CT ALCOHOL AND DRUG POLICY COUNCIL OVERVIEW: *PRESENTATION TO THE BEHAVIORAL HEALTH PARTNERSHIP OVERSIGHT COMMITTEE*

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CT SA Treatment Admissions

- Admissions for heroin use have been steadily increasing since 2011 after a five-year decline and has replaced alcohol as the primary drug reported at admission to *substance abuse treatment programs*
- In FY16 and 17, heroin and other opioids accounted for 41% of all *substance abuse treatment admissions*

Connecticut Accidental Drug Intoxication Deaths
Office of the Chief Medical Examiner

	2012	2013	2014	2015	2016	2017 (Jan to June)	2017 (Projected Year)
Accidental Intoxication Deaths*	357	495	568	729	**917**	538	**1076**
-Heroin, Morphine, and/or Codeine detected	195	286	349	446	**541**	276	**552**
-Heroin in any death	174	258	327	417	**508**	258	**516**
-Heroin + Fentanyl	1	9	37	110	**279**	177	**354**
-Heroin + Cocaine	50	69	73	107	**153**	94	**188**
-Morphine/Opioid/Codeine NOS	21	28	22	29	**33**	18	**36**
-Cocaine in any death	105	147	126	177	**274**	171	**342**
-Oxycodone in any death	71	75	107	95	**110**	41	**82**
-Methadone in any death	33	48	51	71	**84**	50	**100**
-Hydrocodone in any death	15	19	15	20	**20**	9	**18**
-Fentanyl in any death	14	37	75	189	**483**	323	**646**
-Fentanyl + Cocaine	2	16	14	42	**143**	96	**192**
-Fentanyl + Prescription Opioid	4	7	14	23	**72**	37	**74**
-Fentanyl + Heroin	1	9	37	110	**279**	177	**354**
-Fentanyl/Opioid Analogues**						57	
-Any Opioid + Benzodiazepine	41	60	140	221	**232**	127	**254**
-Hydromorphone	1	0	12	17	**22**	13	**26**
-Amphetamine/Methamphetamine	7	5	11	20	**19**	18	**36**
-MDMA	0	0	2	1	**1**	2	**4**

*Some deaths had combinations of drugs; pure ethanol intoxications are not included.
** These include Acetyl Fentanyl, Furanyl Fentanyl, Carfentanil, Fluorobutyryl Fentanyl, Butyryl Fentanyl, and U47700,
NOS, not otherwise specified
Updated 8/30/17

What has been CT's response?

- Legislation
- The Alcohol & Drug Policy Council
- Governor Malloy's CORE Initiative
- Federal grants
- Other targeted strategies

