health Management Subcommittee Goals	Progress to date	Status
The ADPC will adopt the "Recovery Language" document developed by the Recovery and Health Management Committee to ensure that all members of the Council and members of the sub-committee are familiar with some alternatives to traditional terminology and can promote the use of such terminology. Revision (update)being drafted	A "Recovery Language" document was developed by the original sub-committee and adopted by the full Council	Completed Completed A revision to the original document was adopted.
NEW 6/2018 The ADPC will adopt the *"Recovery Friendly Community Guidelines"* that have been promulgated and piloted in a minimum of two locations by the sub-committee.	Draft guidelines complete. Pilots have been completed in numerous communities. The DMHAS Regional Behavioral Health Action Organizations (RBHAOs) along with this sub-committee will continue to consult with and support additional communities interested in implementing guidelines. Approved by Council 6/19/18	Completed
Criminal Justice Subcommittee Goals 9/18/17 *new*	**Progress to date**	**Status**
MAT for DOC Reduce disparities in access to medical treatment by expanding the availability and clinical use of **MAT to a broader group of incarcerated offenders and offenders re-entering communities** using community-based standards of care. This recommendation expands DOC's implementation of MAT in two facilities to the entire corrections system. In doing so, equitable opportunity to access MAT is offered to inmates regardless of facility. *Licensed OTP "inside DOC" will be licensed and run by community providers RNP, APT and CHR. DEA and DPH licensed, SAMHSA certified and NCCHC accredited.	MAT New Haven jail (2013)-ongoing 65-70 patients daily. **Inductions occur regularly** (2019) -Purchased and installed automated methadone dispensing equipment (state funded budget) *Licensed Opioid Treatment Program (OTP) MAT Bridgeport jail (2014)-ongoing **60-65** patients daily. (2019) **Inductions occur regularly** -Purchased and installed automated methadone dispensing equipment (state funded budget) *Licensed Opioid Treatment Program (OTP) MAT Hartford jail (2018)-ongoing, **45-50** patients daily. **Inductions occur regularly** (2020) -Purchased and installed automated methadone dispensing equipment (state funded budget) *Licensed Opioid Treatment Program (OTP) go live date 3/24/21.	Completed- ongoing Completed- ongoing Completed ongoing Completed ongoing

	• MAT York CI expansion (initially, pregnant women on methadone). Expansion to other patients 2018, Purchased and installed automated methadone dispensing equipment completed 2019 (funded by SOR/DMHAS). **Inductions occur regularly** -60-70 patients daily (~53 methadone and ~ 14 Subutex and ~1 Naltrexone) - Purchase and installation of automated methadone dispensing equipment completed 2019 (funded by SOR/DMHAS). Internal Opioid Treatment Program (OTP) licensed by DOC.	Partially Completed-ongoing Go live end of October 2021
	• MAT in Osborn CI, (2018 with STR funding), 30 - 35 patients daily and have inducted approximately 5 on methadone. Osborn is receiving sentenced patients from the three jails, and treating TOP (time out program) patients as well. **Inductions occur regularly** (2018) *Licensed Opioid Treatment Program (OTP) projected start April/May	Partially Completed-ongoing Go live end of October 2021 Completed-ongoing
	• **MAT in Corrigan-Radgowski jail** (2018 with STR funding), 17-20 patients daily. ***Inductions have not started yet** *Licensed Opioid Treatment Program (OTP) projected start April/May	Completed-ongoing
	• BRAND NEW PROGRAM **MAT in Carl Robinson** prison (2020) (State funded budget) Projection goal to start treating patients with all 3 FDA medications by spring 2021. *Licensed Opioid Treatment Program (OTP) go live date 3/31/21.	Completed-ongoing
	• BRAND NEW PROGRAM **MAT in Walker Reception Center** prison (2020) (State funded budget) Projection goal to start treating patients with all 3 FDA medications by spring 2021. *Licensed Opioid Treatment Program (OTP) projected start April/May	Completed – Program operated from 2017- 2021

	• BRAND NEW PROGRAM **MAT in Willard Cybulski** prison (2020) (State funded budget) Projection goal to start treating patients with all 3 FDA medications by spring 2021. *Licensed Opioid Treatment Program (OTP) projected start April/May • Step Forward program in New Britain (initially funded with STR 2017). Between 1/1/2018 – 9/30/2020 program served 163 people in step forward and 284 in-reach clients	
10/2018 **Police PD/PAD Plan** Develop a plan for Police Preventative Deflection and Police Assisted Diversion for persons with problem substance use that can be quickly implemented when funding becomes available.	• A workgroup formed following the May 2019 subcommittee meeting to develop a "toolkit" for police to provide guidance on connecting people to substance use treatment services, providing resource information to family and friends, and providing guidance on implementing arrest diversion models. November 2020 workgroup re-formed, exploring options re: Police resources/needs • DMHAS has provided over 220 Narcan kits to the CT Police Chiefs Association for distribution to municipal police departments.	Partially Completed Completed
PD/PAD Report per HB7052 Study SA tx referral programs that have been established by municipal police departments to refer individuals to SA treatment facilities for opioid dependence. Identify barriers and determine feasibility.	• Workgroup met 9/28/17; will begin gathering information on programs in CT and elsewhere • Met 10/19/17 and 11/13/17, next meeting 11/27/17 • Preliminary ideas presented at ADPC December meeting	Deliverable due on or before February 1, 2018. Completed

