

ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, April 21, 2026
Video Conference Call Through TEAMS
10:00 a.m.

ATTENDANCE

Members/Designees: **Dr. Craig Allen**, Treatment Co-chair; **Luiza Barnat**, DMHAS Designee; **Brendan Burke**, Office of Child Advocate Designee; **Jacqueline Calayag**; Recovery Tri-Chair; **Paulo Correa**, Carelon; **Maria Countant Skinner**, Treatment Co-chair; **Courtney Dollar**, Co-Chair Recovery Committee; **Brian DeLude**, Tri-chair, Criminal Justice Committee; **Danielle Ebrahimi**, Criminal Justice Representative (DMHAS); **Katie Farrell**, Public Defender Representative; **Tammy Freeberg**, The Village for Families & Children; **Ingrid Gillespie**, Liberations; **Deborah Lake**, Prevention Committee Co-chair; **Abigail Lieberman**, Co-Chair Prevention Subcommittee; **Justin Mehl**, Recovery Committee Representative (DMHAS); **Nancy Navarretta**, Commissioner, DMHAS; **Gerard O'Sullivan**, DOI; **Gary Roberge**, Judicial Designee; **Amy Rodriguez**, Criminal Justice Representative (DCF); **Sarju Shah**, Prevention Representative (DMHAS); **Scott Szalkiewics**; DCP Designee; **Nicole Taylor**, DCF;

Visitors/Presenters: Sarah Messier-Smith, Elsa Ward, Kelly Sinko, Christy Knowles, Rayallen Bergman, Joshua Bernegger, Michael Blom, Christopher McClure, Robert Heimer, Liz Evans, Chandra Persaud, Michael Aiello, Nicole Hampton, Chantelle Archer, Karonesa Logan, Fiorigio Fetta, Jeanette Goyzueta, Jennifer Vinci, Rebecca Petersen, Melissa Morton, Ece Tek, Lauren Pisto, Morica Hutchison, Jennifer Buckley, Kathryn Hanly, Holly Hansen, Cameron Breen, Amy Bogert, Francis Gregory, Diana Shaw, Nidia Rosario, Catherine Sisco, Ana Gopoian, Karolina Wytrykowska, David Fiellin, Mel Maichack, Shelly Nolan, John Lally, Allyson Nadeau, David Kaplan

Recorder: Karen Urciuli

The April 21, 2026, 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 Dr. Nicole Taylor, DCF.

Topic	Discussion	Action
Co-Chair Welcome	Commissioner Navarretta welcomed everyone to the April meeting.	Noted
Review and Approval of Minutes	The February 17, 2026 minutes were approved as written.	Noted
OSAC Update	Sarah Messier-Smith, DMHAS Opioid Services Division provided the following report: Budget Update • Total amount received in OSAC fund to date: \$185,886,363 • Total amount of funding approved by OSAC to date: \$118,961,413 • Continuation funding requests approved by OSAC on 4/7/26: ▪ Naloxone Saturation Continuation: \$2,323,200 annually 3 for years= \$6,969,600 ▪ LiveLOUD Public Awareness & Education Continuation: \$300,000 for 1 year • Estimated cost of continuation of current projects through FY 29: \$140,844,034 • Estimated cost of continuation of current projects through FY 30: \$169,209,632 Public Input on Funding Initiatives • Updated report published 3/3/26 • As of 2/22/2026, a total of 200 recommendations were received since October 2023 • Each of these recommendations were reviewed by the OSAC Referral Subcommittee and/or Subject Matter Experts and categorized as follows: ▪ 34 recommendations were at least partially utilized for proposal development and approved by OSAC for implementation ▪ 74 recommendations may be considered for future project development. It cannot be determined if or when associated projects will move forward. This designation is not a promise of project approval or funding. ▪ 92 recommendations were not recommended to move forward for additional consideration 2026 OSAC Meeting Schedule	Informational