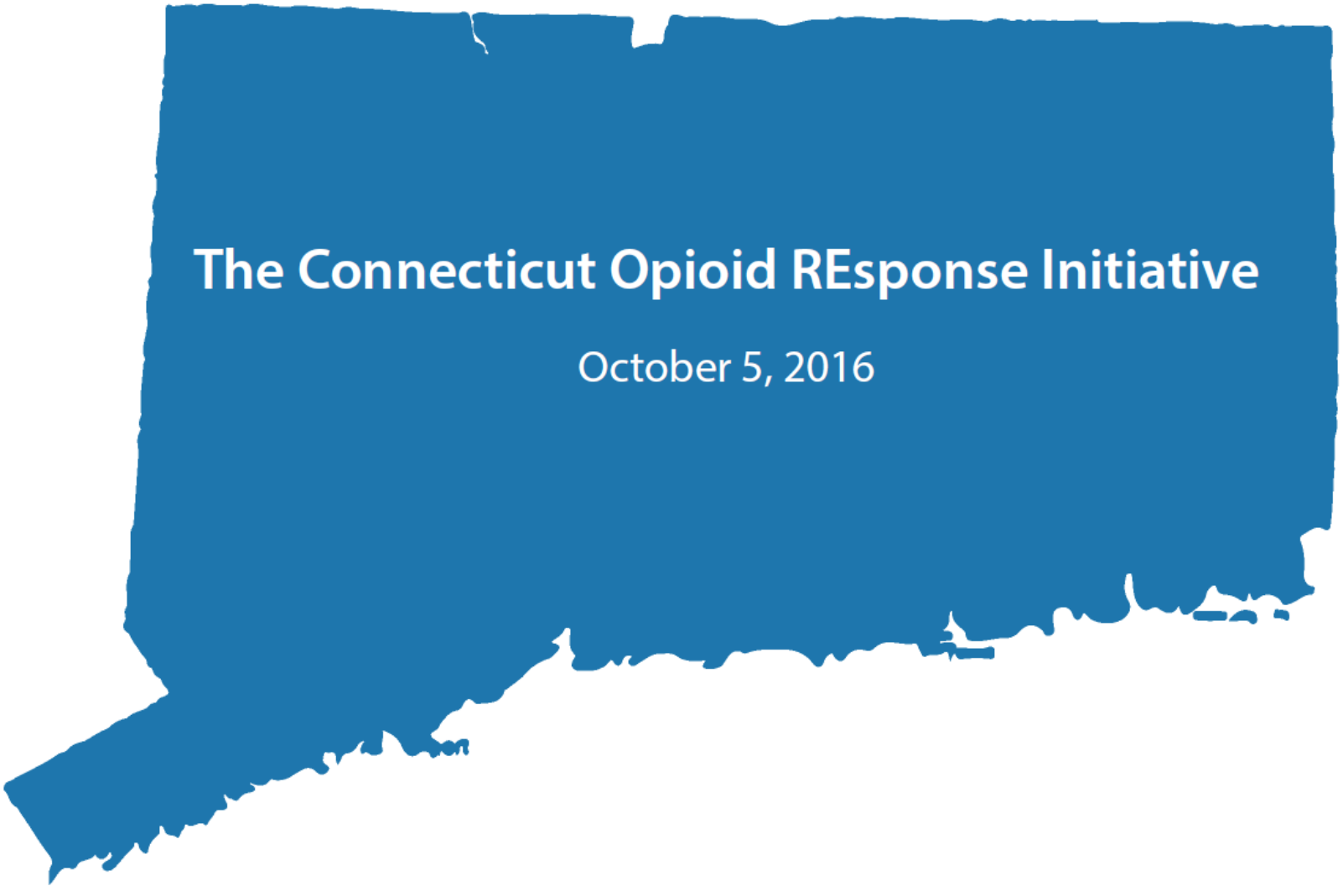
2016 Narcan and prescriber-related law (PA 16-43)

- Places a 7 day limit on opioid prescriptions for minors and adults at 1st outpatient visit (exceptions allowed)
- Requires veterinarians to submit controlled substance prescription information into the PDMP
- Prohibits insurers from requiring pre-authorizations for Narcan

2017 Governor's Opioid Bill: An Act Preventing Opioid Diversion and Abuse

(PA 17-131) These are just the highlights:

- DCP can share PDMP data with other state agencies
- As of 1/18, requires controlled substance prescriptions to be electronically transmitted from the prescriber to the pharmacy (exceptions allowed)
- Allows patients to complete a "Non-Opioid Directive" that must be filed with the prescriber
- The 2016 7 day opioid prescription limit for minors was reduced to 5 days
- Requires the CT Alcohol and Drug policy Council to:
  1. Develop and post an opioid "Fact Sheet"
  2. Investigate the possibility of a media campaign, including Public Service Announcements, to address an array of opioid issues
  3. Investigate the feasibility of establishing a single source of information concerning the availability of detox and treatment beds and slots
  4. Create a workgroup to review programs created by police departments that refer to people to treatment to see what's working and what's not
- Requires insurance companies to cover inpatient detox
- Requires each municipality to have at least 1 EMS provider to be equipped with and trained on the use of Narcan



The Connecticut Opioid REsponse Initiative

October 5, 2016

CT Opioid REsponse Initiative (CORE)

Governor Malloy engaged the Connecticut Opioid Response (CORE) team to supplement and support the work of the ADPC by creating a focused set of tactics and methods for *immediate deployment* in order to have a *rapid impact* on the number of opioid overdose deaths in Connecticut. He asked the CORE team to focus on evidence-based strategies with measurable and achievable outcomes.

