ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, December 19, 2023
Video Conference Call Through TEAMS
10:00 a.m.

ATTENDANCE

Members/Designees: **Saud Anwar**, Senator; **Luiza Barnat,** Treatment Committee Representative; **Paulo Correa**, Carelon Behavioral Health; **Maria Coutant-Skinner**, McCall Center; **Vanessa Dorantes**, Commissioner, DCF; **Ines Eaton**, Criminal Justice Representative; **Katie Farrell**, Criminal Justice Chair; **Tammy Freeberg**, The Village for Families & Children; **Allison Fulton**, Prevention Subcommittee Co-chair; **Ingrid Gillespie**, Liberation Programs; **Claudio Gualtieri**, OPM; **William Halsey**, DSS; **Deborah Lake**, Prevention Committee Chair; **Barbara Lanza**, Criminal Justice Chair; **Lesley Mara**, Higher Education Designee; **Cristin McCarthy Vahey**, State Representative; **Pamela Mulready**, Recovery Committee Chair; **Nancy Navarretta**, Commissioner, DMHAS; **Tammy Nuccio**, State Representative; **Gerard O'Sullivan**, DOI; **Gary Roberge**, Judicial Designee; K**ris Robles**, DCF Designee; **Scott Szalkiewicz**, DCP Designee; **Colleen Violette**, DPH Designee; **Sandra Violette**, Criminal Justice Chair;

Visitors/Presenters: Bridget Aliaga; Samantha Allard; Allyson Nadeau; Ramona Anderson; Christy Knowles; Heather Clinton; Nicholas Cortes; David Fiellin; Gabriela Krainer; Julienne Giard; Francis Gregory; Colleen Harrington; Robert Heimer; Jennifer Kolakowski; David Kaplan; Kim Karanda; Kasandra Rowe; Kim Haugabook; Keri Lloyd; Karonesa Logan; Jennifer Lombardi; Michelene Longo; Chris McClure; Justin Mehl; Deidre Methe; Sara Moriarty; Mya Singh-Johal; Kevin Neary; Nicole Hampton, Shelly Nolan; Shauna Pagilinan; Erica Previti; Rebecca Petersen; Melanie Richard; Rudy Marconi, Sarju Shah; Diana Shaw; Melissa Sienna; Kelly Sinko; Sounthaly Thammavong; Ece Tek; Jeremy Wampler; Elsa Ward; Melissa Weimer

Recorder: Karen Urciuoli

The December 19, 2023 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 Commissioner Dorantes, DCF.

Topic	Discussion	Action
Co-Chair Welcome and Introduction	Commissioner Navarretta welcomed all in attendance, and reported that Commissioner Dorantes would be moving on to the private sector and thanked her for her service and dedication to this council and the many other collaboratives between DMHAS and DCF. Commissioner Dorantes thanked Commissioner Navarretta for her kind words.	Noted
Review and Approval of Minutes	The October 17, 2023 minutes were accepted as written.	Noted

OUD, Fatal ODs and Treatment in CT	Dr. Robert Heimer presented information from a paper that was published earlier this month in the journal, Drug and Alcohol Dependence, and is based on data from state agencies in CT.
	
	Background Overdose trends in CT mirror those in the US, but deaths are about 40% higher. We've seen a huge increase in overdose deaths as a whole across the country, amongst them, the increase in opioid involved deaths has increased from about 50 to about 75%. Opioid involved deaths in Connecticut between 2012 and 2020 have increased. The study focused on the year 2017 when they were able to get data from all the relevant state agencies.
	• Treatment for opioid use disorders did not keep pace with increases in fatalities. Methadone remained relatively stable. Buprenorphine increased somewhat. Non medication based treatment, whether short term detox or long term rehabilitation did not increased over time.
	• Treatment for opioid use disorders did not keep pace with increases in fatalities. CT was facing an increasing gap in the number of people who were dying and the number of people who were in treatment.
	• In 2016, in response to rising opioid OD rates, a CT Opioid Response (CORe) Plan was developed by Yale researchers at Governor Malloy's request following consultations with stakeholders statewide.
	• The six CORe Plan strategies were (and remain):
	  • Expand access to treatment with medications
	  • Reduce overdose risk, especially among those individuals at highest risk
		Informational – The full PowerPoint presentation can be found on the DMHAS ADPC webpage.

