

State of Connecticut

Department of Mental Health and Addiction Services Triennial State Substance Use Plan

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Introduction

The Connecticut Department of Mental Health and Addiction Services has been directed through legislation to triennially develop a state substance abuse plan. The plan historically has served to capture information about all of the state funded substance use services regardless of which agency provides them. The plan is expected to include goals, strategies, and initiatives that will be the focus of the state's efforts over the next three years. Therefore this report includes information from any of the state agencies that are involved in delivering substance use services. The report defines a range of strategies that will guide the state's efforts and then includes information about the accomplishments that have been achieved over the past three years.

Since the last plan was developed, one issue has continued to heavily influence the focus of many of the state agencies' activities. Connecticut has remained in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. This issue remains perhaps the single most important health concern we as a state are facing. Governor Malloy recognized this and his administration proactively introduced legislation designed to reverse this epidemic. During his tenure as Governor, he also focused efforts on reinvigorating the Alcohol and Drug Policy Council (ADPC), charging the group with the development of a plan to address the opioid crisis.

As a substance use service system, DMHAS must maintain a comprehensive treatment system while also dealing with emerging issues or threats. A triennial plan must include goals and strategies that support the breadth of services available to individuals with a wide range of substance use issues while also developing new strategies that address the opioid crisis. This year's plan will build on core strategies and actions that were included in the 2016 Plan. Like the previous plan, this year's plan will continue our focus on the opioid epidemic by including a Triennial Report Opioid Annex. Much has been done over the past three years to address the opioid epidemic but more work remains. The title of this report has been changed to reflect and now uses the term Substance Use instead of abuse. This change is more in line with efforts to reduce stigma associated with substance use problems. The 2019 report includes a section that details efforts focused on women with substance use issues. Legislation enacted in fiscal year 2018 required that DMHAS include a report focused on women in the Triennial Report.

The Department would like to thank Governor Lamont, the Connecticut legislature and all of the state agencies that are involved in this important work. Connecticut is a national leader in the provision of behavioral health services thanks to the leadership at multiple levels within the state. The Commissioners and staff at each of the agencies providing substance use services in the state are involved in a number of activities designed to enhance our service system while also working to address the opioid crisis. It is our hope that this report details the significant accomplishments that have already been achieved while highlighting areas that require our continued efforts.

Background and Legislative Intent

Legislation originally enacted in 2002 required the Department of Mental Health and Addiction Services to submit the state's substance abuse plan biennially. That legislation required DMHAS to submit the Report to the Legislature, Office of Policy and Management and the Alcohol and Drug Policy Council. The legislation was amended in 2013, shifting the report cycle to a triennial basis and the language requiring DMHAS to submit the plan to the groups described above was eliminated. The initial Triennial Report was completed in 2016 and can be found at the following link: <https://www.ct.gov/dmhas/lib/dmhas/publications/triennialreport2016.pdf> . One other legislative change occurred in the FY 2018 session. That change requires DMHAS to include a report on women with substance use issues in the Triennial Report. This will be the first report that addresses the new legislative requirement.

The state's substance use plan is expected to include comprehensive strategies for the prevention, treatment and reduction of alcohol and drug use problems. The legislation specifies a number of elements that must be included in the report such as a mission statement, a vision statement, and goals for providing treatment and recovery support services to adults with substance use disorders. In addition, the Department is supposed to report on emerging substance use trends, statistical and demographic information about the individuals being served in the state substance use treatment system, and the performance measures used to evaluate program effectiveness in addressing substance use issues. The plan organizes actions under key strategy areas.

This year's Triennial Report draws heavily on the work of the Alcohol and Drug Policy Council (ADPC) and the charge that was given to them during Governor Malloy's tenure. During the 2015 legislative session, Governor Dannel Malloy introduced and signed "An Act Concerning Substance Abuse and Opioid Overdose Prevention" into law. That bill, Public Act 15-198, reconstituted the Alcohol and Drug Policy Council with Commissioners Miriam Delphin-Rittmon (DMHAS) and then Department of Children and Families (DCF) Commissioner, Joette Katz, as the co-chairs. Governor Lamont has appointed a new Commissioner at DCF, Vanessa Dorantes. Commissioners Dorantes and Delphin-Rittmon will serve as the co-chairs under the new administration. The Council has directed the state's efforts to coordinate substance use prevention and treatment throughout Connecticut's system of care. The council includes members from the medical, recovery and treatment communities and is uniquely positioned to make expert recommendations to guide our prevention and treatment efforts.

