ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, June 21, 2022
Video Conference Call through Teams
10:00 a.m.

ATTENDANCE

Members/Designees: Dr. Craig Allen; Luiza Barnat, DMHAS; Maria Coutant Skinner, McCall Center;; Ines Eaton, DCF; Katie Ferrel; Tammy Freeberg, Village for Families and Children; Claudio Gualtieri, OPM; William Halsey; Allison Fulton; Ingrid Gillespie; JoShonda Guerrier, DCF Mark Jenkins, GHHRC; Barbara Lanza, Judicial; Susan Logan, DPH; Justin Mehl, DMHAS; Nancy Navarretta, DMHAS; Gerard O'Sullivan, DOI; Dr. William Petit; Sandrine Pirard, Beacon; Surita Rao, UCONN; Gary Roberge, Judicial; Melissa Sienna, DCF; Sarju Shah, DMHAS; Scott Szalkiewicz, DCP; Judith Stonger, Wheeler; Sandra Violette, DOC

Visitors/Presenters: Bridget Aliaga; Samantha Allard; Allyson Nadeau; Ramona Anderson; Andressa Granado; Wesley Antonucci; Cheri Bragg; Brendan Burke; Heather Clinton; Nicholas Coretes; David Borzllino; Deborah Lake; Anuja Dhungana; Danielle Ebrahimi; Ece Tek; Eddie Aledia; Thomas Fulton; Gabriela Krainer; Julienne Giard; Giovanna Mozzo; Robert Heimer; Jared Cortez; Jennifer Kolakowski; Joee Lindbeck; David Kaplan, Kara Sepulveda; Kim Karanda; Kasandra Rowe: Christy Knowles; Karonesa Logan; Jennifer Lombardi; Lyne Stokes; Mollie Machado; Michael Makowski; Erin Mulhern; Pamela Mulready; Shauna Pangilinan; Rebecca Petersen; Callyn Priebe; Rebecca Allen; Robert Kanehl; Vincent Russo; Samuel Saylor; Diane Shaw; Suzanne Doyon; Robin Tousey-Ayers; Colleen Violette; Jeremy Wampler; Wende Cooper; Karolina Wytrykowska; Yashira Pepin

Recorder: Karen Urciuoli

The June 21st meeting of the Alcohol & Drug Policy Council (ADPC) was called to order at 10:00 a.m. by Commissioner Navarretta, DMHAS. The meeting was co-chaired by JoShonda Guerrier, Administrator, DCF

Topic	Discussion	Action
Welcome and Introductions	Commissioner Navarretta welcomed all in attendance.	Noted
Review and Approval of Minutes	The April 19, 2022 minutes were reviewed and approved as written.	Noted
Problem Gambling and Substance Use Disorders (Co-Occurring)	Jeremy Wampler, DMHAS Behavioral Health Clinical Manager, Statewide Services Division, Problem Gambling Services provided the following report. • The Problem Gambling Unit has been around since the early 80's and is the oldest continually funded problem gambling program in the country. They are gambling neutral in their approach, they are not for or against gambling, they try to educate the community, providers or anyone else who is interested in the issue of problem gambling, and its risks. Definitions: • Responsible Gambling: Describes the ways in which games of chance are both offered and participated in a socially responsible way that lowers the risk of gambling harms • Problem Gambling: Pattern of gambling engagement that is so extreme it causes an individual to have important problems in various aspects of their life • Gambling Disorder: clinical term relating to a score assessed by a professional using a recognized set of criteria The Gambling Continuum • Approximately 95% of the population can gamble in a way that does not create significant problems or harm in their lives • Approximately 3-4% of the population develop some issues related to gambling but not severe • Approximately 1-2% of the population that develop a gambling disorder • Youth increase 2x's • Athletes 4x's • SA/MH increase 10x's • DOC/CJ involved population increase 20x's	Informational –The full presentation can be found on the DMHAS ADPC Webpage