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	• Promote improved prescriber adherence to guidelines
	• Expand access to naloxone
	• Increase data sharing across relevant agencies and organizations to monitor and facilitate responses
	• Increase community understanding of opioid use disorder and its treatment to decrease stigma.
	Purpose
	• This study seeks to use administrative data from state agencies and combine it with data from other sources to determine the influence of exposure to different forms of treatment on subsequent opioid-involved accidental fatalities.
	• Use the findings to advise state officials and inform the general public about the relative effective of these treatments in preventing fatal overdoses.
	Study Design
	• Case-control study to determine risk of death following recent exposure to MOUD or non-MOUD treatment modalities.
	• Outcome – opioid-involved deaths reported to CT Office of the Chief Medical Examiner (OCME) in 2017
	• Cases – Exposure to medical treatments for OUD during the six months prior to death (July 1, 2016-December 31, 2017)
	• Controls – No treatment exposure
	Methods: Data Elements, Sources, and Estimates
	Data Source for Fatal Opioid Overdoses
	• CT Office of the Chief Medical Examiner reviews all accidental deaths, collects names and demographic data including date of birth, conducts site investigations, performs post-mortem toxicology, and assigns causality – accidental, suicide, or undetermined
	• All opioid-involved accidental deaths among CT residents from 2017 (N = 965) are included in this analysis
	Data Sources for Treatment Exposures
	• All individuals receiving methadone treatment at accredited opioid treatment programs in CT reported to the CT Dept. of Mental Health & Addiction Services (DMHAS), with demographic data including date of birth
	• All individual receiving non-MOUD treatment including out-patient, in-patient, and residential services at accredited treatment facilities in CT reported to DMHAS, with demographic data including date of birth
	• All individuals prescribed buprenorphine and filling prescriptions reported to the CT Prescription Monitoring & Reporting System (CPMRS) maintained by the CT Dept. of Consumer Protection (DCP)
	Determining Total Treatment Exposures
	• DMHAS provided the number of unique individuals receiving methadone treatment or non-MOUD treatment in 2017
	• Non-MOUD treatments in 2017 were categorized as short-term (aka detox) if ≤14 days and longer-term (aka rehab) if >14 days
	• DCP did not provide data on the number of unique individuals filling buprenorphine prescriptions
	Estimating Total Buprenorphine Exposures
	• DEA's ARCOS Drug Retail Summary Reports for total amount dispensed at CT pharmacies used to estimate number of individuals prescribed buprenorphine in 2017 – 56.87 kilograms
	• Assumptions to estimate number of patients treated:
	  • average dose = 20 mg/day
	  • average duration in treatment = four months
	  • annual dispensing per patient = 2.42 grams over 4 months
	• Estimated number of patients receiving buprenorphine: 23,500 in 2017
	Estimating Total Unexposed to Treatment
	• There is no roster or census of people with untreated OUD, so we used recent efforts to determine the proportion of	

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	people who are receiving no treatment exposure in 6 months
	• Applied two approaches to estimate this number
	  • Jones & McCance-Katz used NSDUH data to conclude that 34.5% sought any OUD treatment at any time.1 Thus, for our six-month window period, the estimate of individuals unexposed in 2017 = [(# in treatment over 6 month / 0.345) – # in treatment over 6 months]
	  • Keyes et al.2 used two multiplier methods to calculate the burden of OUD in the US at 6.7-7.6 million. For CT, the estimate = [7.15 million x 0.0108 (CT proportion of US population x 1.42 (relative rate of fatal ODs CT compared to the US)] - # in treatment over 6 months
	Results: Estimation of Incidence and Relative Risk
	All data can be found within the full PowerPoint presentation located on the DMHAS ADPC webpage.
	Conclusions
	• Exposure to methadone or buprenorphine in the prior 6 months was protective, even for those whose treatment ended before death.
	• Exposure to non-MOUD treatments does not reduce the risk on a fatal opioid overdose and may actually increase the risk.
	• Long-term non-MOUD treatments seem to be especially risky.
	Limitations
	• Assumptions are needed to estimate number of individuals exposed to buprenorphine and having no exposure.
	• Total number in treatment may be an overestimate if people receive multiple modalities in the 6-month window period.
	• Not all opioid-involved fatalities or treatment episodes are captured in state agency databases.
	• Data are from 2016-17. Needs to be repeated with more recent data and with cooperation from all relevant state agencies.
	• Deaths were matched to individuals in the DMHAS database who had received treatment for an OUD diagnosis. We excluded those who received treatment for any other SUD diagnosis. Approximately 90 individuals who had received treatment following other diagnoses also experienced a fatal opioid overdose within 6 months of treatment. Including these decedents would have non-MOUD treatments even riskier.
	• Incarceration may interfere with treatment and increase risk. We are working to find out if any decedents treated with methadone or buprenorphine had an incarceration episode that interrupted or ended their medication.
	Policy Implications
	• Results are consistent with existing data on the relative benefit of MOUD and heightened risk of non-MOUD treatment for people with OUD.
	  • A century of data on high relapse rates following all manner of abstinence-based approaches
	  • Nearly sixty years of evidence on the benefits on methadone to treat OUD
	  • Twenty years of data on the benefits of buprenorphine to treat OUD
	• Stigma against MOUD and restrictive regulations remain the greatest barriers to reducing opioid-involved fatalities.
	Policy Recommendations
	• Expand number of people receiving long-acting agonist medications
	  • Reduce burdens on providers and patients
	  • Increase take-home dose allowance
	  • Promote mobile prescribing and dispensing
	  • Activate efforts to reduce stigma directed at people who use drugs and at programs that provide medications
	• Clinical trials of short-acting agonist medications
	  • Hydromorphone has proven effective, especially for those failing treatment with long-acting agonists	