CORE Recommendations
1. Increase access to treatment, consistent with national guidelines, with methadone and buprenorphine
2. Reduce overdose risk, especially among those individuals at highest risk
3. Increase adherence to opioid prescribing guidelines among providers, especially those providing prescriptions associated with an increased risk of overdose and death
4. Increase access to and track use of naloxone
5. Increase data sharing across relevant agencies and organizations to monitor and facilitate responses, including rapid responses to “outbreaks” of overdoses and other opioid-related (e.g. HIV or HCV) events.
6. Increase community understanding of the scale of opioid use disorder, the nature of the disorder, and the most effective and evidence-based responses to promote treatment uptake and decrease stigma.

CT Alcohol and Drug Policy Council

- legislatively mandated (1997; rev. 2005)
- co-chaired by the DMHAS and DCF Commissioners
- charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens -- across the lifespan and from all regions of the state
- representatives from all three branches of State government *(Executive, Judicial, Legislative)*
- individuals in recovery and family members
- private service providers
- Prevention, treatment, recovery and criminal justice sub-committees
- DMHAS website has schedule and other information

ADPC: Legislation

2005 Connecticut Code - Sec. 17a-667. Connecticut Alcohol and Drug Policy Council.

Sec. 17a-667. Connecticut Alcohol and Drug Policy Council. (a) There is established a Connecticut Alcohol and Drug Policy Council which shall be within the Office of Policy and Management for administrative purposes only.

(b) The council shall consist of the following members: (1) The Secretary of the Office of Policy and Management, or the secretary's designee; (2) the Commissioners of Children and Families, Consumer Protection, Correction, Education, Higher Education, Mental Health and Addiction Services, Motor Vehicles, Public Health, Public Safety, Social Services and Transportation and the Insurance Commissioner, or their designees; (3) the Chief Court Administrator, or the Chief Court Administrator's designee; (4) the chairperson of the Board of Pardons and Paroles, or the chairperson's designee; (5) the Chief State's Attorney, or the Chief State's Attorney's designee; (6) the Chief Public Defender, or the Chief Public Defender's designee; and (7) the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, criminal justice and appropriations, or their designees. The Commissioner of Mental Health and Addiction Services and the Commissioner of Children and Families shall be cochairpersons of the council. The Office of Policy and Management shall, within available appropriations, provide staff for the council.

(c) The council shall review policies and practices of individual agencies and the Judicial Department concerning substance abuse treatment programs, substance abuse prevention services, the referral of persons to such programs and services, and criminal justice sanctions and programs and shall develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions. On or before January fifteenth of each year, the council shall submit a report to the Governor and the General Assembly that evaluates the plan and recommends any proposed changes thereto. In the report submitted on or before January 15, 1998, the council shall report on the progress made by state agencies in implementing the recommendations of its predecessor, the Connecticut Alcohol and Drug Policy Council established by Executive Order Number 11A, set forth in its initial report dated February 25, 1997.

(P.A. 97-248, S. 3, 12; P.A. 98-250, S. 35, 39; June Sp. Sess. P.A. 99-2, S. 35, 72; P.A. 00-27, S. 6, 24; 00-104; P.A. 04-234, S. 2.)

History: P.A. 97-248 effective July 1, 1997; P.A. 98-250 added Commissioners of Consumer Protection, Motor Vehicles and Transportation to the council, effective July 1, 1998; June Sp. Sess. P.A. 99-2 amended Subsec. (b)(7) by adding "and ranking

http://www.ct.gov/dmhas/cwp/view.asp?q=334676

DMHAS: Alcohol and Drug ...