Topic	Discussion	Action
	Impacts • On average, 1 individual working through a gambling addiction impacts an additional 9 people in their families and communities. **Gambling, Substance Use, & Mental Health** DSM 5 Criteria Gambling Disorder - Must have 4 or more of the following: • Is preoccupied with gambling (relives past experiences…). • Needs to put increasing amounts to get the same excitement. • Has repeated, unsuccessful attempts to control, cut back, or stop. • Becomes restless or irritable when trying to stop gambling. • Gambles as a way to escape problems or deal with dysphoric mood. • After losing money gambling, often returns another day to get even. • Lies to family/friends/coworkers to hide the extent of gambling losses. • Has jeopardized, or lost, a significant relationship, job, educational, or career opportunity because of gambling. • Relies on others to provide the money to relieve a desperate financial situation caused by gambling. (bailouts) DSM 5 Criteria Substance Use Disorder - Must have 2 or more of the following within a 12-month period • Hazardous use: You've used the substance in ways that are dangerous to yourself and/or others, i.e., overdosed, driven while under the influence, or blacked out. • Social or interpersonal problems related to use: Your substance use has caused relationship problems or conflicts with others. • Neglected major roles to use: You've failed to meet your responsibilities at work, school, or home because of your substance use. • Withdrawal: When you've stopped using the substance, you've experienced withdrawal symptoms. • Tolerance: You've built up a tolerance to the substance so that you have to use more to get the same effect. • Used larger amounts/longer: You've started to use larger amounts or use the substance for longer amounts of time. • Repeated attempts to control use or quit: You've tried to cut back or quit entirely, but haven't been successful. • Much time spent using: You spend a lot of your time using the substance. • Physical or psychological problems related to use: Your substance use has led to physical health problems like liver damage or lung cancer, or psychological issues, such as depression or anxiety. • Activities given up to use: You've skipped activities or stopped doing activities you once enjoyed in order to use the substance. • Craving: You've experienced cravings for the substance Must have 2 or more of the following within a 12-month period Similarities Between Gambling and Substance Use • Pre occupation • Tolerance • Loss of control • Withdrawal • Continued use despite negative consequences • Impacting important aspects of life (relationships, work, school, etc • Impact on the brain Substance Related and Gambling D/O: Similarities • Substance related disorders (American Psychiatric Association,2013*). "All drugs that are taken in excess have in common direct activation of the brain reward system , which is involved in the reinforcement of behaviors and the*	

Topic	Discussion	Action
	production of memories. They produce such an intense activation of the reward system that normal activities may be neglected" • Gambling disorder (American Psychiatric Association,2013). *"Gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to the substance use disorders"* So what's different? • Chasing losses • Not telling the truth about extent of gambling • Financial bailouts to cover losses • Often perceived as a solution • Fantasies of success/magical thinking • Unpredictable outcomes/intermittent reward • Hidden addiction/ appears to be a money problem • Less public awareness = Greater STIGMA! Substance Use Disorders • Researcher shows problem gambling rates are higher in those with SUDs when compared to the general population • 41% of people seeking treatment for gambling problems meet the criteria for lifetime AUD & 21% meet criteria for SUD • One can trigger the other/ replacement behaviors • Pre-existing vulnerabilities in brain function, such as in the prefrontal cortex, could be partially to blame. People with high impulsivity scores tend to make rash decisions about both substances and gambling putting them at higher risk of developing a difficult to break habit. • Many individuals with AUD & SUD have been able to achieve sobriety from alcohol & drugs but are unable to control their gambling Impacts of Problem Gambling on Mental Health • Across studies, problematic gambling appears to be related to mental health. Individuals who engage in problem gambling behaviors are at least twice as likely to experience a psychiatric condition at some point in their life. Gambling and Trauma • Individuals who met three or more Adverse Childhood Experiences (ACEs) were more than three times as likely to report disordered gambling. Rates of Suicide • In 2019, 4.8% of adults 18 or older in the U.S. had serious thoughts of suicide and 0.6% attempted suicide • Individuals with a substance use d/o are nearly 6x's as likely to attempt suicide • Up to 50% of individuals in treatment for gambling disorder have suicidal ideation, and about 17% have attempted suicide • Spouses of gamblers have suicide attempt rates 3x's higher than the general population. Awareness & Education • Education and Awareness Topics • Campaigns • Resources/Materials • Student/Teacher/Community Education Safeguards • Setting Limits • "Cool Off" Period	