6/19/19 **Early Screening and Intervention Program** Reduce criminal justice involvement of low risk adults with substance use disorders who have low level criminal charges and connect them to services in lieu of prosecution. Provide social work-trained Resource Counselors to assist dedicated prosecutors in screening, assessment, and appropriate referral of low-level offenders with issues such as substance abuse, mental health, or homelessness underlying their criminal behaviors.	• The SFY20 state budget did not include funding to continue the Office of the Chief State's Attorney's Early Screening and Intervention (ESI) program in Bridgeport, Waterbury, Hartford, New Haven, New London, and Norwich GA courts. • DMHAS' SOR Supplement grant funds will sustain the program through SFY20. • DMHAS funding and support to ESI program extended through 2022	<u>Partially Completed</u> Completed
12/15/20 Enhance access to the ATM model to a targeted population of youth and young adults who are transitioning out of the Department of Correction and/or who are under the supervision of the Juvenile/Adult Probation. The utilization of ATM will expand the continuum of services for youth and young adults. The focus will be on client centered recovery services to reduce opioid use and commonly associated substance use problems.	• provide information to referral sources and develop an effective referral process that meets the needs of the clients. • Referral sources will be educated on the specialized programming available through ATM with an emphasis on services not currently available through the Department of Correction or the Court Support Services Division contracts.	Completed All trainings requested completed: Tuesday 3/2 @ 3pm - Wheeler Thursday 3/4 @ 9am - UCFS Monday 3/8 @ 9am - CHR Friday 3/12 @ 12:30pm - CJR

Conclusion

This section was designed to formalize key strategies and to highlight the major efforts that have been ongoing as Connecticut attempts to address the opioid epidemic. The summary table included above shows the goals that were set by the ADPC in the areas of prevention, treatment, recovery and criminal justice (across the lifespan) and the considerable amount of progress that has been achieved. The information in the table shows the state's overarching strategy to reduce opioid addiction and overdoses and the role state agencies and private partners within the state are playing. Much remains to be accomplished. While our last report showed a slight decline in overdose deaths, that trend has changed. Overdose deaths continue to increase, fueled by a rise in the use of fentanyl which is being increasingly mixed with other drugs. Previously fentanyl was largely being combined with heroin but this has shifted and is now being combined with a number of other drugs. The strategies delineated in this section have served as a guide for state activities over the past three years and will continue to be a guide for activities over the next 3 years.

DMHAS Triennial Report Subsection
Women's Services

Women's Services (WS), as part of DMHAS Statewide Services Division, is the education and implementation unit for women's behavioral health and wellness initiatives across Connecticut for DMHAS. The department currently consists of a Program Director and three Program Managers who are licensed clinicians.

WS staff are subject matter experts in a variety of topics related to women's holistic health, including: trauma responsiveness, behavioral health treatment and recovery (including mental health, substance use and opioid use disorders), medication assisted treatment/medication for use of opioids, gender specific best practices, intimate partner violence, and prenatal and postpartum wellbeing. Additionally, WS staff have extensive experience in prevention, advocacy, policy development, and clinical and program operations.

WS furthers DMHAS' mission in a number of ways through program daily operations. These activities include:

- WS staff organize and/or are contributing members of numerous interagency workgroups, legislative councils and learning collaboratives aimed at improving the lives of women, birthing persons, and children in CT.
- Internal to DMHAS, WS staff work collaboratively with other divisions including Evidence- Based Practices and Grants Division (EBP), Evaluation, Quality Management and Improvement (EQMI), Fiscal Services Division, Community Services Division (CSD), Managed Services Division, (MSD) and the Office of Multicultural Health Equity. Internal collaboration includes data collection and sharing, grant identification and submission, contract development and oversight, and SUD program performance improvement.
- WS oversees contracts for statewide women-specific SUD treatment programs across the DMHAS continuum of care. On-going operational oversight activities includes site visits (annual and follow up as needed), technical support, staff trainings, and review of critical incidents and client cases.
- In FY 2020, WS began managing the DMHAS contract with the CT Women's Consortium (CWC). The CWC provides technology, and expertise to organize and execute numerous meetings and trainings both at their location as well as virtually for the DMHAS continuum of care throughout the year and has been instrumental in the /trauma and Gender.
- WS developed new partnerships to enhance services, knowledge, and treatment for women across the state.

Overview of Women Specific Programs overseen by WS

Women's Services currently oversees a variety of programs including: 7 Women's Residential programs, (5 Pregnant and Parenting Women's Substance Use Residential programs, 2 Pregnant and Parenting Women's Recovery Support Programs (WRSP), 5 Outpatient programs, 2 Intensive Outpatient programs, 5 Women's REACH programs, and 1 Women's Behavioral Health Services program. All program services are gender-specific and trauma-responsive.

In addition, WS oversees a number of special projects related to SAMHSA grants and Block Grant (COVID -19 supplemental, and ARPA) including: PROUD (Parents Recovering from Opioid Use Disorder); expansion of Doula services throughout the system of care; expansion of the REACH program by 5 positions statewide to help address the needs of LGBTQ+ families and non-traditional support systems; expansion of LGBTQ+ training, expansion of Hoarding training and consultation targeted to the DMHAS funded provider system; enhancement of Intimate Partner Violence (IPV) services in collaboration with the Connecticut Coalition Against Domestic Violence (CCADV); and technology and training enhancements for the 5 PPWDC residential programs and 1 Women's Recovery Support Program.

