ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, March 1, 2016
Chrysalis Center, Inc.
Hartford, CT
10:00 a.m.

ATTENDANCE

Members/Designees: Charles Atkins, CMHA; Craig Allen, Rushford; Theresa Conroy, CT General Assembly; Miriam Delphin-Rittmon, DMHAS; Ingrid Gillespie, CT Prevention Network; David Guttchen, OPM; William Halsey, DSS; Deborah Henault, DOC; Christine Jaffer, CT Junior Republic; Robert Kane, CT General Assembly; Joette Katz, DCF; John Kissel, CT General Assembly; Chinedu Okeke, DPH; Betsy Ritter, Department on Aging; Gregory Shangold, Windham Hospital; Judith Stonger, Wheeler Clinic; Katherine Wade, Department of Insurance; Ashley Wheeler;

Visitors/Presenters: Deb Dettor, CCAR; Carol Meredith, DMHAS; Rebecca Michlin; Mary Painter, DCF; Kristina Stevens, DCF; Ece Tek, Cornell Scott Hill Health; Maura Casey, Hartford Courant; Karen Hanson, Yale; Janet Storey, DMHAS; Kristin Bidde, Yale; Kyle Zimmer, CT LAP; Brian LeBlanc, CT LAP; Julienne Giard, DMHAS; Elizabeth Duryea, DCF; Nancy Navarretta, DMHAS; Nancy Turner, ABH; Diana Lejardi, DMHAS; Kathy Maurer, DOC; Cathy Foley Geib, Judicial

Recorder: Karen Urciuoli

The March 1, 2016 meeting of the Alcohol & Drug Policy Council (ADPC) meeting was called to order at 10:15 a.m. by DMHAS Commissioner Miriam Delphin-Rittmon. The meeting was co-chaired by DCF Commissioner Joette Katz.

| Topic | Discussion | Action |
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| Welcome and Introductions | Members of the Council introduced themselves and Commissioner Delphin-Rittmon welcomed all in attendance. | Noted |
| Sub-Committee Structure and Charters | Commissioner Delphin-Rittmon reported that three subcommittees were created based on discussions and feedback from the December 2015 ADPC meetings regarding critical areas this committee should address. Missions for each committee were developed along with cross-cutting issues that will be addressed. | Informational<br>Healthcare outcomes and prescribing patterns/practices will be added as cross-cutting issues [part of data-driven planning]. |
| Introduction of Committee Chairs and Departmental Representatives | The following committee chairs and departmental representative were introduced:<br>Prevention, Screening & Early Intervention Sub-Committee:<br>Ingrid Gillespie, Judith Stonger, Dr. Mark Grossman<br>DMHAS/DCF Representatives: Carol Meredith/Mary Painter<br>Treatment & Recovery Support Sub-Committee:<br>Dan Rezende, Dr. Charles Atkins, Phil Valentine<br>DMHAS/DCF Representatives: Julienne Giard/Melissa Sienna<br>Recovery & Health Management Sub-Committee:<br>Shawn Lang; Deb Henault<br>DMHAS/DCF Representative: Lauren Siembab/Ines Eaton | Commissioner Delphin-Rittmon recognized and thanked subcommittee chairs for their involvement. |
| Sub-Committee Reports | | |
| • Prevention, Screening, and Early Intervention Subcommittee | Subcommittee Charter and Purpose<br>Carol Meredith and Mary Painter discussed the charter and purpose of this subcommittee with the tri- | Informational |