DMHAS Mission and Vision

MISSION STATEMENT

The mission of the Department of Mental Health and Addiction Services is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect.

VISION STATEMENT

Connecticut envisions a recovery-oriented system of behavioral health care that will offer all State's citizens, across the lifespan, an array of accessible services and recovery supports. Also, that people will be able to choose those services which are most effective in addressing their particular behavioral health condition or combination of conditions. These services and supports will be culturally and gender responsive, build on personal, family, and community strengths, and have as their primary and explicit aim promotion of the person/family's resilience, recovery, and inclusion in community life. Finally, services and supports will be provided in an integrated and coordinated fashion within the context of a locally managed system of care in collaboration with the surrounding community, thereby ensuring continuity of care both over time (e.g., across episodes) and across agency boundaries, thus maximizing the person's opportunities for establishing, or re-establishing, a safe, dignified, and meaningful life in the community of his or choice. Connecticut's vision is based on the following underlying values:

- The shared belief that recovery from mental illnesses and substance use disorders is possible and expected;
- An emphasis on the role of positive relationships, family supports, parenting in maintaining recovery, achieving sobriety, and promoting personal growth and development;
- The priority of an individual's or family's goals in determining their pathway to recovery, stability, and self-sufficiency;
- The importance of cultural inclusion, cultural competence and gender- and age-responsiveness in designing and delivering behavioral health services and recovery supports;
- The central role of hope and empowerment in changing the course of individual's lives; and
- The necessity of state agencies, community providers, and consumer/recovery communities coming together to develop and implement a comprehensive continuum of behavioral health promotion, prevention, early intervention, treatment, and rehabilitative services.

DMHAS Statewide Substance Abuse Service System

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance use prevention and treatment throughout Connecticut.

While the Department's prevention programs serve all Connecticut citizens regardless of age, its treatment mandate is to serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance using pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance use and mental illness, and special populations transitioning out of the Department of Children and Families.

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance use. As such, it provides a variety of [treatment services on a regional basis](#) to persons with substance use disorders, including residential detoxification, long-term rehabilitation, intensive and intermediate residential services, medication assisted treatment (including methadone maintenance, buprenorphine and naltrexone), outpatient, partial hospitalization, and recovery supports. DMHAS' budget for substance use services in FY 18 was just over \$149,000,000 and blends state general funds with federal discretionary grants and block grant funds. DMHAS has benefited significantly over the past three years from specialized federal funding directed at the opioid crisis. DMHAS has received over \$33,000,000 in federal funds during the period from FY 17 through FY 19. These funds have been utilized to enhance DMHAS' service system through the expansion of clinic-based MAT alternatives such as buprenorphine and vivitrol, new engagement strategies that employ persons in recovery to link persons with opioid disorders to treatment, and broadening efforts to make Narcan even more widely available across the state.

The DMHAS substance use treatment system includes approximately 51 providers with over 300 programs. These services focus on individuals with co-occurring disorders as many people who struggle with mental illnesses also struggle with alcohol or drug addiction as well. Building our capacities to treat co-occurring disorders has been a major priority of DMHAS for the past 10 years.

DMHAS also provides these substance use services within state-operated facilities, primarily at Connecticut Valley Hospital. Detoxification and intensive residential services are provided in Middletown and in Hartford at the Blue Hills location. All of the other state-run facilities offer specialized Medication-Assisted Treatment services as well. Specialized services for HIV-infected clients include counseling, testing, support and coping therapies, alternative therapies and case management. Where appropriate referrals are made to DPH's Partner Notification Services and clients are linked to follow-up treatment.

The department also provides [prevention services](#), designed to promote the overall health and wellness of individuals and communities by delaying or preventing substance use; these include information dissemination, education, alternative activities, strengthening communities, promoting positive values, problem identification, and referral to services. Through this model, attitudes and behaviors that contribute to alcohol and other drug use are changed, leading to healthier communities. DMHAS administers and funds 156 prevention councils covering 169 towns, and approximately 60 community-based prevention programs provide services statewide or at the regional or local level.

DMHAS served approximately 57,500 unduplicated clients with substance use disorders in FY 18. There were almost the same numbers of admissions to funded or operated substance use programs over the course of the year. The most highly utilized levels of care or programs were the Pre-Trial Intervention Program, methadone maintenance, inpatient and residential, and outpatient services. For a more complete analysis of DMHAS' annual statistical information, please reference the 2018 Annual Statistical Report at the following link: <https://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreport2018.pdf>. This provides a much more comprehensive analysis of our substance use service system.