All programs participate in annual site visits that include a review of selected client treatment and service records, a review of program staff supervision and training history, and an examination of policies and procedures. Additionally, a client focus group is facilitated by WS staff to ensure that the client recovery experience is captured. Technical assistance and opportunities for staff training are provided to programs on an on-going basis. Historically, all site visits have occurred on site within programs. However, a temporary change in policy and procedure was updated to enable staff to conduct visits virtually in response to the COVID-19 pandemic based on the increased vulnerability of pregnant women, and infants and young children who had not yet qualified to be vaccinated.

Women's Residential SUD Services (88 beds Statewide - excluding PPWDC)

All services are gender-responsive and trauma-informed, and are tailored to meet the specific needs of women with co-occurring disorders. Harm reduction practices and overdose risk reduction education are components of all programs. Treatment incorporates evidence-based practices and evolves to meet the needs of women in care. Priority admission is given to women with an opioid use disorder and consistent with SABG priority access guidelines.

Additionally, the programs provide and/or refer women to the following services:

- Individual and/or Group Therapy
- Medication Assisted Treatment/Medications for Opioid Use Disorder
- Peer Support/Recovery Coaching
- Reproductive Health Education
- Mental Health Evaluations

- Parenting Skill Development
- Case Management Services
- Employment Readiness Skills

The Women's Residential SUD programs are located statewide:

- Community Health Resources – Milestone Program (Putnam)
- McCall Center for Behavioral Health – Hanson House (Torrington)
- Perception Programs – Perception House (Willimantic)
- MCCA—Trinity Glen Women's Program (Kent)
- SCADD – Coit Street Women's Program (New London)
- Mercy Housing and Shelter Corp. — Recovery House (Hartford)
- Recovery Network of Programs – Tina Klem Serenity House (Bridgeport)

Pregnant and Parenting Women with Dependent Children (PPWDC) Residential Treatment SUD Services (48 beds Statewide)

Provide specialized state-funded substance use residential treatment to pregnant women and women with dependent children. Pregnant women are granted priority access. Program applicants must be connected to residential treatment within 48 hours of their request. If a bed is not available at that time, applicants must be offered interim services that include, at a minimum, a referral for prenatal care, the REACH program, and PHP or IOP treatment. Residential program services include: substance use and mental health assessments, medication management, overdose risk reduction education, on-site case management, connection to recovery resources, individual, group and family therapy, reproductive health education, Child Abuse Prevention and Treatment Act (CAPTA), education and assistance with development of Plans of Safe Care/Family Care Plan, and linkages to Medication Assisted Treatment/Medications for Opioid Use Disorder. In addition to the parent, services are also coordinated for the children including pediatric care, connection to Birth to Three, WIC, early childhood intervention, etc.

Women receive 20 hours of treatment per week that includes:

- Relapse Prevention and Overdose Risk reduction
- Reproductive Health and Family Planning
- Recovery Planning & support network development
- Parenting & Attachment Education and Skill Building
- Management of Trauma and Co-Occurring Disorders

The PPWDC SUD residential programs are:

- Apt Foundation— Amethyst House (New Haven)
- Community Health Resources— New Life Center (Putnam)
- InterCommunity, Inc. – Coventry House (Hartford)
- Wellmore – Women & Children's Program (Waterbury)
- Liberation Programs – Families in Recovery Program (Norwalk)

Women's Recovery Support Program

The Women's Recovery Support Program (WRSP) is a 7 bed step-down program where pregnant and/or parenting women participate in community treatment while living in a safe and structured environment. Clients meet with their case manager on a weekly basis and attend daily psychoeducational groups related to parenting skills, recovery promotion, women's wellness, overdose prevention, discharge planning and related recovery focused topics.

Prior to transitioning into WRSP, a discharge meeting is held with the referring provider, client, Women's Recovery Support Specialist (if applicable) and the WRSP team to review future scheduled appointments with established providers (Behavioral health treatment, OBGYN, Psychiatric, MAT/MOUD, Recovery Supports, etc.), the client's treatment plan goals, and program operations.

Women Specific Intensive Outpatient (IOP) and Outpatient (OP) Services

DMHAS contracted agencies provide outpatient services to women age eighteen (18) or older who have severe and persistent substance use or co-occurring disorders. IOP is defined as non-residential treatment for a minimum of three (3) hours per day, ranging from 9 to 20 hours of structured programming per week. OP treatment activity hours are variable and based on client need and/or preference. Women specific IOP and OP services are gender-specific and trauma-responsive. Additionally, in an effort to reduce barriers to accessing and participating in treatment, all women's service OP and IOP offer on-site childcare.

During the COVID- 19 pandemic, the need arose for the IOP/OP service providers to develop virtual telehealth modalities (audio/visual) for clients to continue to engage in group and individual treatment, without having to physically come into an actual building and be in spaces where social distancing could be difficult. This flexibility has allowed for countless clients to continue to receive care and have access to their recovery supports, clinicians and medication prescribers without taking on additional contagion risk. While all women specific IOP/OP programs have returned to primarily in person treatment, telehealth remains as an option in all programs to some extent and is utilized based on the individual needs of a client.