Substance Use - Home | Suggested Sites | Web Slice Gallery | DCF SUHomepage

Ct.gov State of Connecticut | Governor Dannel P. Malloy | Search

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Miriam Delphin-Rittmon, Ph.D.
Commissioner

- Programs & Services
- Finding Services
- Prevention Services
- Problem Gambling
- Advocacy & Support
- Agency Directories

Language Assistance

The Connecticut Alcohol and Drug Policy Council

The Connecticut **Alcohol and Drug Policy Council (ADPC)** is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use and abuse in Connecticut. The Council, co-chaired by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), is charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens -- across the lifespan and from all regions of the state.

- ADPC Recommendations and Co-Chairs' Responses (final)
- Triennial 2016 Substance Abuse Report ***NEW!***
- ADPC - Letter from the Governor 10.29.15
- ADPC - Letter to Members of Council 1.19.16
- ADPC - Membership List
- ADPC - Subcommittees
  - Subcommittee Co-Chairs
- ADPC - Criminal Justice Subcommittee Charter
- ADPC - Biennial Report 2013: Collection & Evaluation of Data Related to Substance Use, Abuse & Addiction Programs
- Gov. Malloy Signs Comprehensive Bill Combating Opioid Abuse and Launches Strategic Plan to Tackle Addiction
- Connecticut Opioid Response (CORE) Initiative Feedback Form
- The CT Opioid REsponse (CORE) Initiative (10.6.16)

ADPC MEETINGS, AGENDAS &; MINUTES:
(Meeting handouts and presentations appear as links in the agenda)

- ADPC - Schedule of Meetings for 2016
- ADPC - Schedule of Meetings for 2017

ADPC Sub-Committees

Treatment Sub-committee

Prevention Sub-Committee

Recovery Management Sub-Committee

Criminal Justice Sub-Committee

- Each has a “Charter”
- Each has 2-3 co-chairs and 1 staffer each from DCF and DMHAS
- Sub-committees meet monthly
- There is a process for generating “recommendations” to the full Council for approval and implementation

Current Treatment Sub-Committee Recommendations

- Implement Adolescent Screening, Brief Intervention and Referral to Treatment *(A-SBIRT)* protocols according to national standards and/or as established by DCF, DMHAS and/or the UConn Health SBIRT Training Institute.
- *Expand professional trainings* available on adult and adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT) to increase the frequency and number of individual screenings for opioid misuse, brief interventions, and referrals to treatment.
- Enhance early identification of substance use problems by requiring children's Enhanced Care Clinics (ECC), for youth age 12-17 inclusive**,** at intake to services to:
  - *Conduct urine toxicology screening* for common substances of abuse/misuse including opioids. Screening protocols should be trauma-informed and follow best practice standards of care for the populations served.
- *Require the 13 DMHAS operated/funded Local Mental Health Authorities to provide medication assisted treatment*, including psychosocial and recovery support services (an assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate; the individual's stage of readiness and receptivity to the recommendations.

Treatment Sub-Committee Recommendations *(continued)*

- Establish a workgroup to identify and address regulatory barriers that limit access to care i.e., LADC scope of practice; lack of integrated MH/SA program license; limits on which practitioner licenses can be used in outpatient hospital clinics; hiring regulations and practices regarding persons in recovery; and Medicaid eligibility interruptions given incarceration/ hospitalization.

  Note: The Treatment Sub-committee will:

  - Involve DPH in definition of limitations of existing regulation
  - Explore activities/workgroups in existence to limit duplication of efforts
  - Provide examples that are specific to ADPC and governor's charge
  - Involve DSS in discussion of Medicaid rules related to incarcerated individuals; clarify any misinformation regarding benefits

- **Task from HB7052:** Feasibility of establishing a publicly accessible electronic information portal with bed availability for detox, rehabilitation, outpatient MAT.

Current Prevention Sub-Committee Recommendations

- Identify *core competencies* for Continuing Medical Education around Safe Opioid Prescribing and Pain Management for both prescribers and non-prescribing medical staff.

- Create a statewide *Prevention and Education Communication Strategy* which will raise awareness of and provide education on the dangers of opioids and reduce stigma and other barriers for individuals and family members seeking help.

- Provide education and resources regarding *dispensing, safe storage and disposal* of prescription medications.