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| | chairs. The Governor's charge in his letter to the ADPC was also discussed.<br>Subcommittee Membership<br>Judith reported that the Connecticut Prescription Drug Abuse Prevention Workgroup led by DPH met on February 11, 2016. Group members voted to become part of the Prevention, Screening and Early Intervention subcommittee of the ADPC. Membership on this group includes DPH, DMHAS, the Governor's Office, three Regional Action Councils (HVCASA, NECASA, and Communities 4 Action), the Connecticut State Medical Society, the Governor's Prevention Partnership, AIDS CT, the Connecticut Conference of Municipalities, the First Selectman of Ridgefield, and Wheeler Clinic.<br><br>Additional membership is needed, including but not limited to: individuals and families in recovery, youth, UConn SBIRT initiative, MD prescribing to adults, CT Department of Education, older adult serving agency, CT Commission on Health Equity, and the FASD statewide coordinator among others. The subcommittee needs to be as diverse as possible and should include expertise in data and finance.<br>Areas of Focus<br>Statewide Awareness Campaign - The Connecticut Prescription Drug Abuse Prevention Workgroup has disseminated a "Mind Your Meds" PSA tagged with a message by Lt. Governor Nancy Wyman. Reminder emails about the PSA have recently been distributed. A new website at www.DrugFreeCT.org has been created and will be modified to improve its look and ease of navigation. Billboards are being created with the message "Many Heroin Deaths Begin with Prescription Drug Misuse" that will include the new website address.<br>Prescriber Education - Members of the Prescriber Education work group have been organizing training opportunities on addiction and pain management for prescribers in CT. These trainings include recommendations such as "SCOPE of Pain" (Safe and Competent Opioid Prescribing Education).<br>The Connecticut State Medical Society is hosting an Interdisciplinary Approaches to Proper Opioid Prescribing" training on April 27 from 4:00 PM to 8:30 PM at their office in New Haven. Registration fee is $45 and CMEs will be provided. This subcommittee will follow up and get an update on the status of prescriber education.<br>Also need to disseminate information on the online "Naloxone Certification Course for Pharmacists". This course can be found on the websites of University of Connecticut School of Pharmacy, Connecticut Pharmacy Association, and the Connecticut Department of Mental Health and Addiction Services.<br>Screening - Work with existing SBIRT initiatives to include screenings for opioids and heroin.<br>General - Need to align with other initiatives including the Mental Health and Substance Abuse Healthy CT 2020 Action Team, DCF Project IMPACCT, the Johns Hopkins "The Prescription Opioid Epidemic: An Evidence-Based Approach" report and other working committees, evidence-based strategies, and initiatives.<br><br>This subcommittee also recognizes the importance of communication among the three subcommittees of the ADPC to align work and avoid duplication of services. | |
| • Treatment and Recovery Support Subcommittee | Task #1 - Develop Subcommittee Membership<br>In addition to this ADPC Subcommittee leadership from DCF, DMHAS, CCAR, CJR and CMHA, additional membership would be comprised of individuals representing the following groups:<br>• Young person in recovery from opiate addiction<br>• Municipal law enforcement (Chief of police)<br>• Parent | Informational |

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| | • Education (Superintendent level)<br>• Methadone Provider (CEO or COO)<br>• Hospital Health System (Medical Director)<br>• ADPC Voting Members (3 spots) to focus on specific targeted areas, to include, but not be limited to: School, family, persons in recovery, treatment programs<br>Task #2 - Areas of Focus<br>The subcommittee leadership preliminarily identified the following areas of focus related to the Governor's overall ADPC charge:<br>1. Ensure rapid access to services across the lifespan<br>2. Expand/enhance community-based treatment for opiate and co-occurring mental health disorders<br>3. Expand/enhance peer recovery supports<br>4. Develop a map of the existing service system for opiate disorders with/out co-occurring mental health<br>a. Financial and Services Mapping<br>5. Identify barriers for providers to deliver (evidence-based) treatment, and for families to access them.<br>6. Improve identification by medical providers of substance use through routine use of urine toxicology and/or other screening methods<br>a. A-SBIRT, SBIRT initiatives | |
| • Recovery and Health Management Subcommittee | This sub-committee has as its goal to develop a spectrum of strategies:<br>• To provide harm reduction including safer use managed to use and abstinence as well as overdose prevention<br>• To provide for recovery oriented care and support systems that help people with mental health and substance use disorders manage their health and behavioral health conditions successfully<br>• That support recovery including but not limited to housing, employment, medical care and community reentry<br>Priorities<br>1. Narcan – ensuring access across all ages and venues<br>2. Medication assisted treatment – increasing access of medicated assisted treatment for clinic-based providers<br>3. Insurance parity for substance-abuse treatment<br>4. Establish intervention or hospital emergency rooms following overdoses<br>5. Insure the development of recovery resource inventory that includes the ones already in development are easily accessed by potential patients<br>6. Further the use of SBIRT (Screening, Brief intervention, and Referral to Treatment) by emergency room and primary care doctors. (Note: there is a SBIRT app for smart phones)<br>Looking for Subcommittee members from the following groups:<br>1. Coalition of high school based healthcare centers<br>2. Board of Regents for college students<br>3. Representative of the community health providers , especially federally qualified health centers<br>4. Representative of the State Department of Education<br>5. Persons in recovery and family members<br>6. Representative Physicians, including an ASAM member, specialist in pan management and a | Informational |