Statewide Women Specific IOP and OP programs:

Intensive Outpatient Services

- Family & Children's Agency – Project Reward (Norwalk)
- Wheeler Clinic – Lifeline (New Britain)

Outpatient Services

- CASA, Inc. – Project Courage (Bridgeport)
- Wheeler Clinic – Lifeline (New Britain)
- MCCA – Women & Children's Program (Danbury)
- The Connection – Counseling Center (Groton)
- APT Foundation – Access Center (New Haven)
- Wellmore – Behavioral Health (Shelton and Waterbury)

Women Specific Key Initiatives & Programs

Women's Behavioral Health Services

Women's Behavioral Health Services (WBHS) is a program created by DMHAS and administered by Advanced Behavioral Health (ABH) an Administrative Serve Organization. WS oversees this contract and provides ongoing monitoring, technical assistance, and oversight of all program operations.

Four Women's' Recovery Specialists provide specialized care management for women engaged in the 5 PPWDC residential substance use treatment programs. To ensure a smooth transition to community based-recovery services, WRS can remain engaged with women for 6 months post-discharge, or longer on a case-by-case basis, from a PPWDC residential program. WRS services include; case management, linkages to existing community resources, supportive housing assistance, vocational & educational planning, budgeting, and assistance with child-related needs and resources. Additionally, WRS's also provide reproductive health education, overdose risk reduction education, and CAPTA/POSC education and support.

Women's REACH (Recovery, Engagement, Access, Coaching & Healing) Program

WS oversees REACH contracts with five private non-profit agencies (Chemical Abuse Services Agency (CASA), McCall Center for Behavioral Health, Advanced Behavioral Health (ABH), The Village for Children and Families, and The Connection Inc.). Each of the five REACH programs provides outreach and engagement services to one DMHAS geographic region. The five regionally based Women's REACH programs are staffed with three female Recovery Navigators, who offer pregnant and parenting women comprehensive case management and recovery coaching services.

Recovery Navigators are women with lived experience who are in recovery from their own substance use or co-occurring disorders; they use their personal journey to help support others. WS staff facilitate monthly meetings with the recovery navigators and supervisory staff, provide ongoing technical assistance and training, and offer an annual retreat for all recovery navigators. COVID specific funding has allowed for expansion of the scope of individuals able to access the REACH program; effective September 1, 2021 each program added a "Family Recovery Navigator." This family recovery navigator helps support families impacted by substance use disorders including partners, single fathers, LGBTQ+ families, grandparents and/or relatives acting in the primary caregiver role.

PROUD: Parents Recovering from Opioid Use Disorders Program

WS oversees the DMHAS PROUD program which is funded by a three-year, $2.7 Million SAMHSA grant awarded to DMHAS in August 2020. The goal of PROUD is to engage 480 Pregnant or Postpartum women (PPW) with Opioid or other substance use disorders (OUD/SUD) in services over the course of the three years. PROUD began accepting referrals to the program on January 1, 2021. PROUD targets a geographic area in central CT where data reveals disproportionate racial, social and economic disparities as compared to other areas of CT. This includes the urban and suburban communities in and around Hartford, Manchester, Enfield, Windham, Middletown, Meriden, Waterbury, Bristol and New Britain.

Intercommunity and Wheeler Clinic, 2 private non-profit agencies, are the direct service providers of the PROUD initiative while WS provides ongoing technical assistance, programmatic oversight, and monitoring to ensure compliance with contract and grant specific expectations. Each site has a multidisciplinary team of staff including: clinicians, care coordinators/case managers, and peer recovery coaches to work with the PPW and any members of her household who may benefit from services and/or referrals. Special attention was paid to address traditional barriers PPW encounter when trying to access or remain in treatment, when developing the PROUD service model. In response to this, PROUD site teams work with women and families in the home, in the community, and at the two (2) program sites, based on client need and preference. Telehealth is also offered to clients and its' use has facilitated receipt of services when there are COVID- 19 related concerns. Additionally, Wheeler Clinic and Intercommunity provide wrap-around services to PPW and their family members/partners to support whole-person health, including: behavioral health, primary care, MAT/MOUD, and pediatric care. The PROUD site teams engage in extensive community outreach and engagement activities including ongoing collaboration with the birthing hospitals in their geographic catchment area. The PROUD teams work closely with birthing hospitals to promote individualized and recovery-oriented discharge planning for women and infants impacted by perinatal substance use, and ensure that hospital personnel are educated on CAPTA/Plans of Safe Care/Family Care Plans.

A portion of PROUD SAMHSA funding is designated to provide training and education to healthcare professionals on topics related to best practices in working with PPW with OUD/SUD.

As such, DMHAS contracts with the Connecticut Hospital Association (CHA) to provide virtual educational sessions to professionals within their network. CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are accountable to the community and committed to health improvement. In addition to CHA, DMHAS has partnered with The Connecticut Women's Consortium to continue efforts to train DMHAS providers on topics related to reproductive health and the One Key Question model. Lastly, funding is being utilized to support the creation and dissemination of marking materials by the O'Donnell Group.

DMHAS WS meets with all contractors on a monthly basis and as needed to support contract and grant-specific compliance, plan for upcoming activities, and promote collaboration and professional development.