Topic	Discussion	Action
	- July 14th from 10:00-12:00 - October 13th from 10:00-12:00 CT Opioid Settlement Dashboard - Dashboard available at: https://portal.ct.gov/cosac	
ODU Public Health Crisis Goal	Kelly Sinko, Chief of Policy and Governmental Affairs, DMHAS, Luiza Barnat, Opioid Services Director, DMHAS, and Chandra Persaud, Legislative Program Manager, DMHAS provided the following report: OVERVIEW Overview and Background - PA 25-168 declared opioid use disorder a “public health crisis” until goals defined by an ADPC workgroup are met. - Unlike the federal “public health emergency” designation, under state law, “public health crisis” has no definition, does not include funding, and does not waive or expedite any regulations to help address the “crisis”. - Goals must be reported to the Public Health Committee by July 1, 2026. Statutory Language §§174-175 of PA 25-168 (HB 7287) Sec. 174. (NEW) (Effective from passage): It is hereby declared that opioid use disorder constitutes a public health crisis in this state and will continue to constitute a public health crisis until each goal reported by the Connecticut Alcohol and Drug Policy Council pursuant to subsection (f) of section 17a-667a of the general statutes is attained. Sec. 175. Section 17a-667a of the general statutes is amended by adding subsection (f) as follows (Effective from passage): (NEW) (f) The Connecticut Alcohol and Drug Policy Council shall convene a working group to establish one or more goals for the state to achieve in its efforts to combat the prevalence of opioid use disorder in the state. Not later than July 1, 2026, the council shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding each goal established by the working group. METHODOLOGY & OBSERVATIONS Methodology - OCME did not start tracking opioids specifically in accidental intoxication deaths until 2013. To obtain an approximate number for 2004 through 2013, DMHAS calculated the average percent of deaths with opioids from 2013 to 2024 (91%) and applied this to the total number of accidental intoxication deaths from 2004 to 2014. Observations - While opioid-involved deaths in Connecticut fluctuated between 2004 and 2010 without sustained growth, beginning in 2013 the state experienced a marked and persistent acceleration. This period represents a clear departure from prior trends. PRIMARY GOAL Recommendation for Calculation - Baseline: Average of 2004-2010 – 276 deaths a year - Rationale: The 2004–2010 period represents the last sustained era of relative stability, prior to the onset of abnormal growth in opioid-involved mortality. Using this period as a baseline reflects conditions before the crisis-driven acceleration began - Current mortality remains multiple times higher than baseline levels Primary Goal - Reduce opioid-involved deaths to the pre-crisis baseline (276 deaths a year) and sustain that level for a minimum of five consecutive years. - By reversing the post-2011 acceleration in opioid-involved mortality, the state will work toward reducing annual opioid-involved deaths to the average level observed during the 2004–2010 pre-crisis period and maintaining that level, or	Informational – The full PowerPoint presentation that includes data can be found on the DMHAS ADPC webpage.

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	lower, for at least five consecutive years. Why Does Maintenance Matter? • The goal emphasizes not only reaching the baseline but sustaining it over multiple years • Short-term declines in opioid-involved deaths can result from temporary factors, including fluctuations in the drug supply or reporting variability • Sustained maintenance of baseline levels over a defined period indicates that underlying systems are functioning effectively and durably • Examples of underlying systems: prevention, treatment, harm reduction, and recovery supports Why Five Years? • Provides sufficient time to distinguish lasting progress from short-term variation • Also aligns with planning and evaluation cycles commonly used in public health and allows for assessment across multiple cohorts, funding cycles, and policy implementations The use of a pre-crisis baseline as a goal does not imply that any level of opioid-involved death is acceptable, nor does it diminish the importance of continued prevention efforts beyond that point. NEXT STEPS Stakeholder Feedback • Tested by statistical/data experts in the field • Review of goal from the Co-Chairs of ADPC subcommittees • Review from the Alcohol and Drug Policy Council (today) • Approval by OPM/OTG in submitted report • Report is due July 1, 2026 • Aim to get to OPM beginning of June for review, edits, and approval Input/Feedback • What questions do you have about the presented goal or the methodology? • What context would be helpful to add to a final report? Example: state by state comparison; overview of current resources (triennial report) • Is there any other feedback you want considered?	
CLEAR Presentation	Lauren Pristo, McCall Behavioral Health Network, Chief Berneggar, Watertown Police Department and Christy Knowles, DMHAS Opioid Services Division provided the following report: CLEAR is a Sequential Intercept Model that provides different opportunities to engage somebody through the criminal justice system. CLEAR aims to address Intercept 0 and -1. • Intercept 0 – Community Services • Intercept 1 – Law Enforcement • Intercept 2 – Initial Detention/Initial Court Hearings • Intercept 3 – Jails/Courts • Intercept 4 – Reentry • Intercept 5 – Community Corrections Deflection vs Diversion • Deflection programs do not result in arrest and typically do not have criminal justice involvement beyond contact with officers in the field. Oftentimes an individual has not committed a criminal offense or has committed a lower-level offense, and an officer has no intention of arrest. Individuals voluntarily work with deflection team members to access treatment or other services. In deflection, there are no penalties for not engaging in a treatment service or completing a program.	Informational - The full PowerPoint that includes data can be found on the DMHAS ADPC webpage.