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| | current prescriber of Buprenorphine and/or Vivitrol<br>7. Criminal justice system and reentry provider representatives | |
| National Heroin Task Force Recommendations | Commissioner Delphin-Rittmon provided the following update regarding the National Heroin Task Force Final Report and Recommendations. The Task Force convened in March 2015, and is co-chaired by the Department of Justice and the Office of National Drug Control Policy and represents more than 25 Federal agencies.<br>The Task Force found three major findings:<br>• The need for public safety and public health focus,<br>• Substance use disorders are chronic brain diseases that can be prevented and treated, leading to recovery<br>• Visible community based recovery supports must be available, affordable and accessible.<br>Recommendations regarding Public Health and Public Safety:<br>• Safe and appropriate opioid prescribing practices<br>• Integrate data management, reporting and analysis<br>• Reduce excessive supply of opioids<br>• Enlist pharmaceutical companies<br>• Look to examples of promising strategies<br>• Prevent overdose deaths<br>Recommendations regarding Treatment and Recovery:<br>• Provide linkages to services at the first sign of an opioid use disorder<br>• Treatment, including MAT, readily available<br>• Long-term treatment and recovery services<br>• Prevention at the local level<br>• Improve opioid training and expertise of providers<br>Crosswalk with ADPC Subcommittees<br>• Prevention, Screening and Early Interventions: safe opioid prescribing; data; enlist pharmaceutical companies; promising strategies; linkages at first sign of use; prevention at community level<br>• Treatment and Recovery Support: data; enlist pharmacy companies; promising strategies; linkages at first sign of use; treatment (including MAT) readily available; provide training/expertise<br>• Recovery and Health Management: data; promising strategies; prevent overdose deaths; long-term treatment and supports | Informational<br>The link to the National Heroin Task Force and Final Report can be found on the DMHAS website |
| Innovative Approaches | | |
| • Family Based Recovery Project | Karen Hanson provided an overview of a DCF presentation entitled Family-Based Recovery:<br>A Home-based Treatment for Families Affected by Parental Substance Use Disorder. Ms. Hanson reported that the reciprocal interaction between substance use disorders and child neglect makes it necessary to treat both issues concurrently and clinicians need to focus on promoting stronger parent-child bonds and bolstering parental confidence as a means of breaking the cycle of substance use disorders and neglect. DCF recognized the need to address the dual challenges and in 2006 partnered with Johns Hopkins University and the University of Maryland with regard to contingency substance abuse treatment and Yale Child Study Center regarding attachment-based parent-child therapeutic approach and created Family Based Recovery (FBR) which integrates the two modalities to focus on parenting and | Informational |

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| | substance use disorders through dual approaches. Teams of three were created and each team provides services to a caseload of 12 families. Each team consists of two master level clinicians that provide parent-child related interventions, caregiver sobriety-related intervention and group therapy for parent and child. In addition a family support specialist support the clinical work and provides case management services. Families eligible for FBR includes a parent who meets criteria for substance use disorder and has used substances within 45 days of referral, A child under the age of 36 months for FBR 0 -3, or a child under the age of 72 months for FBR 3-6. The substance use disorder treatment component is based on an evidenced-based treatment model, "Reinforcement Based Treatment", and believes that positive reinforcement is the most effective means of producing behavior change. In addition, FBR utilizes an "Infant Mental Health" approach where the clinician will explore with the parent how early relationships with caregivers affects parenting now, will speak for the child to focus on child's feeling and needs, will help the parent feel her/his unique importance to their child, and will provide developmental guidance. FBR collects clinical measures on parental depression, stress and bonding with index child at intake and discharge. Statistically significant changes in the Total Scores on the Edinburgh Depression Scale, Parenting Stress Index-Short Form and Postpartum Bonding Questionnaire suggests that FBR is meeting its goal of improving parental well-being, which we believe benefits the parent-child relationship.<br><br>Elizabeth Duryea provided the following update regarding Connecticut Family Stability Pay for Success Project. The Family Stability Pay for Success (PFS) project is an innovative strategy to better serve families struggling with substance use by expanding an intensive, in-home treatment program to families presently involved with the Department of Children and Families. PFS is a public-private partnership which funds effective social services through a performance based contract, and by engaging private funders to cover the upfront costs to increase high impact programs and by establishing performance goals that allow government funders, and project partners to measure outcomes and track success over the long term. The Family Stability PFS Partners are:<br>• Government Agency: DCF<br>• Technical Assistance: Harvard Kennedy School of Government SIB Lab<br>• Intermediary: Social Finance, LLC<br>• Program: Family Based Recovery (FBR), Yale Child Study Center<br>• Evaluator: University of Connecticut Health Center<br>The Pay for Success Project Development Sequence is:<br>Phase 1<br>• Assessment<br>Phase 2<br>• Project Scope<br>• Referral and Enrollment<br>• Impact Analysis<br>Phase 3<br>• Evaluation Design<br>• Financial Structure<br>• Intermediary Contract<br>Phase 4<br>• Fundraising | |