Topic	Discussion	Action
	• Voluntary Self Exclusion • Age Requirements 21+ Voluntary Self Exclusion • What is voluntary self-exclusion? Self-exclusion allows a person to request to be excluded from legalized gaming activities in Connecticut. Individuals who enroll in self exclusion are prohibited from collecting any winnings, recovering any losses or accepting complimentary gifts or services or any other thing of value from a licensee or operator. Operators may choose to exclude participants in the Connecticut Self Exclusion list from their services in other states or countries. • How can voluntary self-exclusion be helpful? Voluntary self-exclusion can be a beneficial and empowering tool for those who feel they may be developing or have a problem with their gambling. By creating a barrier, it allows those who want to decrease or stop their activity, reduce the harms associated with gambling. Self-Exclusion • The self-exclusion list is maintained by the Connecticut Department of Consumer Protection (DCP) and carries over to all online gaming and retail wagering locations • Players can exclude themselves for 1 year, 5 years, or lifetime. Lifetime exclusion is only offered through the DCP. • To request removal, you will need to contact the DCP through its portal after your exclusion period is over. Prevention • RBHAOs • GamblingAwarenessCT.org • Asian American Pacific Islander (AAPI) Ambassador Program • Congregation/Community Assistance Program (CAP) • Youth PSAs and Fox61 student news • Responsible Gambling Campaign • Disordered Gambling Integration (DiGIn) programs Why Integration is Important • Gambling at first mention is not seen as problematic. Problem Gambling is often seen as relational to negative outcomes, not addiction. • When pressed addiction/ gambling are seen as having similarities. • Gambling is legal, government sponsored and embedded in a variety of cultures (religion, ethnic) increasing belief that it is a safe, acceptable form of • Help is known (back of lotto tickets, advertisements) but lack of public knowledge and awareness leads to underutilization. Assessing Impact on Recovery • Beyond diagnosis and labeling • Integrate gambling throughout the assessment in addition to specific screening items • In what ways does gambling support or detract from recovery? • In what ways does gambling support or detract from life goals? • In what ways does gambling support or detract from your probation? Recovery Support Services • Speakers Bureau • Community Outreach • Social media events • Agency/group presentations	

Topic	Discussion	Action
	• Scholarships for Recovery Coach Academy and Recovery University • Peer Collaborative • Bettor Choice Treatment Programs • Problem Gambling Helpline – Call, Text, Live Chat	
REACH Program	Rebecca Peterson, DMHAS, Program Manager, Women's Services, STATEWIDE Services Division provided the following report: Understanding Stigma • Defined by Cambridge Dictionary as: a strong lack of respect for a person or group of persons or a bad opinion of them because they have done something society does not approve of • Clouds our lens of seeing a person clearly as a multifaceted individual and often putting them into a box of only a single characteristic Consequences of Stigma: • Mental Health/Trauma – chronic exposure to prejudice, avoidance, rejection, judgement, and discrimination • Internalizing stigma -- Feelings of shame and guilt which decrease the likelihood of seeking treatment or having access to harm reduction strategies and resources • Decreases chance of seeking treatment which leads to increased economic, social, and medical costs • Distrust of community/medical/police/criminal justice providers • Health disparities • Legal and/or Child protective involvement Peer Recovery Support Services • Delivered by peer recovery coaches, and are one form of peer support • Non-clinical assistance to support long-term recovery from substance use disorders • Can support or be an alternative to clinical treatment for substance use disorders • Help people in recovery build recovery capital – the internal and external resources necessary to begin and maintain recovery Women's REACH Program • Recovery ▪ Multiple pathways to support healthy lives • Engagement ▪ Meeting women in their community ▪ No wrong door to enter services • Access ▪ Making connections for community- based resources ▪ facilitating warm handoffs to treatment • Coaching ▪ Using shared experiences to encourage, support, advocate & provide a listening ear • Healing ▪ Modeling that recovery is possible and accessible Structure of the REACH Program • Implemented March 1, 2019 • Services delivered by 5 DMHAS contracted agencies. Each program provides the following; ▪ 3 full time Recovery Navigators ▪ Community based outreach and engagement to women with priority access to those who are pregnant & parenting	Informational –The full presentation can be found on the DMHAS ADPC Webpage