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	• Diversion refers to approaches where potential clients are contracted during enforcement activities, where there is a potential for arrest. Some diversion programs include a formal arrest, and booking, while others may occur pre-arrest. Ultimately, treatment initiation and compliance are court-ordered, and participants must complete the required service/program to have their charges dismissed. Foundations of the Co-response Model • Behavioral Health/Public Health leads • MOU established between Behavioral Health agency and Law Enforcement, as well as other participating agencies for each community • Police and partners trained in Deflection: 2-day Post accredited Deflection Academy • Assessment, to determine facilitators of success and future growth points for the deflection initiative Key Components of CLEAR – FY 2021 Collaboration between behavioral health and law enforcement • Building deflection, referral, and co-response • Community Engagement • Outreach • Community training • Overdose prevention strategies • Mobile Medication for Opioid Use Disorder • Ongoing one-on-one support for people with an SUD • Family Recovery Coaching Community and Law Enforcement for Addiction Recovery (CLEAR) • Funded through statewide BJA COSSUP Grant in FY21 • Supported by Department of Mental Health and Addiction Services (DMHAS) • Original pilot sites were selected to represent a diverse set of communities • Watertown • Winsted • Torrington • Greenwich • Norwalk • Stamford • Bridgeport Behavioral Health Partners • DMHAS serves as lead in COSSUP application and is involved in weekly implementation meetings and monthly statewide meetings • McCall Behavioral Health Network leads Region 5 • Liberation Programs, Inc. leads Region 1 • Both organizations are Mental Health and substance use disorder treatment providers with a full continuum of care • Serve as regional leaders for the CLEAR program and employ the CLEAR behavioral health teams CLEAR Roles Community Engagement Specialists • Responsible for ongoing follow up with referred individual	

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	• Provide a wide range of supports, including overdose and unintentional injury prevention, wellness planning, education, peer support, and connections to care • Engagements can be in person or by phone, as directed by the program participant • Provide community outreach, random outreach, and community training to raise awareness Family Recovery Coaches • Work with family members and loved ones • Support families on their own, individual journey • Provide community outreach and training to raise awareness and educate communities and families CLEAR Trained Officers • Any officer may make referrals of individuals with any substance use disorder (alcohol or drugs) • 24-48 hours after an incident, CLEAR trained officers conduct a warm hand off with community engagement specialists. This includes reviewing background and safety information and making the introduction. Response Mechanics • Police partners refer individuals through electronic referral form, integrated into behavioral health data system (Cordata) for one way push • Co-response between a deflection trained officer and a CLEAR outreach specialist within 24-36 hours • Ongoing engagement based on participants identified goals by behavioral health team • Data tracked via Cordata system with built in tools for evaluation component • May be joined by other community partners based on nature of response (i.e. Family Supports / Grief Supports / Hospitals / Mobile Crisis). Creating a Culture of Change • Police – mechanism for transforming policing culture away from viewing people who use drugs and other individuals impacted by social determinants of health and systems of oppression through criminality and instead through their humanity • Agencies – As we broaden access to overdose prevention strategies as an approach, opens up spaces for people in our systems who have also been traumatized, to be more open, and for transformation and healing • Community – We see among people who use drugs an openness and receptiveness based on this approach Police Perspectives – from Officer Bernegger • The Watertown Police Department started CLEAR in 2020. Law enforcement prior to working under the CLEAR model had very limited options in dealing with substance use disorder in their community. When officers experienced somebody who was at risk or somebody who overdosed there were only three options that they had. One was to take them into protective custody and send them to the hospital for an evaluation. Two was to make an arrest, and the third option was simply to walk away from the situation and do absolutely nothing. Having officers conduct that warm handoff is not only changing the culture in their department, but the community benefit that their department is receiving back is enormous. Individuals from the community are starting to believe that the officers really care. Officers feel more attached to the Community and feel they're doing something good. DATA • CLEAR's care management data shows that CLEAR is very effective in engaging clients who are referred to the program and is providing ongoing support (3+ visits) to nearly half of clients who engage with the teams. • These referrals include street engagements and outreach, where you will notice a strong presence of this aspect in communities like Bridgeport where law enforcement is not yet involved in deflection referrals. • Treatment Initiation is easier for teams to document than connection to support services, which makes Treatment Initiation Rates appear to be higher.	