Access Mental Health for Moms (go live June 15, 2022)

Connecticut ACCESS Mental Health for Moms is a consultative psychiatry service available to all of Connecticut's perinatal practitioners (Obstetricians, Gynecologists, Midwives, Primary Care Providers, MH/SUD Treatment Providers) working with pregnant and post-partum women presenting with mental health and substance use concerns irrespective of insurance coverage.

The purpose of ACCESS Mental Health for Moms program is to improve access to treatment for perinatal women with mental health and/or substance use concerns. By providing real-time access to a team of behavioral health experts, the program is designed to increase the competencies of front-line medical providers to identify and treat behavioral health disorders in perinatal women and to increase their knowledge/awareness of local resources designed to serve the needs of perinatal women with these disorders and their families.

The service is to be delivered primarily through telephonic communication by members of the ACCESS Mental Health for Moms consulting team (Hub). When warranted, circumstances may require face-to-face consultation with the perinatal practitioner or in-person behavioral health assessment of the pregnant or post-partum woman for whom the practitioner is seeking consultative support.

DMHAS Women's Services Collaboratives, Initiatives, Partnerships and Workgroups

Women's Services Practice Improvement Collaborative (WSPIC)

- Co-facilitated by DMHAS WS and the Connecticut Women's Consortium (CWC), WSPIC convenes every other month and focuses on improving the quality of services throughout the women's specific continuum of care.

Substance Exposed Infant Statewide Initiative (Part of FASD/SEI CT Strategic plan 2016-2021)

- In collaboration with the Department of Children and Families (DCF), DMHAS co-funds a full time position to oversee this statewide initiative. DMHAS participates in a monthly leadership meeting and quarterly core team meetings to support the implementation and sustainability of the state plan. In January 2022, the second 5- year strategic plan was finalized, approved by DMHAS and DCF Commissioners, and distributed to stakeholders.
- WS staff are members of the Substance Exposed Infant initiative core group meeting. Additionally, WS provides staff to represent DMHAS on additional SEI/FASD workgroups: Executive team, Treatment and Wellness, Awareness, Marketing, and Training, Screening and Early Identification, and CAPTA/Plans of Safe Care.

DCF CAPTA/Plan of Safe Care Stakeholder Workgroup

- Ongoing participation in a monthly workgroups aimed at implementing CAPTA legislation statewide.
- WS staff continue to provide trainings on CAPTA and the creation of Plans of Safe Care throughout the DMHAS system of care and to professional groups who are touchpoints for pregnant people who may give birth to a substance exposed infant.

Maternal Infant and Child Health Coalition/MIECHV Advisory Board

- Quarterly collaborative aimed at optimizing the health and well-being of women, infants, children and families with a focus on disparate populations.

CT Women and Opioids Workgroup

- Bi-monthly collaborative facilitated by DMHAS WS with the focus of identifying collaborative system strategies to combat the opioid crisis and its impact on women and families statewide.

Every Woman CT (EWC) Learning Collaborative

- WS staff participate in a quarterly collaborative. Every Woman Connecticut is a collaborative initiative that works with consumers, health care providers, state agencies, professional organizations, and community-based partners. EWC's mission is to work collaboratively to help initiate rapid improvements in how CT cares for women and men of childbearing age.

Early Head Start Collaborative

- Office of Early Childhood/DCF/DMHAS WS plan and facilitate a quarterly meeting whose mission is to support all young children in their development by ensuring that early childhood policy, funding, and services strengthen the critical role families, providers, educators, and communities play in a child's life.

Birth Support Education and Beyond and DMHAS Partnership

- Upon receipt of a SAMHSA Block Grant Technical Assistance grant, WS partnered with Birth Support Education and Beyond (BSEB) to facilitate and maintain biweekly perinatal support services to women in the DMHAS PPWDC Programs and The Connection's Women's Recovery Support Program. In addition to biweekly groups, perinatal support specialists also provide virtual individual consultation and doula support during labor. In 2021, COVID 19 Block Grant Supplemental funds allowed for an extension of the existing work and expansion of the work into the PROUD and REACH programs.

LGBTQ+ Collaborative

- Facilitated by DMHAS WS, The LGBTQ collaborative is comprised of state partners within the Office of the Commissioner and the State-Operated and private non-profit Local Mental Health Authorities (LMHA's). The goal of the LGBTQ collaborative is to better understand the needs of the LGBTQ+ population and how to better address these needs within the state system.
- As a result, of SAMHSA's technical assistance funds and COVID 19 Supplemental dollars, WS has led efforts to increase knowledge related to treating LGBTQ+ clients within our system of care. To date, this has included a 4 session virtual training series, development of updated Learning Management Service trainings, clinical consultation hours, DMHAS lunch and learns, a conference in June 2022, as well as an additional multi-session training series covering a wide range of LGBTQ+ topics and best practices.

Trauma and Gender Learning Collaborative (TAG)

- Co-facilitated by DMHAS WS and the CWC, TAG convenes bi-monthly to discuss topics related to Trauma and Gender.

CT Perinatal Quality Collaborative

- The Connecticut Perinatal Quality Collaborative works to promote high quality maternal and newborn care across the continuum of acuity, from the community hospital to the neonatal intensive care environment. Monthly meetings are attended by WS staff.