- Inform prescribers by *developing and adopting Opioid Prescribing Fact Sheets*; support the dissemination process of such Fact Sheets to prescribers.

- Promote *ADPC adoption of one or more of the Public Service Announcements* that have been developed by DMHAS and other currently available educational materials for distribution.

Prevention Sub-Committee Recommendations *(continued)*

- Support the integration of the Prescription Drug Monitoring Program (PDMP) with Electronic Medical Records (EMRs) to improve access to patient data and reduce prescription drug misuse and overdose.

- Insure that school administrators and/or nurses and college public safety personnel have naloxone available to them and that the ADPC assists with obtaining funds, if necessary.

- Tasks from HB7052
  - One page fact sheet- Opioids: risks, symptoms and services; strategy for dissemination
  - Feasibility of marketing campaign and monthly PSAs - Opioids: risks, symptoms and services (including opioid agonists) – **"Change the Script"**
  - Advise Council of any recommendations for statutory or policy changes that would enable first responders or healthcare providers to safely dispose of a person's opioids upon death.
  - Led by DPH with DCP and DMHAS - develop a voluntary non-opioid directive form and post on DPH website

Current Recovery Management Sub-Committee Recommendations

- The ADPC will adopt a “Recovery Language” document developed by sub-committee to ensure that all members of the Council and members of all sub-committees are familiar with alternatives to traditional terminology and can promote the use of such terminology.

Current Criminal Justice Sub-Committee Recommendations

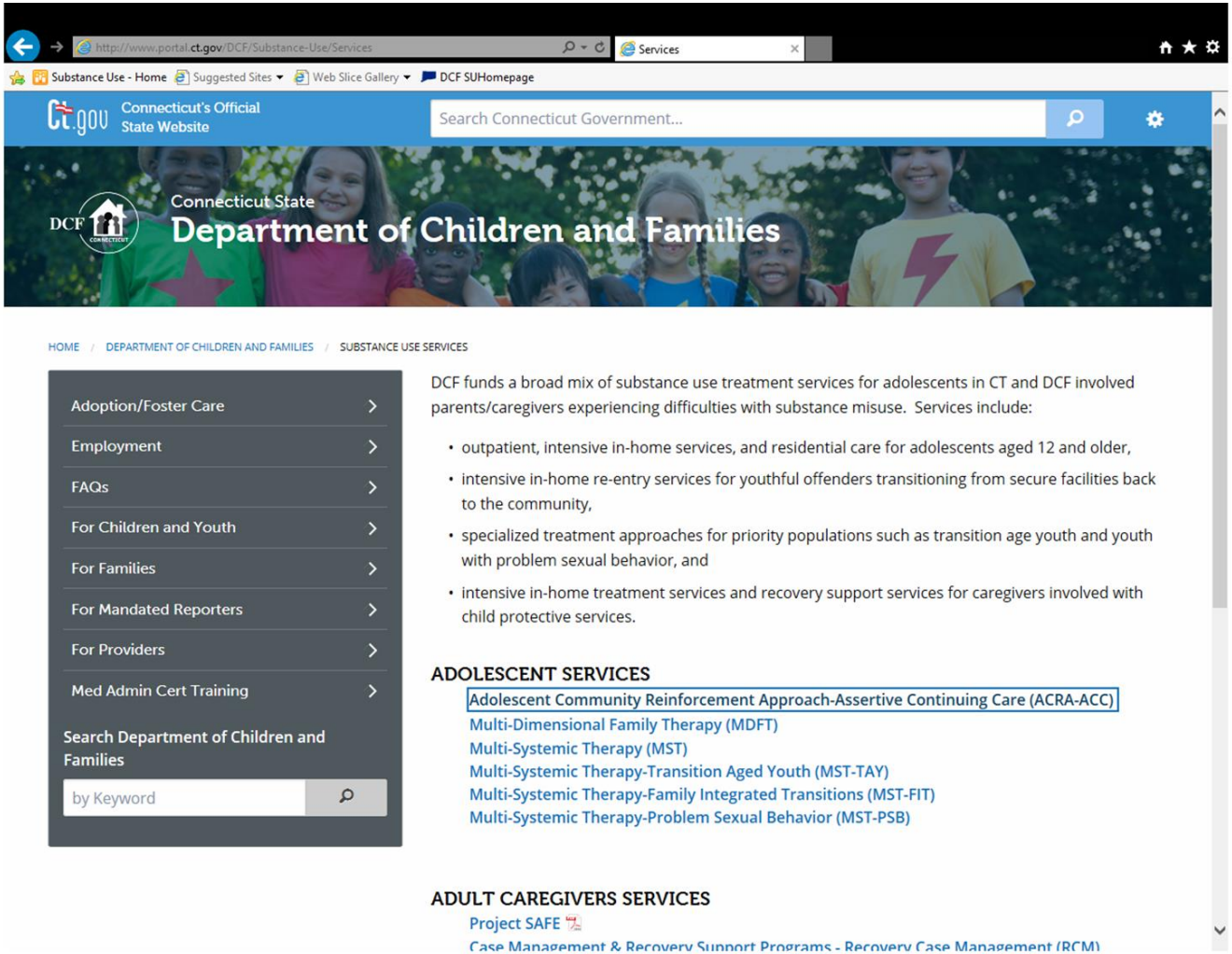
- Reduce disparities in access to medical treatment by *expanding the availability and clinical use of MAT to a broader group of incarcerated offenders and offenders re-entering communities* using community-based standards of care. This recommendation expands DOC's implementation of MAT in two facilities to the entire correction system. In doing so, equitable opportunity to access MAT is offered to inmates regardless of facility.
- **Task from HB7052:** Study SA tx referral programs that have been established by municipal police departments to refer individuals to SA treatment facilities for opioid dependence. Identify barriers and determine feasibility.