The Commissioner and the DMHAS Executive Group are advised by many constituency and stakeholder groups. These include the State Board of Mental Health and Addiction Services, a 40-member advisory group consisting of 15 gubernatorial appointees, the chairperson, one designee each from the 5 Regional Behavioral Health Advocacy Organizations (RBHAO's), and other representatives of consumer interests. The RBHAO's were formed in 2018 in an effort to integrate substance use and mental health advocacy organizations. DMHAS initiated a competitive bid process for the services that were previously provided by the Regional Mental Health Boards and the Regional Advocacy Councils. This resulted in the selection of 5 RBHAO's.

Connecticut also has a number of other state agencies that are involved to some extent in the delivery of substance use treatment and prevention services. The Departments of Children and Families (DCF), Social Services (DSS), Public Health (DPH), Correction (DOC), Department of Consumer Protection (DCP), and the Judicial Branch Court Support Services Division (CSSD) all provide a range of treatment and prevention services that are focused on the unique clients that these agencies serve. The report will detail major initiatives that each Department is involved in and the amount of funding that is being used to support substance use prevention and treatment services.

Evidence Based Practices in the DMHAS Substance Use Treatment System

DMHAS is actively working to expand the adoption of evidence-based practices within our substance use treatment system. Evidence-based practices (EBP's) are typically categorized under two classifications, pharmacotherapies, or behavioral therapies. Both are used in the DMHAS treatment system. Pharmacotherapies include treatments like methadone, buprenorphine and naltrexone, which are commonly used to treat opiate addiction. Evidence-based behavioral therapies include Cognitive Behavioral Therapy (CBT), Contingency Management, and Motivational Interviewing, which have been shown to be effective with certain populations. A major focus for DMHAS over the past three years is to increase access in behavioral health clinics to other medication assisted treatments like buprenorphine and naltrexone.

Connecticut utilizes a number of evidence-based practices within our substance use system. In 2010, DMHAS initiated the EBP Governance Committee as a means to further the use of EBP's within our service system. The group is co-chaired by the DMHAS Deputy Commissioner and the Director of Evidence-Based Programs (EBP's) and meets quarterly to promote the adoption of EBP's. Foremost among these services is DMHAS' use of Medication Assisted Treatment (MAT), which is considered the gold standard for treating opioid addiction. DMHAS has a statewide network of funded methadone maintenance providers that served over 13,500 individuals during FY 18. This FY 18 number increases to 21,592 when one includes unduplicated clients served in non-funded methadone programs. There are over 25 distinct clinics, some of which have opened in response to growing needs of certain communities. For example, the Waterbury area has seen a significant growth in persons using opioids and the Connecticut Counseling Center responded by opening a clinic in that area.

DMHAS has also been actively working to increase the number of physicians who prescribe buprenorphine, a form of MAT that has proven to be effective at dealing with opioid addiction. Although less regulated than methadone, the federal government restricts who can prescribe buprenorphine and the number of individuals each prescriber can "treat". The drug is a synthetic opioid medication that does not produce the euphoria and sedation caused by heroin. It has other advantages in that it reduces withdrawal symptoms and has a lower risk for overdose. It can be provided in its pure form or may be combined with naloxone in a more common formulation of the drug called Suboxone. The federal government recently relaxed the restrictions on the maximum numbers that can be treated at any one time from 100 to 275 individuals which has likely increased access to another evidence-based option to people addicted to opiates. More recent changes have allowed Advanced Practice Registered Nurses (APRN's) to prescribe buprenorphine.

In FY 18, DMHAS served almost 600 unduplicated individuals in specialized, federally funded, buprenorphine programs. This number is an underestimate of the number of individuals now using buprenorphine or vivitrol as the DMHAS data system does not capture prescription or claims data. Recent data provided by Beacon Health Options for just the 4th quarter of 2018

shows over 7,200 Medicaid clients had received buprenorphine during that period. That same data showed a steady increase of clients receiving buprenorphine over a several year period which demonstrates that efforts to increase access to alternative forms of MAT have been successful.

Behavioral therapies are used across the DMHAS substance abuse system at many of our provider agencies. They include CBT and Motivational Interviewing (MI), a counseling approach that is intended to engage clients and increase motivation to make positive changes. In recent years, DMHAS has focused more heavily on MI because of its effectiveness in engaging clients in treatment.

