ALCOHOL & DRUG POLICY COUNCIL (ADPC)
Meeting of Tuesday, June 28, 2016
Legislative Office Building
Hartford, CT
10:30 a.m.

ATTENDANCE

Members/Designees: Charles Atkins, CMHA; Craig Allen, Rushford; Theresa Conroy, CT General Assembly; Miriam Delphin-Rittmon, DMHAS; Katie Farrell, Public Defender; John Frassinelli, DOE; Ingrid Gillespie, CT Prevention Network; Matthew Grossman, Yale; David Guttchen, OPM; Deborah Henault, DOC; Joette Katz, DCF; Shawn Lang, AIDS CT; Raul Pino, DPH; Dan Rezende, CT Junior Republic; Betsy Ritter, Department on Aging; Prasad Srinivasin, CT General Assembly; Judith Stonger, Wheeler Clinic; Melissa Ziobron, CT General Assembly

Visitors/Presenters: Michael Michaud, DMHAS; Nancy Navarretta, DMHAS; Ece Tek, Cornell Scott Hill Health Center; Jim Siemianowski; DMHAS; Melissa Sienna, UCONN Health; Gabriela Krainer, Family & Children's Aid; Joseph Riter, RSI; Julienne Giard, DMHAS; Fatmata Williams, DSS

Recorder: Karen Urciuoli

The June 28, 2016 meeting of the Alcohol & Drug Policy Council (ADPC) meeting was called to order at 10:00 a.m. by DMHAS Commissioner Miriam Delphin-Rittmon. The meeting was co-chaired by DCF Commissioner Joette Katz.

Topic	Discussion	Action
Welcome and Introductions	Members of the Council introduced themselves and Commissioner Delphin-Rittmon welcomed all in attendance.	Noted
Review and Approval of Minutes	Minutes were reviewed and approved as written.	Noted
Update on Strategic Planning Process	David Fielin with Yale School of Medicine and his team have been gathering information from multiple State agencies that will ultimately be part of any overarching statewide strategic plan, information from the last ADPC meeting along with sub-committee recommendations will also be part of the plan. They are looking to have an initial draft by August 1st.	Will continue to update.
Review DMHAS's Triennial Report	DMHAS is legislatively required to produce a triennial substance abuse plan and report. Jim Siemianowski, DMHAS Director of Evaluation, Quality Management, and Improvement provided an overview of what will be in the Plan. Legislative Mandate 17A-451 Duties of the Commissioner - Develop comprehensive substance abuse plan - Address • Access • Quality and Evidence Based Practices • Broad array of prevention and treatment services • Outcomes • Re-entry strategies • Evaluation of the ADPC Plan Elements of the State Substance Abuse Plan • Emerging substance use trends • Important Substance Abuse Legislation • Key strategies and initiatives	Informational

Topic	Discussion	Action
	• Accomplishments • Other State agency updates and initiatives • CT Substance Abuse expenditures • Opioid Annex Triennial Report Key Strategies Prevention and Education – Treatment – Recovery Criminal Justice – Inter-Agency Collaboration – Accountability and Care Opioid Annex • Triennial plan responds to emerging trends • Opioids are the primary emerging trend • Focus of considerable state agency activity • Will remain a primary focus of DMHAS and other state agencies over next 3 years Key Strategies of the Opioid Annex Overdose Prevention and Reversal – Prevention and Education – Treatment Criminal Justice – Law Enforcement – Accountability and Quality Care Relation to CT Opioid Response (CORE) Initiative • Beginning framework • Preliminary data gathering • Catalogue of current activities • Building block for future efforts Schedule for Distribution • Reviewed by state agencies early July • Finalized by early July • Distributed to ADPC by mid-July • Posted on DMHAS website late July	
a. Discussion	Areas of concern from committee members include: • The amount of money tax payers have invested in substance abuse treatment, how much is actually being spent and is it a full complete cost – it was indicated that information is gathered from multiple state agencies (DCF, DMHAS, DSS, DCP, Court Services, DPH, the State Department of Education and a Youth Advisory Board), and does not include private spending and is organized by what's being spent on prevention, deterrents, and treatment. • Data Gathering – what kind of data is being gathered and what is being done with it. Jim indicated that client level data is collected on every treatment admission and discharge in CT's substance abuse system and includes demographic information, information about what levels of care patients are using, what are their drugs of choice, how long have they been using, what they are using and how it is being administered. DMHAS has a federal block grant which requires submission of aggregate data. All of this data provides a very good picture of what is happening within the state. • Is Narcan data being captured – Jim indicated that within the plan there is a strategy related to better tracking reversals. • Tracking individuals following overdose reversal - Jim indicated that there have been some preliminary efforts done by DMHAS through mobile crisis teams going to emergency rooms to provide outreach to individuals who have overdosed.	Informational