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| | • Preparation for Launch<br><br>DCF FAMILY STABILITY PFS PROJECT SCOPE<br>• Project will fund 6 Family Based Recovery (FBR) teams for a total of 4 years of service delivery beginning in June 2016.<br>• Target population to be served: 500 families<br>• SCOPE OF FBR EXPANSION:<br>  • DCF Region 2 (New Haven): 2 Teams for 3-6<br>  • DCF Region 3 (Middletown, Norwich, Willimantic): 1 Team for 0-3, 1 Team for 3-6<br>  • DCF Region 5 (Danbury, Waterbury, Torrington): 1 Team for 0-3, 1 Team for 3-6<br>• OUTCOMES:<br>  • Reduced out-of-home placement<br>  • Reduced rates of re-referral<br>  • Reduced positive toxicology screenings<br>  • Sustained enrollment in FBR<br>  • If these are not achieved, the state does not pay.<br>• EVALUATION:<br>  • Project will utilize a Randomized Control Trial to measure the effect of FBR for 0-3 and 3-6 cohorts.<br>  • Evaluation will drive outcomes' payments.<br>  • Opportunity to expand FBR model to serve caregivers with children up to age 6.<br>Next Steps:<br>• February 2016: DCF and Social Finance execute contract.<br>• February – May 2016: Social Finance execute contracts with Yale and UCHC.<br>• May 2016: Social Finance secure funder commitments.<br>• June 2016: Launch of Family Stability PFS Services. | |
| • Medication Assisted Treatment Department of Corrections (DOC) | Dr. Kathleen Maurer provided an overview of medicated assisted therapy (MAT) in Corrections. MAT is medication utilized as an adjunct to other substance use disorder treatment such as cognitive behavioral therapy and other counseling. For opioid treatment several pharmaceuticals available include Methadone, Buprenorphine or Buprenorphine-naloxone combination, and Naltrexone. CT DOC addictions treatment includes in-house licensed addiction counselors, out-patient treatment, and residential therapeutic communities in 3 facilities, expanding to 4 in the new Community Re-integration Unit, methadone for pregnant females prior to delivery, and New Haven and Bridgeport Community Correctional Center (CCC) methadone programs. MAT in the New Haven CCC began in October 2013 and treated a total of 256 patients by the end of 2015; MAT in the Bridgeport CCC began in February 2015 and treated a total of 106 patients by the end of 2015. Medical services including responsibility for re-entry is place with an external opiate treatment provider. The Opiate Treatment Program (OTP) provider is a contracted vendor who provides program management and methadone treatment (in New Haven through APT Foundation and in Bridgeport through the Recovery of Network of Programs). Early New Haven CCC outcome data shows a significant improvement in re-engagement with community providers, significant improvement in time to re-engagement with community providers, and evidence of less disruptive behavior in the jail. A pre-trial diversion program in Bridgeport started in April 2015 with support from TASC and Public Welfare Foundation. RNP is the care provider and manages the program and places mental health/substance use disorder clinician in the court to assess referrals from bail | Informational |

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| | commissioners. The bail commissioner refers the offender to the clinician who determines if they appropriate for the program. The offender decides to participate or not, however, the judge makes the final decision. To date, 365 offenders have been screened/62 have been successfully diverted/20 were unsuccessful in treatment.<br>Lessons Learned:<br>• MAT needs to follow patient from jail to prison and through release and re-entry for continuity of care<br>• There are challenges to data collection across agencies<br>• There are several factors affecting the ability to expand on-site program capability such as, court schedules, sentencing, space, security needs, and resources<br>• Staff have articulated the many benefits they see in the program<br>• Only 2 incidents have occurred in the year<br>• Cap waiting list creates need for detox or induction<br>• Treatment model very effective for criminal justice population<br>• Induction is next and a critical component of program<br>Observations about MAT in Corrections<br>• Many challenges involved in initiating a new medial program in a safety and security oriented custodial environment<br>• Multiple state agencies (DOC, DMHAS, DPH) joined together to make this program work<br>• Data management is essential but represents a huge challenge<br>• Difficult to assess programs and outcomes without an in house research capability<br>• Corrections organizations need research capacity in house<br>Next Steps<br>• Expand to begin MAT Induction and increase MMT<br>• SAMHSA Offender Re-entry grant includes funding for MAT<br>• Integrate MAT maintenance an induction program with the Community Reintegration Center<br>• Pilot extended release naltrexone (Vivitrol) treatment for those in therapeutic community programs<br>• Expand New Haven and Bridgeport programs to include induction and expand capacity<br>• Expand to Hartford Correctional Center<br>• Provide naloxone to releasing patients with opioid substance use disorders and their families | |
| Other Business | Commissioner Delphin-Rittmon provided committee members with posters that list assessment and treatment facilities in Connecticut. | Noted |

NEXT MEETING*

June 7, 2016 – 10:00 a.m. to 12:00 p.m. (this meeting has been rescheduled for June 28, 2016 from 10:30 to 12:30. Location to be determined)

*An additional meeting has been scheduled for Monday, May 9, 2016 from 10:00 – 12:00

ADJOURNMENT

The March 1, 2016 meeting of the Alcohol and Drug Policy Council adjourned at 12:08 p.m.