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	▪ Case Management & Recovery Coaching ▪ Development of collaborative relationships within their communities with medical and behavioral health providers, hospitals, DCF, police, recovery resources, etc. Women's Recovery Navigators Participation in community meetings and taskforces • All 15 Women's Recovery Navigators: ▪ Are women in personal recovery who are open to sharing their story to support others ▪ Have completed Recovery Coach Training ▪ Receive weekly supervision from their respective agency ▪ Participate in a monthly DMHAS facilitated learning collaborative and ongoing DMHAS funded trainings: ▪ Open to and knowledgeable about diverse pathways to recovery, community resources, and women's health issues ▪ Embrace the notion that one size does not fit all REACH Enhancement • In 2021, DMHAS utilized SAMHSA funding to support the addition of a Family Recovery Navigator to each of the 5 REACH teams. • The Family Recovery Navigator uses their history of lived experience to assist the REACH team and expand the scope of services to support parenting caregivers impacted by substance use: ▪ Partners of REACH clients ▪ Single parent fathers, LGBTQIA+ parents, and primary caregiving relatives • The Family Recovery Navigator provides holistic services though connection to treatment, recovery coaching, and case management. • Perinatal Support Specialty Services provided to all eligible REACH clients. Birth Support, Education & Beyond • In 2021, DMHAS utilized SAMHSA funding to provide perinatal support/doula services to pregnant and postpartum REACH clients • Empowers positive birth experiences for clients engaged in the REACH Program • Connection of expectant birthing persons to Perinatal Support Specialists that provide doula support throughout pregnancy, labor, and birth • In-home postpartum doula and perinatal support services provided in the initial postpartum period Plan of Safe Care/Family Care Plan • In line with the Child Abuse Prevention and Treatment Act (CAPTA), the Recovery Navigators will support pregnant women/birthing persons and their health care providers in the development of a Plan of Safe Care/Family Care Plan. ▪ Through their relationship with the woman/birthing person, education on CAPTA is provided to dispel myths and allow time for questions and processing. ▪ REACH Navigator can be a constant as mom/birthing person moves through various providers and can readily access plan at time of delivery. ▪ Navigators support the development of comprehensive plans which address physical health, behavioral health, infant health and development, and parenting/family support. A Look at some REACH Data from March 1, 2019-May 2022 • Over 1,600 individuals have been enrolled in the program • Extensive community outreach has been done statewide including to: ▪ Behavioral Health Providers ▪ Hospitals ▪ Social Support & Community Resource Agencies	

Topic	Discussion	Action
	▪ Medical Offices including FQHCs ▪ DCF Offices ▪ Police Departments Providers • Chemical Abuse Services Agency (CASA), Inc. - Region 1- Serving greater Bridgeport, Norwalk, & Stamford • The Connection, Inc. - Region 2- Serving greater Meriden, Middletown, & New Haven • Advanced Behavioral Health (ABH) - Region 3- Serving Greater New London, Norwich, & Windham • The Village for Families & Children - Region 4- Servings Bristol, Hartford, Manchester, & New Britain • McCall Center for Behavioral Health - Region 5- Serving Danbury, Torrington & Waterbury	
SAFE Family Recovery Model	Ines Eaton from DCF and Melissa Sienna from UCONN Health provided the following report: **MDFR** • Multidimensional Family Recovery (MDFR) empowers caregivers to provide a safe and healthy environment for their children by addressing their substance use and other factors that impact their parenting. MDFR serves the whole family: parents and caregivers, affected child(ren), and other significant family members. Target Population: • Caregivers who are recommended for community-based substance use treatment • Would benefit from services • Court-involved care givers have priority access Possible Activities • Help clients get to recommended services • Family education sessions that address DCF concerns • Recovery Support Plans • Advocate for and support caregiver recovery **RMS** • Recovery Monitoring and Support (RMS) starts after substance use treatment ends to help caregivers practice skills learned during treatment. Early detection of return to substance use and re-referral to treatment are key benefits of RMS. • RMS emphasizes pro-recovery activities, pro-recovery friends, using skills learned in treatment, goal setting & goal checks, and planning for high-risk situations. Target Population: • For those who would benefit from recovery supports and checkups • AFTER substance use treatment • Caregivers must have a history or indicators of substance use that may be impacting their parenting abilities Continuity • RMS can stay working with caregivers who re-enter treatment to prevent dropout • On-going Supports & Check-ins – Early reconnection to treatment if caregiver returns to substance us Accomplished Through • Regular contact with caregivers • Early identification of return to use • Rapid reconnection to treatment • Motivate caregivers to work their recovery plan, and/or get treatment Performance Outcome Measures • Parents/caregivers who complete MDFR/RMS – MDFR 65% / RMS 74%	Informational –The full presentation can be found on the DMHAS ADPC Webpage