Topic	Discussion	Action
	• Are the multiple efforts for distribution of Narcan being tracked – Jim indicated that distribution through DMHAS and DPH is being tracked. DMHAS recently applied for a federal grant that will help with tracking purchases and distribution of Narcan and will require that an educational plan be put in place also.	
Vetting, Approval & Implementation of Sub-Committee Recommendations	Commissioner Delpin-Rittmon reported that a formal vetting, approval and implementation process for sub-committee recommendations have been developed. Subcommittees may make recommendations to the ADPC on a rolling basis at any meeting of the ADPC and will only be considered if presented in the required format, and must be operationalized, fully developed and measurable. Subcommittees have until July 25th to submit their current recommendations to your sub-committee chair so they can be reviewed and voted on at the August 3rd ADPC meeting. It is expected that this group of recommendations will be rolled into the Strategic Plan being developed by Yale.	Informational
a. Discussion	The need to monitor and evaluate the recommendations was discussed; Commissioner Delphin-Rittmon indicated that metrics and monitoring would be added to the recommendation form. Commissioner Katz asked that recommendations take into consideration youth and families and to look at recommendations through a racial justice lens. Commissioner Delphin-Rittmon also asked that feasibility and cost be taken into consideration.	Noted
Subcommittee Reports		
• Prevention, Screening and Early Intervention	Since the last quarterly ADPC meeting, this group has met on April 18th, May 16th and June 20th. Their focus has been: 1. Continue to develop membership and coordinated efforts and 2. Review other state prevention opioid plans and based on these reports, expertise of members, and evidence-based practices, we developed this list of recommendations. At the next monthly meeting, they will prioritize and submit recommendations. Ideas for Recommendations: PREVENTION Education and Awareness • Support the increased use of evidence-based prevention programs such as Botvin LifeSkills Training • Identify core standards for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff) • Develop and distribute a community awareness and stigma reduction strategy • Update the drugfreect.org website to improve user interface and increase ease of access to information • Develop and implement the distribution of medication disposal information at the time of dispensing Reduce Access • Explore the use of blister packs for pharmacists as a recommended alternative for opioid medication • Develop recommendations for lock boxes for safe medication storage and monitoring • Provide education and resources regarding safe storage and disposal to hospice providers, funeral directors, realtors, and others as identified • Expand mechanisms for disposing of used medications (have a second look at pharmacy disposal)	Will continue to update.

Topic	Discussion	Action
	• *Support the integration of the PMP with EMRs to eliminate the need for multiple system sign-in • *Increase full access to the PMP system to include APRNs and other appropriate medical staff (* Also potential opportunity for early intervention) PREVENTION of overdoses (may be for another subcommittee) • Create a central data repository for Naloxone distribution and use and standardize reporting statewide • Advocate for the availability of over the counter Naloxone • Support methadone maintenance for incarcerated individuals facing release* SCREENING • Increase training on SBIRT for adults and adolescents to increase the frequency of asking about opiate use and reinforcing non-use EARLY INTERVENTION • Use Recovery Coaches to intervene with OD individuals in emergency rooms (including access to Telephone Recovery Support Services)	
• Treatment and Recovery Supports	Overall, the substance use treatment system relies on the acute care approach: identification of specific problems, time delimited treatment and discharge. The recommendations proposed by the Substance Use Treatment and Recovery Support Subcommittee reflect the critical importance of moving toward adopting chronic disease management and recovery-oriented lifespan approaches to intervening with individuals with substance use problems. Detailed Recommendations: Improve access to care at all levels and in all settings - While a toll-free access number currently exists, it does not provide a robust and personal response to callers, it is limited to adult services, and feedback from youth and family indicate that follow-up is not occurring to identify if a connection to care was made. In correctional settings, unlike care for other medical conditions, access to substance use treatment, particularly Medication Assisted Treatment (MAT) is limited, and when available, community standards of care are not routinely followed. Recent legislative efforts have improved access to Naloxone, but wide acceptance of Naloxone is limited by a lack of public education about how it works. Peer recovery supports are a critical component to long-term, stable recovery yet fiscal support for these services lags behind funding for traditional treatments. Action Steps: • Implement an enhanced Toll-Free Call System that supports access to substance use treatment and recovery supports for adolescents and adults. This program could be rooted in existing infrastructure such as regional crisis centers, or Access Mental Health. • Efforts requiring that Naloxone be available in public settings and by public organizations should be expanded and combined with a public awareness campaign. Require public schools to have Naloxone available on-site in facilities that provide education to youth 12 and older. Public schools shall provide at least annual training in Naloxone administration to staff responsible for its administration. • Require LMHA's to provide Buprenorphine treatment on-site, and psychosocial and recovery support services either directly or through referral. • Require LMHA's to provide Buprenorphine treatment on-site, and psychosocial and recovery	Will continue to update.