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	• Reduce funding for and increase restrictions on non-MOUD treatments
	  • "Meds not beds" as the funding priority as new revenue streams to support treatment become available
	  • Restrict non-MOUD treatment to adolescents and initial treatment episodes	

Opioid Settlement Advisory Committee (OSAC) Update	Chris McClure, DMHAS Chief of Staff provided the follow OSAC update
	Municipal Reporting Requirement
	• Under Public Act 23-92, the municipalities are to annually report to the Opioid Settlement Advisory Committee about proceeds received and expended.
	• The report was due on or before October 1, 2023. Because this was the first time through the process, we extended the deadlines and worked with partners to enhance participation.
	Summary of Municipal Reports
	• 166 Municipalities Submitted Reports
	• Of the reporting municipalities, just over $1 million has been allocated or spent of nearly $9.8 million of proceeds received.
	• Successes Reported:
	  • Collaboration between many towns and departments (police, fire, EMS, local health departments, human services and schools)
	  • Expansion of existing programs for continued success
	  • Identified short- and long-term projects that would have the most impact on their communities
	  • Provided Naloxone to First Responders
	  • Training and Education
	OSAC Public Input Portal
	• To ensure robust public involvement, OSAC opened a link to receive input from diverse stakeholders regarding recommendations for funding of initiatives to combat the opioid crisis that are evidence-based or a promising practice
	• The portal was open for 30 days between October 17 through November 17.
	• In that time, we received 132 recommendations. The OSAC Referral Subcommittee is currently reviewing those submissions.
	Opioid Settlement Advisory Committee Funding Recommendation
	• On November 14, OSAC approved its first funding recommendation; a $500,000 expansion for DPH's Needle and Exchange Program.
	• The additional $500,000 will support needed supplies for programs and other sites where services can be expanded in regions of the state where there are limited to no SSPs currently. This funding can support 4,000 additional SSP clients
	• The funding recommendation has been approved by OSAC, OPM, and the Attorney General's Office.
	Next Steps
	• Next OSAC meeting January 9, 2024, 10 am- 12 pm via TEAMS
	• OSAC Subcommittees continue meeting monthly
		Informational – The full PowerPoint presentation can be found on the DMHAS ADPC webpage.

Youth Recovery in CT	Pamela Mulready provided the following report: Background • A need was identified for teen and young adult specific recovery support in Connecticut • The CROSS (Connecticut Recovery Oriented Support System for Youth) Initiative was developed to address this need • The initiative was originally funded in 2017 by SAMHSA State Targeted Response to the Opioid Crisis (STR) funds and then by State Opioid Response (SOR) funds through the CT Department of Mental Health and Addiction Services (DMHAS) • DMHAS contracted with the CT Department of Children and Families (DCF) to develop and implement a statewide	Informational – The full PowerPoint presentation can be found on the DMHAS ADPC webpage.