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	• Parents/caregivers who complete MDFR/RMS and (re)initiate substance use treatment – MDFR 79% / RMS 68% • Parents/caregivers who complete MDFR/RMS and (re)engage in substance use treatment – MDFR 94% / RMS 100% • Parents/caregivers who complete MDFR/RMS will have a child(ren) remaining home or have a permanency plan of reunification – MDFT 78% / RMS 78% • Parents/caregivers who complete MDFR/RMS and are abstinent or have a reduction in substance use/misuse (data is based on abstinence 30 days prior to discharge-reduction was not able to be calculated) – MDFR 81% / RMS 83% • Parents/caregivers who complete MDFR/RMS and are connected to a community or natural recovery resource – MDFR 91% / RMS 86%	
Sub-Committee Reports		
• **Prevention, Screening and Early Intervention**	Judith Stonger provide the following update: • Cannabis workgroup – Engage with O'Donnell Company to create an awareness campaign, they have been conducting in-depth interviews with key informants online and in person, doing focus groups, one on one interviews, and have now expanded that to launch a digital survey to try and reach additional target populations. In addition, are renewing current cannabis law billboards that were created by the Clearinghouse through September. • Continue to work on policy recommendations regarding the cannabis law and moving forward with internal presentations by various members of the workgroup who have reviewed sections of the cannabis law and are making policy recommendations. • There have been two recent bills, HB 5329 concerncing cannabis is now PA 22-103. There are a number of changes to the law regarding limitations on cannabis gifting and sale. Safe parameters have been increased around schools, recreation centers, childcare centers, playgrounds, parks and libraries as well as houses of worship. The safe parameter was increased from 500 to 800 feet. The billboards regarding cannabis have been limited to the hours of 11:00pm to 6:00am to reduce the advertising viewing by youth. • A 2nd legislation and act regarding pre-school and mental health and behavioral health services for children is now PA 22-81, it requires the Department of Consumer Protection (DCP) to develop documents on consumer safe storage and disposal of opioids, cannabis and cannabis products. The documentation will be on the DCP website and retailers will be required to post signage. • Media and Stigma Workgroup – they have finalized the development of a CT speaker database on substance use and mental health. The goal is to have a diverse database of presenters including individuals with lived experience, family members, and professionals who are able to speak in a non-stigmatizing way on a variety of topics when media request come in. The workgroup will also provide technical assistance and will work to build capacity among people around the state to be able to respond and to present. An email and link will be broadly disseminated this week for people to join that database and all are encouraged to consider joining and share this opportunity with others. • Leadership – Judith will be stepping down as co-chair of this subcommittee, there are new guidelines for membership and subcommittee chairs now have a term of 3 years. Allison Fulton will continue as a co-chair. There are two excellent candidates for the additional co-chair, they will be voting on them this week.	Informational
• **Treatment**	Dr. Craig Allen Maria Coutant Skinner provided the following update: • Recently took a look at the composition of this subcommittee and wanted to be sure that they are focused appropriately. Have returned to following the goal tracking document. One of the items on there has to do with the importance of general hospitals offering and inducting patients on MOUD while inpatient, and then transitioning those patients in a seamless way to outpatient services. Emergency departments we highlighted as an important component of that process and opportunities. COVID may have taken some of the focus off of this in some healthcare settings. This procedure is being followed in some hospitals but there is a clear lack of standardization. There is a push to get the CT Hospital Association involved. Want to be sure we are aligned prior to COVID, DPH was very involved with some facts	Informational