DCF Federal Grants and Pay for Success Funding

- IMPACCT
- ASSERT
- Family Stability Project

More DCF Initiatives

- KID Project
- CROSS (CT Recovery Oriented Support System for Youth)
- Community-Based service array for youth & caregivers
- A-SBIRT


http://www.portal.ct.gov/DCF/Substance-Use/Services
Services
Substance Use - Home
Suggested Sites
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DCF SUHomepage
Ct.gov Connecticut's Official State Website
Search Connecticut Government...
DCF
Connecticut State
Department of Children and Families
HOME / DEPARTMENT OF CHILDREN AND FAMILIES / SUBSTANCE USE SERVICES
Adoption/Foster Care
Employment
FAQs
For Children and Youth
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Med Admin Cert Training
Search Department of Children and Families
by Keyword
DCF funds a broad mix of substance use treatment services for adolescents in CT and DCF involved parents/caregivers experiencing difficulties with substance misuse. Services include:
• outpatient, intensive in-home services, and residential care for adolescents aged 12 and older,
• intensive in-home re-entry services for youthful offenders transitioning from secure facilities back to the community,
• specialized treatment approaches for priority populations such as transition age youth and youth with problem sexual behavior, and
• intensive in-home treatment services and recovery support services for caregivers involved with child protective services.
ADOLESCENT SERVICES
Adolescent Community Reinforcement Approach-Assertive Continuing Care (ACRA-ACC)
Multi-Dimensional Family Therapy (MDFT)
Multi-Systemic Therapy (MST)
Multi-Systemic Therapy-Transition Aged Youth (MST-TAY)
Multi-Systemic Therapy-Family Integrated Transitions (MST-FIT)
Multi-Systemic Therapy-Problem Sexual Behavior (MST-PSB)
ADULT CAREGIVERS SERVICES
Project SAFE
Case Management & Recovery Support Programs - Recovery Case Management (RCM)