Middlesex County Perinatal Health Collaborative

- WS staff attend a bi-weekly community-based meeting charged with developing resource plans for pregnant and post-partum people that may be at increased risk due to substance use and/or mental health disorders.

NASADAD Women's Services Network

- As a component of the National Association of State Alcohol/Drug Abuse Directors (NASADAD) and the National Treatment Network (NTN), the Women's Services Network functions as a specialty network under the auspices of the NTN, and in collaboration with the National Prevention Network (NPN) and has women's treatment and prevention issues as the focus while remaining dedicated to the NTN's overall goal of effective, socially responsive treatment delivery for all populations. WS staff attend all NASADAD events. Currently, the WS Director acts as the Region 1 representative and serves on the WSN leadership team.

One Key Question (OKQ)/Power to Decide

- OKQ focuses on integration of reproductive health and optimal birth spacing training into DMHAS's women specific continuum of care. In partnership with the CWC, WS has provided nine OKQ trainings from 2019 to 2021 for providers of all levels of care with the goal of implementing this practice for women statewide. As a result of PROUD SAMSHA funding, these efforts will continue through 2022.
- Utilizing PROUD SAMHSA funding, WS is partnering with Power to Decide and the CWC to fund OKQ certification trainings for DMHAS staff and designated treatment providers, with the goal of enhancing existing efforts, increasing access to technical assistance/training, and ensuring sustainability of this important initiative.

Hoarding Workgroup

- A statewide multidisciplinary team focused on hoarding disorder. This working group holds monthly meetings as well as an annual conference related to hoarding disorder. WS organized with the CWC an additional no cost hoarding disorder training for staff within the DMHAS continuum of care and consultation session with Hoarding expert, Dr. Randy Frost, PhD, LCSW. Because of COVID 19 Block Grant Supplemental funding, these training efforts will continue into March 2023.

Trafficking in Persons Council

- DMHAS is an appointee to the Trafficking in Persons (TIP) Council convened by the Commission on Women, Children and Seniors, and chaired by Representative Jillian Gilchrest. The council consists of members from a diversity of backgrounds, including representatives from state agencies (including DMHAS WS), the judicial branch, law enforcement, motor transport and community-based organizations. These stakeholders work with victims of sexual and domestic violence, immigrants, and refugees, to address behavioral health needs, social justice, and human rights.

CT Multi-System Trauma Informed Collaborative (MSTIC)

- WS is an active member of this interagency initiative aimed at enhancing the ability of state systems to identify, implement, and monitor impacts of effective trauma-informed strategies to improve outcomes and applying culturally competent, family-focused approaches and increase knowledge of evidence-based policies, practices, and programs to improve service provision

Help Me Grow (HMG) Collaborative and Advisory Board

- HMG CT is a program originating from the Office of Early Childhood. HMG promotes early childhood development and is part of a national network that ensures all children reach their full potential by connecting CT children and their families to community services and resources related to child health, behavioral, development and learning.

DV Standards and Fatality Review Board

- WS staff participate in monthly meetings convened to review CT DV standards and cases of death or near death involving DV.

Governor's Council on Women and Girls

- Upon taking office in January 2019, one of Governor Lamont's first actions was to form the Governor's Council on Women and Girls – a group tasked with providing a coordinated state response to issues that impact the lives of women, girls, their families, and the State of Connecticut. DMHAS WS staff attend bi-monthly meetings, have presented on our service continuum and participated in the Women and Girls Day at the Capitol in March 2020.

DMHAS and CT Coalition Against Domestic Violence (CCADV) Collaboration

- As a result of increased isolation and lack of access to legal and community services during the COVID 19 pandemic, victims of intimate partner violence (IPV) and their families are increasingly at risk of heightened violence, resulting in severe injury and/or death. This has put a considerable strain on the 18 IPV agencies in CT, resulting in an additional need for resources to meet these demands and to respond with the immediacy required to keep victims safe. Utilizing funding from SAMHSA, DMHAS WS has contracted with CCADV to implement an Outreach/Public Awareness Campaign to highlight access and availability of help through CT Safe Connect for vulnerable and underserved populations impacted by IPV.
- Additionally, this funding is utilized to increase the capacity of CT's 18 lethality advocacy teams to conduct lethality assessments, increase advocacy, and access to resources during the COVID-19 pandemic.

Maternal Mortality Due to Violence Advisory Board

- CCADV received a five-year grant from the Office on Women's Health to reduce maternal mortality due to violence. WS participates in this meeting monthly along with other key stakeholders including but not limited to BSEB, March of Dimes, DSS, and DPH.

CT State Taskforce on ACES and Resilience (CSTAR)

- CSTAR was formed in the Fall of 2019 in an effort to create a trauma-informed and resilient Connecticut. WS participates in quarterly CSTAR meetings and events. CSTAR recognizes the impact of a wide variety of adverse childhood experiences (ACEs) that shape behavior and health. The task force seeks to promote resilience-building practices and policies for all families, organizations, systems and communities regardless of race, gender, ethnicity and socioeconomic status.

Medical Assistance Program Oversight Council (MAPOC) – Women and Children's Health and Safety Subcommittee

- The Medical Assistance Program Oversight Council (MAPOC) is a collaborative body established by the General Assembly in 1994 to initially advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A). Current statutes charge the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under Administrative Service Organizations (ASOs), transitional issues from managed care, eligibility standards, benefits, health care access and quality measures. WS staff attend the Women and Girls Health and Safety Subcommittee meetings.