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	substance use recovery support system specifically oriented to the needs of youth aged 16-24 years
	• DCF contracted with Wheeler through the Connecticut Clearinghouse for Prevention, Wellness, and Recovery to implement CROSS, which is now known as YouthRecoveryCT
	Goals and Process
	• Build a Statewide Youth Recovery Network of sites that facilitate:
	  • SMART Recovery meetings for Teens (ages 16-18) or Young Adults (ages 18-24)
	  • SMART Family & Friends meetings for caregivers, supportive peers, adults
	  • Alternative Peer Groups
	• Maintain, support, and grow the network to serve a diverse population of young people and families affected by substance use throughout the state
	• Non-profits, organizations, and institutions have received mini-grants to implement the program
	Collaboration and Networking
	• Over the past 5 years, 51 unique agencies, organizations, and institutions including behavioral health providers, community nonprofits, faith communities, high schools, colleges, and prisons have been within the YouthRecoveryCT network.
	• Grantees across the state have had the opportunity to meet monthly to network and receive support for the implementation of their SMART Recovery meetings, SMART Recovery Family and Friends meetings, and Alternative Peer Group Activities.
	• Ongoing support and education is available to group facilitators and program locations
	Our Model – SMART Recovery
	• YouthRecoveryCT uses SMART Recovery, the leading, evidence-informed approach to overcoming addictive behaviors and leading a balanced life. SMART is stigma-free and emphasizes self-empowerment.
	• SMART Recovery's international model incorporates materials from cognitive-behavioral therapy, rational emotive behavior therapy and motivational interviewing into a facilitated, mutual support meeting format.
	• SMART Recovery was created through the collaborative efforts of substance use disorder treatment professionals and peers in recovery.
	SMART Recovery's 4 Point Program
	• Build and maintain motivation.
	• Cope with urges.
	• Manage the thoughts, feelings, and behaviors.
	• Live a balance life
	Advantages Of SMART Recovery
	• Secular yet anyone is welcome to incorporate spirituality into their own recovery
	• Can be combined with any other recovery pathway, such as 12 Step meetings, clinical treatment, medication assisted recovery
	• Does not require anyone to label themselves or adhere to any specific recovery goal
	• Encourages peers to speak directly with one another, with the support of a trained facilitator
	• Is accessible due to being offered freely to participants as well as being available on virtual platforms and in a free app
	Family and Friends Groups
	• A SMART Recovery Family and Friends meetings are based on the tools of SMART Recovery and Community Reinforcement Approach & Family Training (CRAFT). Studies have shown that CRAFT results in a significantly higher rate of treatment entry for Loved Ones than Al-Anon or Johnson Intervention.
	• The wellbeing of the attendee is strongly emphasized. Tools based on cognitive therapy are taught to help participants	

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	manage their emotions. Additional tools focus on balance and self-care
	• Tools are shared for providing effective, non-confrontational support for a loved one who is using substances or engaging in harmful behaviors:
	  • Effective Communication Skills
	  • Boundary Setting
	  • Learning about the recovery process and dispelling myths
	Alternative Peer Group Activities
	• An opportunity to improve social skills in a sober environment while potentially making new friends
	• A way to structure one's time
	• Introduction to new hobbies or activities
	• May serve as an introduction to the recovery community
	Site Specific Implementation: Examples of Network Groups
	• A lunch time group at a high school
	• An intensive outpatient program offering a SMART meeting as an option to attend during a treatment day
	• A college inviting parents/guardians to attend a Family and Friends group based on their child's participation in SUD counseling (with permission from the student)
	• SMART Recovery meetings in 10 DOC facilities
	• The SMART Recovery national Young Adult meeting
	Site Specific Implementation: Examples of APGs
	• Yoga, Sports, Outdoor Activities
	• Board games, art and crafts
	• Cooking
	• Music production class and performance
	• Sober parties, events, outings
	Year Ending September 2023
	• Number Of Meetings Held: 921
	• Total Number Duplicated Participants: 8693
	• Total Number of New (Unduplicated) Participants: 2343
	*Numbers include all types of meetings and represent in-person, hybrid (in-person and online), and online meetings (including the National Young Adult meeting)
	Challenges
	• COVID 19
	• Staff turnover, competing priorities
	• Closed to the public meetings
	• Effective advertising
	• Transportation
	• Siloed agencies
	• Population specific challenges
	• Stigma
	Innovations In Progress
	• Reinvesting in committed programs
	• Increasing reach of SMART Recovery statewide network by add "all ages" groups	