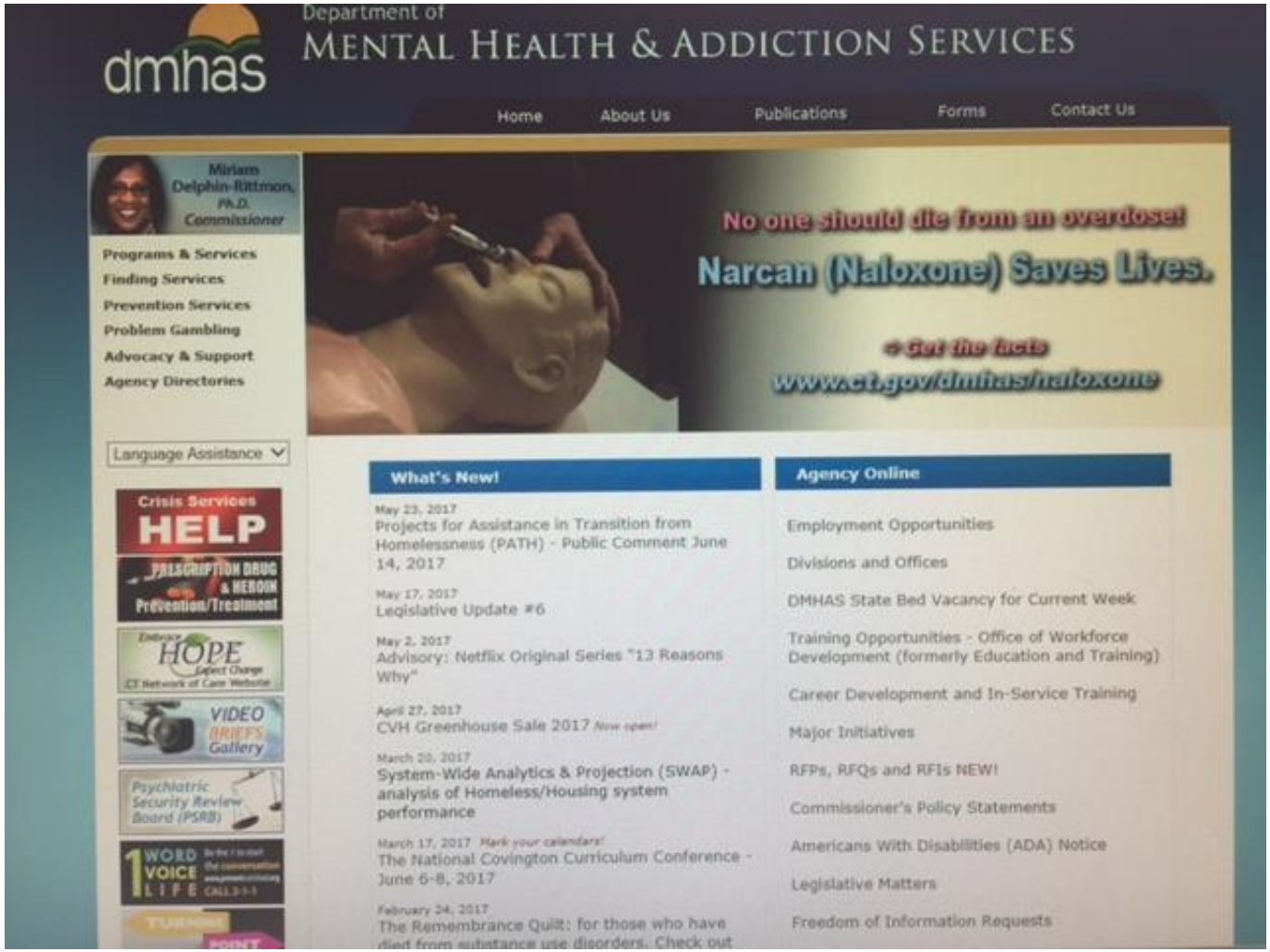
DMHAS Federal Grants

- Prescription Drug Prevention Grant
- Medication Assisted Treatment Expansion Grant
- State Targeted Response (STR) to Opioids Grant

Other DMHAS Strategies

- Statewide Access Line (1-800-563-4086)
- Recovery Coaches in Hospital Emergency Departments
- Community Forums
- DMHAS Website
- Remembrance Quilt

DMHAS Website



Remembrance Quilt

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