Endometriosis Working Group

- The Endometriosis working group was formed in the Fall of 2020 by State Representative Jillian Gilchrest. The working group provides space for interested parties to discuss what Endometriosis is, to understand its impact on women in CT, to provide additional education on a wide variety of endometriosis related topics by subject matter experts and to propose legislation to improve the outcomes for people affected by this disease in CT.

[i] Mohlman, Mary K., et al. "Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont." *Journal of Substance Abuse Treatment*, vol. 67, 2016, pp. 9-14.

DMHAS Triennial Report Subsection
Harm Reduction

Harm Reduction is an approach aimed at reducing negative consequences associated with substance use. Harm reductionists accept that individuals may choose to use substances and work to minimize the harmful effects rather than condemn substance using individuals. This approach acknowledges that some ways of using substances are safer than others and calls for a non-judgmental, non- coercive provision of services and resources. Proponents of harm reduction practices compare the approach to examples such as wearing seatbelts while driving or using facemasks during the COVID-19 pandemic.

Medication for Opioid Use Disorder (MOUD) can be viewed as a harm reduction approach used in treatment settings for individuals early in recovery. While the medication is not risk free, it significantly reduces the risk of overdosing and dying. There are three approved medications for Opioid Use Disorder: methadone, buprenorphine, and naltrexone. The Department of Mental Health and Addiction Services (DMHAS) has a robust system of methadone clinics which serve individuals across the state. Some individuals do well on the other two medications and DMHAS has focused on increasing access to buprenorphine and naltrexone since receiving the first federal grant to support MOUD (MATX grant) in 2016. The initial pilot included four (4) non - profit providers, who employed addiction specialists and recovery coaches to assist in getting individuals with an opioid use disorder (OUD) connected to treatment with medication. The Recovery Coaches are trained professionals with personal lived experience who engage individuals with a possible substance use diagnosis and offer a wide variety of support and information on available treatment modalities. With federal State Opioid Response grant funding, DMHAS has focused on further increasing access to MOUD treatment in all regions of the state by supporting ten (10) outpatient providers to provide MOUD as well as outreach through four (4) mobile MOUD vans. These mobile vans employ a psychiatrist and recovery coach who provide services in the community for individuals who are not accessing treatment in the traditional setting. DMHAS is also funding recovery coaching positions in methadone clinics and supporting the Department of Corrections (DOC) with funding for MOUD for the incarcerated population. Overall, DMHAS supports 45 MOUD programs across 16 community treatment providers, making treatment available in all regions of the state. In fiscal year 2022, these 45 programs provided services to 15,058 individuals, an increase of 672 individuals compared to state fiscal year 2019.

New Admissions to DMHAS Supported MOUD Programs

	Region 1	Region 2	Region 3	Region 4	Region 5	Total
FY19	1,728	421	477	2,200	1,071	5,897
FY20	1,626	440	786	2,783	1,044	6,679
FY21	1,351	280	702	2,478	826	5,637*
FY22	1,660	327	788	2,784	965	6,524
FY23 (as of 12/29/22)	217	143	205	1,103	294	1,962

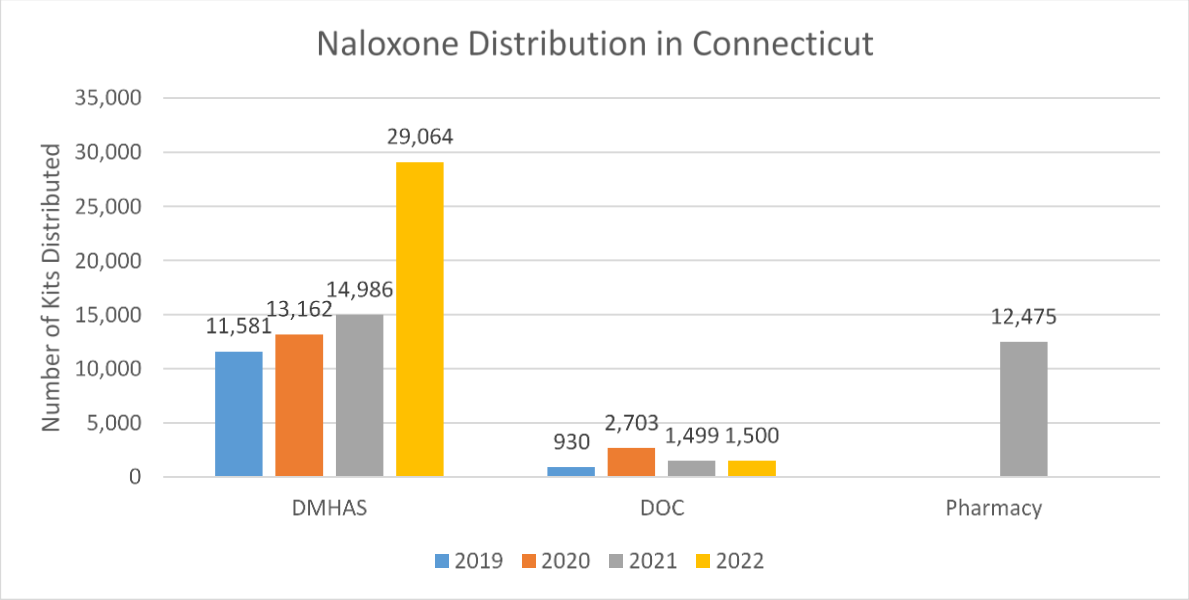
*Decrease in admissions was associated with COVID-19 Pandemic