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	Key Takeaways from our 2021 COSSUP Evaluation data • CLEAR's engagement rates are higher than those for similar programs (30-40%). • In general, CLEAR sites are meeting their goal of providing ongoing support to clients. • Many clients receive more than one referral, and some have received as many as 15+ referrals for different services. • Positive change in law enforcement culture and community collaboration has increased as a result of CLEAR. • Overall decreases in overdose rates in CLEAR communities. Statewide Perspective and Next Steps • Awarded a 2nd COSSUP Grant in 2024 with the following expansion goals: • Expanded collaboration with additional first responder agencies, hospitals, and other partners • Addition of re-entry services for people returning to the community with a substance use disorder • York • Carl Robinson • Hartford • Bridgeport • Pilot "Handle With Care" • Expanding use of Family Navigators • Drug Checking Specialists • Facilitate statewide structure for additional communities to onboard	
Drug Checking	Cameron Breen, Liberation Programs Inc., and Liz Evans, Liberation Programs Inc. provided the following report: The Overdose Crisis in Connecticut • Fatal Overdose Deaths in Connecticut are declining. However, there are still thousands of non-fatal overdoses each year. 2020 - 1374 2021 - 1530 2022 - 1464 2023 - 1337 2024 - 986 2025 – 835 Current research points to: • Drug supply changes - likely affecting both overdose frequency and lethality. • Naloxone and Harm Reduction Expansion - Includes drug checking - Reducing the chance that an overdose becomes fatal. • Behavioral adaptation –Taking Test shots, not using alone - has likely improved chances of survival. • Treatment access - improved access has likely helped some groups, though probably unevenly across demographics. Highest Overdose Risk: Marginalized Populations Across epidemiology, public health, and addiction research, the strongest predictors of overdose mortality include: Structural and socioeconomic factors • Poverty and low income • Unstable housing or homelessness • Neighborhood deprivation • Unemployment and low education • Lack of healthcare access Social marginalization	Informational - The full PowerPoint that includes data can be found on the DMHAS ADPC webpage.

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	• Criminal justice involvement • Racialized structural inequality • Medicaid dependence or uninsured status Institutional transitions • Release from incarceration • Discharge from treatment or hospitalization • Eviction or housing loss Researchers increasingly describe overdose as a “risk environment” phenomenon, meaning social structures shape exposure to drug harms. DRUG CHECKING 101 • 5 Senses - Touch, Sight, Hearing, Taste, Smell • Immunoassay Test Strips - FTS, XTS, BTS, NTS, MTS • Fentanyl, Xylazine, Benzodiazepine, Nitazene, and Medetomidine • FTIR - Fourier Transfer Infrared Spectroscopy • Raman/Ion Mobile Spectroscopy • Gas Chromatography Mass Spectrometer [GCMS] & Liquid Chromatography-Quadruple Time of Flight [LC-QTOF] Using FTIR in Harm Reduction Programs People who use drugs want to determine the actual identity of the substance they intend to consume • Help prevent harms associated with consuming unknown substance We have an unstable drug supply • Iron Law of Prohibition Drug Checking and Community Engagement • CLEAR uses drug checking as a tool to build rapport, foster connections, and create a space that reduces overdose risk. • To make better informed decisions around substance use and mitigate risk of overdose or other complications due to a volatile drug supply. • Creating an environment that fosters deep connections with our community members. FTIRs in our Area In Connecticut there are 5 active drug checking programs that use FTIR spectrometers. • Bridgeport – Liberation • Hartford - CTHRA • New Haven - Yale • New London - AFL • Torrington – McCall In New England there are 15 - 20 active drug checking programs that use FTIR spectrometers. • Connecticut • Massachusetts • Maine • New York • Rhode Island • Vermont Drug Checking Data 2025 What Drug Checking Shows (Bridgeport & Statewide)	