Topic	Discussion	Action
	support services either directly or through referral.	
• Recovery and Health Management	Follow-up and Review of short-term (ST) and long term (LT) issues and strategies were identified at the March and April sub-committee meetings. Short Term: Expand access to naloxone. • Prescribers - A summary of suggestions from the OD Prevention Workgroup was discussed. Suggestions relate to access, stigma, marketing, and prescriber CEU requirements among others. A naloxone Fact Sheet for Prescribers was reviewed, approval and distribution plans still need to be discussed. • Community members – The focus may be primarily on stigma and education. It is not clear if Infoline or the 800# DMHAS number to obtain information on assessment centers has information on naloxone and/or what they should say about it. Suggestions from the OD Prevention Workgroup and this sub-committee will be shared at the next ADPC meeting; in addition, Infoline will be contacted to verify if they have information on naloxone and how they disseminate. Short Term: Reduce stigma and discrimination for people in recovery • Some of the language related to addiction and recovery does not reflect the "illness" of addiction or "hope for recovery" from the illness. The "Language of Recovery" document was reviewed, this sub-committee will recommend it be approved and adapted by the ADPC. • People remain concern over any repercussions for getting naloxone through their insurance. Short Term and Long Term: Not fully discussed • ST: People who are in early recovery are at acute risk for relapse and overdose. There is a "captive audience" to whom providers can offer naloxone and overdose risk reduction education that includes people in prisons and inpatient/residential treatment. • LT: People who show up in the emergency rooms with behavioral health issues, especially those who have overdosed, don't get connected to services. • LT: CT medical and pharmacy schools may not provide adequate information about opioids and opioid prescribing to students as is done in other states. • LT: Individuals attempting recovery or in early recovery benefit most from having hope for the future. This sub-committee will continue to explore ideas and resources related to "Recovery Capital".	Will continue to update.
Legislative Updates	Commissioner Delphin-Rittmon reported that Public Act 16-435, House Bill 5053 – An act concerning opioid use and access to overdose and reversal drugs, passed unanimously in the House and Senate.	Informational
Innovative Practice: Neo-natal Abstinence Syndrome	Dr. Matthew Grossman provided a presentation addressing Neonatal Abstinence Syndrome Dr. Grossman reported that women of child bearing age are a big demographic in the opioid epidemic, with approximately 400 affected babies being born each year. At Yale New Haven Children's Hospital they have developed new protocols for treating these babies, their first change started with the scoring tool which now focuses on 3 main items; can the baby eat, can the baby sleep, and can the baby be consoled. They developed new protocols: • Goal: Having infant function as a normal neonate • Mother and child together • Eat/Sleep/Console: treat the infant • Supportive care	Informational – presentation available upon request.

Topic	Discussion	Action
	• No feeding schedule • Meds on page 3 • Prenatal preparation • Staff coaches parents Results: • Average length of stay: 2003 approximately 30 days / 2015 approximately 6 days • Babies treated with Morphine: 2003 – 100% / 2015 – approximately 20% • Average maximum Morphine Dose (mg/dose): 2003 – 0.49 / 2015 – 0.15 • Breastfeed Rate: 2003 – 0 / 2015 – 40% • Total Average Cost of Care went from approximately $50,000 to approximately $10,000 Conclusions: • Hugs before drugs • Empower families • Rethink and reconsider Goals: • Share with the rest of CT • Share with the rest of the region	
Other Business		

NEXT MEETING – August 4, 2016 – 2:00 a.m. to 4:00 p.m.

ADJOURNMENT - The June 28, 2016 meeting of the Alcohol and Drug Policy Council adjourned at 12:30 p.m.