Unduplicated Clients Served in DMHAS Supported MOUD Programs

	Region 1	Region 2	Region 3	Region 4	Region 5	Total
FY19	3,848	911	1,432	5,768	2,780	14,386
FY20	3,857	1,012	1,618	6,294	2,845	15,030
FY21	3,819	892	1,655	6,281	2,655	14,829*
FY22	3,788	893	1,773	6,530	2,688	15,058
FY23 (as of 12/29/22)	2,801	713	1,342	5,441	2,245	12,386

*Decrease in clients served was associated with COVID-19 Pandemic

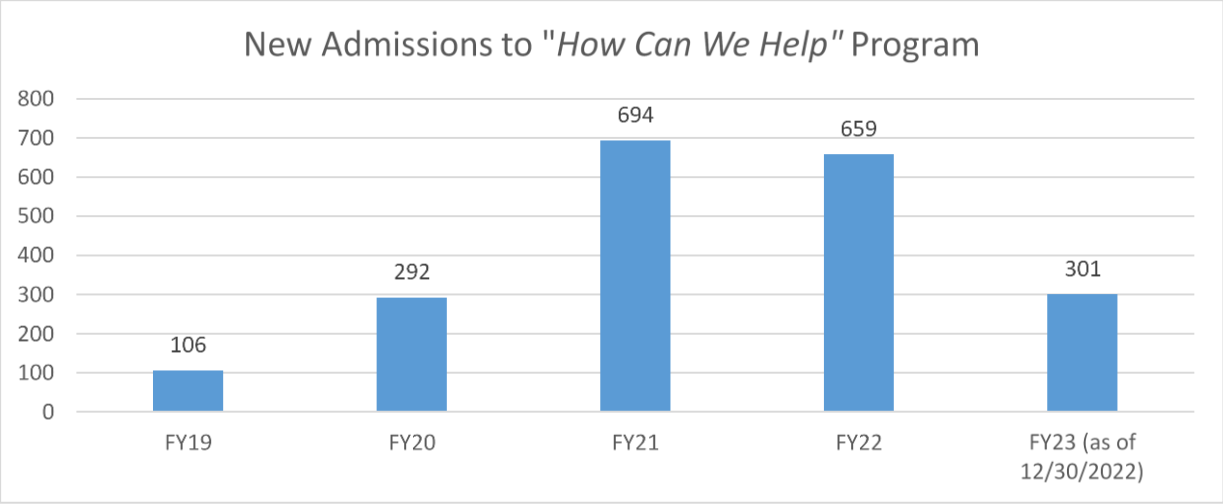
Another powerful medication, naloxone (brand name Narcan), is used as a harm reduction tool to reverse an active overdose. The Department has made it a priority to make this life saving medication available to all hospital emergency departments, treatment and recovery support providers, and harm reduction service organizations. DMHAS has distributed close to 30,000 naloxone kits in 2022, a major portion of the 45,000 needed to saturate the state and a significant increase from 2019 (11,581). Naloxone is also available through pharmacies and municipal funding for emergency response.



Recent legislation changes allowed DMHAS to purchase and distribute fentanyl testing strips to harm reductionists in the state. Fentanyl and its analogs have been found in 85% of overdose deaths in the last three years. Testing strips allow for safer use as individuals are able to check their substances for the presence of fentanyl.

The federal State Opioid Response (SOR) grant has provided much needed funding and allowed the Department to support additional harm reduction strategies. These include outreach programs such as: *How Can We Help?,* where recovery coaches partner with first responders to provide services to those who have recently overdosed; mobile vans providing quick and efficient access to MOUD and recovery

coaching; and drop-in centers, providing access to naloxone and other harm reduction supplies, recovery support, coordination with shelters and syringe exchange programs, and connection to treatment.



The Department recognizes the importance of educating the public, to minimize stigma associated with substance use disorders. In May of 2022, the second CT Harm Reduction Conference was held with 218 attendees. Connecticut providers had the opportunity to learn about strategies that are helpful and hear from experts, panelists, and those who are currently using opioids. A webinar on harm reduction as well as the presentations from the conference were posted on the DMHAS website. Ongoing public education efforts continue through the LiveLOUD media campaign. LiveLOUD focuses on destigmatizing harm reduction messaging, information sharing, and awareness raising. The campaign includes a website, www.liveloud.org, with information for drug using individuals, and their loved ones; billboards on major highways; images on local buses and train stations, as well as powerful social media posts. The designs below were visible on billboards in four major cities in CT: New Haven, Hartford, and Bridgeport.

Over the previous three years, DMHAS has made significant effort to incorporate the Harm Reduction principles and strategies outlined above within the departments' overarching plan of action to reduce opioid addiction and overdoses. During the next three years, the department will continue to explore national and emerging best practices in Harm Reduction and identify opportunities for expanding services and resources in Connecticut that are aligned with this approach.