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	- Fentanyl levels dropped below FTIR detection early 2025 → still positive on strips (which detect lower quantities). - Fentanyl levels moving back towards “normal” quantities since late May → overdose risk rising. - Other substances detected in the supply: medetomidine (veterinary tranquilizer), benzodiazepines, BTMPS. - Only 2 of 109 Fairfield County opioid samples contained BTMPS Statewide spike (May–June 2025): 61 suspected fatal overdoses (May 16–Jun 6). 44 EMS overdose calls on June 2 (highest since Jul 2024). - Lab: rising fentanyl levels + sedatives mixed in. What Drug Checking Shows (Fairfield County) – - In 2025, 109 illicit opioid samples were tested. - Many results from the CT Public Health Laboratory’s LC-QTOF Machine are still pending. 49.5% (54/109) tested positive for xylazine via test strips, FTIR, and LC-QTOF at CT Public Health Lab. - Common cutting agents found include mannitol (102), caffeine (58), procaine (21), paracetamol (14), and phenacetin, per FTIR analysis. Medetomidine → extreme sedation, hallucinations, slowed healing; test strips in use. Nitazenes → a group of synthetic opioids with potencies that vary widely—some weaker, some similar, and some significantly stronger than fentanyl. Fairfield County 2025 total samples (n=192): 10% of opioids (n=192) contained medetomidine 2% of opioids (n=192) contained nitazenes 10% of opioids (n=192) contained benzodiazepines 2024: no medetomidine or nitazenes detected Action Steps to Share with Participants: - Do not use alone → Safe Spot Hotline: 1-800-972-0590 and start with a small test dose. - Carry naloxone and practice rescue breathing. - Encourage drug checking before use.	
Sub-committee Reports		
Criminal Justice	Brian DeLude provided the following update: - Had a presentation from Doctor Sandra Springer from Yale. She talked about bringing healthcare services to the community in Waterbury, Hartford and Norwich. They have a van that goes out and is looking at holistic healthcare, there is also some pharmacy opportunities within that van as well. - Discussed Kratom being banned and whether that may have an impact on the criminal justice system and what we may need to look out for. - Had a great presentation from Carrie Roy from DCF. They’re moving forward with a program of peer support for ages 14 to 17 and it provides a very important piece to youth about just ensuring that individuals look to engage in treatment or provide encouragement, practical help guidance to helping them through the system, and helping them to understand that recovery is achievable.	Informational
Recovery and Health Management	Nicole Hampton provided the following update: - Had Cameron from Liberations present on drug checking surveillance, a highlight they took away was the stash ID, the public platform that shares anonymous results, trends and alerts. They’re going to be putting the stash ID in safe spot. Cards that will be added into the opiate overdose rescue kits that are distributed through the RBHAOs. - Discussed Recovery Friendly Campuses – the toolkit is in the final stages with strong positive feedback from their campus partners. They’re working towards integration with the Recovery Friendly Connecticut framework that focuses	Informational