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	• Adding national platform meetings • Increasing internal staffing to support community outreach efforts, additional meetings and APGs, and to increase SMART Recovery Facilitator training capacity • Website rebranding • High school specific offerings, in collaboration with Jordan Porco Foundation, in addition to SMART Recovery • Advertising directly to potential referral sources • Working with SMART Recovery national, The Phoenix, Toivo, HeyPeers • DMHAS workforce and Recovery Support Specialist Facilitator Training • Statewide Youth Recovery Needs Assessment • Working with the Connecticut Healthy Campus Initiative to reach college population • Opening the monthly network meetings to any interested professionals Feedback From Participants Out of 573 participants responses: • 88.1% shared they attend meetings "Because I find value in it" • 26.5% attend because "I am required" • 15% attend "to support a friend or loved one" Note: survey allowed multiple answers	
Sub-committee Reports		
• **Prevention, Screening and Early Intervention**	Deborah Lake provided the following update: The following recommendation was put forth for approval. Naloxone is a life-saving medication that can reverse an overdose from opioids when administered in time. As a life-saving medication, naloxone should be as readily available and as easily accessible as Automated External Defibrillator (AED) devices, auto-injectable devices that deliver the drug epinephrine (EpiPens), and other emergency medical supplies. This recommendation supports the convening of a workgroup of the Prevention Subcommittee to research, implement, and evaluate strategies to increase the availability of naloxone statewide as recommended by the ADPC Naloxone Workgroup. Action Steps: 1. Identify and recruit workgroup participants from various agencies and organizations-DMHAS, DPH, DCP, SDE, RBHAO, Wheeler, etc. 2. Investigate, pilot, and evaluate the effectiveness of placing naloxone vending machines and naloxboxes in various settings.	Appointed council members were asked to vote on this recommendation. *Recommendation was approved by appointed council members.
• **Recovery and Health Management**	Pamela Mulready provided the following update: • This committee met on November 9th and December 14th. They had presentations from Mobile Employment Services to hear about the work they are doing to engage people in recovery as well as gainful employment. They also received a presentation from the Prevention Regional Prioritization report and considered what that means for this subcommittee. They also receive regular OSAC updates in order to make appropriate recommendations. • This committee has a special populations work group that is talking about creating a website with various resources throughout the state more known and accessible to the general public. • The recovery friendly workgroup has completed a survey to be launched in January to campus recovery professionals to gather more information to create a recovery friendly toolkit for professionals.	Informational
• **Treatment**	Maria Coutant Skinner provided the following update: • This committee met on November 2nd and December 7th. • They reviewed the Core report. They had some general observations that were forward to the OSAC team. They wanted to be sure that there are youth and adolescence specific strategies with goals and tactics devoted to youth	Informational

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	specifically. They would also like to see a section for seniors with some treatment considerations for that population. They want to be sure this work is talked about, looked at and evaluated and assess through a culturally sensitive lens. They would also like to see that nontraditional services like alternative to pain management and the roles of faith-based communities are part of the report. They will have an extended meeting on January 25th at Rushford to go through those recommendations in order to balance urgency with thoughtful considerations of the proposals. • Maria thanked Commissioner Dorantes for the work she has done and for the thoughtful progressive way that she leads by making sure to take whole systems into account and that recovery policies had to do with addiction and were not punishing or shame based and were in the spirit of protecting children and whole families.	
• **Criminal Justice**	Barbara Lanza provided the following report: • This committee met in November and December. In November the group focused on the OSAC recommendations that they will be putting forth to the OSAC committee. In December they met with the Director of Addiction and Community Response Services from the Community Renewal Team. They were able to share the services that are offered in the Hartford for those who are reentering the Hartford Community from prison and discussed all of the services that are available to them. • The Department of Corrections is continuing to expand Suboxone, the rollout has expanded to Hartford and Bridgeport Correctional Centers. • The recovery coaches recommendation is on pause as this group is working in collaboration with DMHAS as they are mapping recovery coaches within the state. Once survey results are received, they will determine how they want to move forward. • This committee is getting ready to submit a recommendation for new training requirements for criminal justice professionals. Will tray to submit at next ADPC meeting.	Informational
Other Business		

NEXT MEETING – Tuesday, February 20, 2024 – Virtual

ADJOURNMENT – December 19, 2023 meeting of the Alcohol and Drug Policy Council adjourned at 12:00pm.