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	blasts and other education material around the fact that it is legal and appropriate to identify and intervene in the hospital/healthcare setting. Deacon and DMHAS have done a lot of collaboration with community providers and helped bring them together with the hospital providers to improved discharge processes. Beacon is involved with the Changing Pathways program and is currently running a couple of different projects on inpatient psychiatric units across the state, identifying and intervening for people with MOUD, and they are looking to do more work with emergency departments as well. They would like to broaden the education around healthcare systems to families and loved ones to empower them to ask for MOUD services. They may be able to track this by looking at data from inpatient psychiatric units with a diagnosis of OUD and when they were started on MOUD. • Harm Reduction– The harm reduction conference sponsored by DMHAS and the Women's Consortium last month was an extraordinary event, the keynote speaker talked about the journey of a safe use site that opened in Canada, New York now has a safe use site and hopefully CT won't be too far behind. There was a lot of positive energy at the conference around this and there was participation from people who are actively using. That caused this group to look at what is a successful interaction and intervention and recognizing that it is not always just abstinence. There is now a statewide group that is being co-chaired by Marc Jenkins and Joanne Montgomery around harm reduction, people are invited to join if they would like. • 1115 Waiver – They had a presentation from Robert Haswell, DMHAS. The service system rolled out the residential SUD demonstration component from that on June 1st, the group is now working on PHP and IOD. • Grief resources and supports – conducting a current assessment of existing resources and identifying resourcing programs and options to meet all populations throughout the state. • Opioid Settlement – this group would like to have urgent appeal for reconsideration of the membership configuration, there is a concern that there will not be any providers at the table. • There are a lot of great resources that this group has shared for youth with SUD, there are youth recovery groups, SMART recovery groups, there are now, through CCMC, youth recovery groups in the north end of Hartford serving ages 16-24 and they are also doing family and friends groups. Turning Point CT is offering a Recovery Coach Academy for anyone in CT 29 and younger.	Note: membership is in statute
• **Recovery and Health Management**	Justin Mehl provided the following update: • Currently in a period of transition, Jennifer Chadukiewicz has stepped down as co-chair and Sandy Valentine has accepted the co-chair appointment. Jillian Griffin, from INSPIRE Recovery and Wellness, will also be joining this group as a co-chair. • Sandy Valentine held a Recovery Friendly Campus conference at UCONN. There were approximately 120 participants at the hybrid event; there 7 states in attendance, along with clinicians, students, and college administrators. They are continuing to see momentum with the recovery friendly campus initiative. • Recovery Friend Community Initiative – when communities are identified and wanting to be seen as recovery friendly, a champion is identified, and a rubric is introduced. Simsbury has now joined the recovery friendly community fold; their official status will be announced in September. • Mary Kate Mason provided a legislative update at their last meeting. • Looking forward they would like to start looking at special populations and making sure they are represented at this table.	Informational
• **Criminal Justice**	Barbara Lanza provided the following update: • At the last subcommittee meeting they discussed working to increase getting NARCAN into the hands of the DOC population and their families across the state. They are having conversations about how to get NARCAN in the hands of family members through the mail, which is being met with regulation barriers. They will continue to try and come up with a solution for this.	Informational

Topic	Discussion	Action
	• DOC and Judicial Marshalls are working together to be sure NARCAN is available to inmates with an unplanned release and those in lock-up. • The Judicial Branch Marshalls are the first point of contact in the court houses, NARCAN will be available to them in all the court houses in case there is an overdose situation. • In probation, they are finalizing policies and trainings to get NARCAN in the hands of all probation officers when they do a site or home visit. • MAT in DOC – 10 of the 13 facilities all have MAT. Vivitrol and Methadone and the two primary medications available, they are working on expanding Saboxone in some of the locations as well. Currently there about 700-800 DOC incarcerated individuals that are currently on MAT.	
Other Business		

NEXT MEETING – Tuesday, August 16, 2022, Video Conference Call through TEAMS

ADJOURNMENT – The, June 21, 2022 meeting of the Alcohol and Drug Policy Council adjourned at 12:00 p.m.