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	on supportive recovery, ready campus environments statewide. - Discussed the safety apps, several previously used apps are no longer active or have staff shortage, including a Never Use Alone phone line that's fielding calls to the Safe Spot app. Since they have a staff shortage, the Brave app has retired and the recommendation is to direct individuals to the Safe Spot app, the current active resource for overdose prevention support that is Connecticut funded and has a robust training and organizational structure. - Had a Kratom presentation from Jana Wu from Mountainside Treatment Center. She discussed insurance gap as a major barrier where most insurance plans do not cover Kratom as a stand-alone diagnosis, which creates a huge barrier for individuals seeking access to care. She discussed the whole person recovery approach with emphasis on clinical care and recovery support, addressing physical dependence on the underlying emotional behavioral factors and peer and community support, which is so critical. The Mountain Side offers a free virtual kratom support group every Tuesday night from 7:00 to 8:00. They have participation from across the country. There is a need for increased education for families, providers and communities. The key take away from her presentation was Recovery is possible, but it requires awareness, access to support and continued system development. - Had a presentation on peer support as a billable service, which will be an ongoing discussion. The current focus is defining the services and standards.,. There's support from some stakeholders to move this forward as a way to expand access and strengthen the recovery workforce. - The language matters document - final revisions are in the works and will be reviewed at their next subcommittee meeting. The document will be shared with this council once finalized.	
Treatment	Maria Coutant Skinner and Dr. Allen provided the following update: - Senate Bill 195 is an act concerning prevention of accidental overdose deaths and improving access to treatment and recovery services for SUD. This committee has talked a lot about the efficacy of that work and that level of intervention and individuals in the meeting were supportive. - Peers as billable services - they are vital members of our interdisciplinary teams. This committee is looking at that from a parity lens, knowing that community health workers are hopefully right at the precipice of being billable in mental health and addiction spaces, our opinion is there needs to be people with lived experience giving credibility to their work and as well, as sustainability. - Medicaid Rates - The legislature approved additional dollars, hoping that behavioral health services are a top priority for that as well as some of the fees for labs that we are all dependent on in the clinical space. - Senate Bill 365 proposes establishing a bridge program for emergency treatment and recovery navigation for people with opioid use disorder. Emergency department-based buprenorphine induction is supported, requires naloxone and an active referral, and builds up a statewide bridge system so people can go from crisis to treatment. These are services that are implemented in different parts of the country, and there's evidence showing their efficacy. - Luiza Barnat was recently on television talking about naloxone distribution rates within the state, and how state and municipal police departments and emergency services are partnering to help distribute naloxone and providing access to harm reduction kits. - Discussed Kratom and experiences in treating people that were using kratom and having difficulties with it or withdrawing from it. With the passing of the law, providers are anticipating a potential influx of people looking for treatment or people who are suffering from withdrawal symptoms who may or may not know about the availability of treatment. Sarah had called several treatment centers and had mixed results as to whether they addressed kratom withdrawal or kratom use disorder. - At the request of OSAC, currently looking at opportunities for the neurodivergent population. It's a challenge to find systems that are treating the neurodivergent population. One of the populations that seems to fit that model is acquired brain injuries, a population that is seen across the state probably much more often than we are aware of. There are many people in our treatment facilities who have the morbidity that comes from brain injuries and they respond	Informational

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	differently to interventions and treatments. Doreen Brogan from DMHAS and Devin Bream, who works with acquired brain injury and substance use disorder, provided a presentation which was really helpful in thinking about the different strategies that can be used for patients who have these often invisible or hidden problems. Talked about the benefit of having a presentation for the full council on acquired brain injury and substance use disorders. • The MOUD survey with Jack Lew is getting responses from physicians across the state. He's pushing for responses from 100 physicians. • The SBIRT policy work group is going to be meeting again this month, will have more for this council around some of the barriers that are seen and implementing SBIRT practice standards.	
• Prevention, Screening and Early Intervention	Deborah Lake provided the following update: • Continue to receive OSAC updates. • Discussed Safe Spot at length. • Received a presentation from Sheila Ramos and Gia Montalone on the SEPI Connecticut work and reviewed the CAPTA and the CARA legislative acts that guide their work. • Had a presentation from DCP around Kratom and the work that is being done, and also around some of the newer policies and legislation regarding ENDS (electronic nicotine), the vinyl stickers that now need to be posted that say cannabis is not being sold at various locations. Also discussed compliance checks. • Briefly discussed some of the changes to the concession permits for being able to sell canned cocktails with no more than 6% APV. • Received an update from the Recovery Friendly work group, they are making progress on their new website. • The cannabis work group has been working hard to identify a new vendor for the Be in the Know campaign. • Had a discussion and information session around AI and mental health and how we can support young people not turning to ChatGPT for their mental health, but actually reaching out to parents and caregivers or trusted adults in their school system to keep them safe. • Heard from Vanessa Sinclair and her team around some of the different projects that they're working on, Shobha gave a very good presentation on all of the current data and what we're seeing with the various substances. • The 2026 Prevention Summit will be held on September 9th, in Hartford at the Yard Goat Stadium. Proposals for speakers are currently being accepted. If anyone's interested in participating as a speaker, proposals are due May 8th. • The Future Prevention Leaders Conference will be held on June 26th. If anyone's interested in speaking to youth, please reach out to Deborah Lake. If you know of any youth you would like to participate, it will be held at Goodwin University.	Informational
Other Business		

NEXT MEETING – Tuesday, June 16, 2026 – Virtual

ADJOURNMENT – April 21, 2026 meeting of the Alcohol and Drug Policy Council adjourned at 11:45am.