For years DMHAS has focused on promoting best practices in the areas of co-occurring disorders, trauma informed treatment, and specialty services that are responsive to the needs of women in treatment. These discrete areas of practice have been fostered by training, expert consultation, learning collaboratives, the use of data to improve services, and other practice improvement activities. Each of these is described in greater detail below:

- **Co-Occurring Disorders Initiatives** - Many individuals with substance use disorders have mental health disorders as well. For over 10 years, DMHAS has focused heavily on fostering integrated care. One aspect focused on ensuring that providers were screening all clients for both mental health and substance use disorders. Efforts have been directed at increasing system capacities to provide co-occurring treatment, regardless of where a client presents for treatment. Progress is measured by using a fidelity scale developed by Dartmouth Medical School: Dual Diagnosis Capability in Addiction Treatment (DDCAT). As part of this initiative a practice improvement collaborative has been used to foster the implementation of integrated services. Hundreds of DDCAT fidelity reviews have been completed across DMHAS addiction service agencies.
- **Trauma Initiative** - Similarly many individuals with substance use disorders have histories that include trauma. DMHAS partners with the CT Women's Consortium for training on trauma-informed care and trauma-specific models. As part of this initiative a fidelity scale has been developed and is being utilized to measure a program's adherence to trauma informed, trauma specific, and gender-responsive care. A Quarterly newsletter *Trauma Matters* is disseminated system-wide to further inform system development.
- **Women's Services Practice Improvement Collaborative** – This is another collaborative venture with the Women's Consortium designed to promote gender sensitive practices in the DMHAS system. DMHAS funds a number of specialty treatment programs for women or women and children. These programs, DMHAS, and the Consortium meet on a regular basis to exchange lessons learned and problem solve about how to implement gender responsive treatment within these agencies.
- **MAT Practice Improvement Collaborative** - The Medication Assisted Treatment (MAT) Learning Collaborative brings together treatment providers who are supplementing traditional outpatient clinical services with one or more of the three medications approved to treat opioid dependence. Meetings are held 5-6 times yearly and

often include a presentation on a specific, group-selected topic as well as updates from the providers in attendance. MAT successes, challenges and requests are discussed. The group relies on a facilitator and a consultant for logistics and technical assistance.

Legislative Initiatives Impacting Substance Use Service Delivery

Connecticut has taken a number of steps over the past **seven (7)** years to make Narcan more widely available. Legislation was first introduced in 2011 and each successive legislative session has introduced new pieces of legislation that have made Narcan more accessible. A Good Samaritan law was introduced in 2011 that protected people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012 allowed prescribers (physicians, surgeons, Physicians' Assistants, APRNs, dentists, and podiatrists) to prescribe, dispense or administer Narcan to any person to prevent or treat a drug overdose and the prescriber is protected from civil liability and criminal prosecution. The protection from civil liability and criminal prosecution was extended to the person administering the Narcan in response to an overdose in 2014. Legislation enacted in 2015 allows pharmacists who have been trained/ certified to prescribe and dispense Narcan directly to customers requesting it. Most recently, PA 18-166 allowed prescribers to develop agreements with organizations wishing to train and distribute Narcan. All of these changes have supported efforts to make Narcan widely available.

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 in Connecticut. Governor Malloy reconstituted the ADPC through legislation that was enacted in 2015. The Council, co-chaired by the Commissioners of DMHAS and 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. Then Governor Malloy provided a charge to the ADPC in late October 2015 which was focused on the opioid crisis in Connecticut. He requested that they study and make recommendations in the following areas:

- Best practices in the treatment of alcohol and substance use disorders, including Medication Assisted Treatment (MAT) and other evidence-based treatment strategies.
- A coordinated, audience specific, prevention message including modern messaging to be used by school districts, parents, medical professionals, municipal leaders, state, agencies, and law enforcement.
- A collaborative effort, with medical professionals including doctors, nurse practitioners, dentists, and physician assistants to educate all prescribers on the dangers of

overprescribing narcotics and the current best practices in identifying substance use disorder and the resources available for treatment.

- A strategy to make the overdose reversing drug naloxone widely available and affordable to first responders, in pharmacies and to any individual who may be able to use it to reverse an overdose.

In his charge to the Council, then Governor Malloy encouraged members to make recommendations on issues requiring legislative change, administrative actions and statewide cooperation. The work of the ADPC has also been influenced by the Connecticut Opioid Response (CORE) team which was created 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. The CORE team was asked to focus on evidence-based strategies with measurable and achievable outcomes. The CORE Plan was published in October 2016 and has helped to guide efforts of the ADPC. The CORE Plan can be found at the following link:

http://www.ct.gov/dmhas/lib/dmhas/publications/core_initiative10.6.16.pdf .

Four ADPC subcommittees (Prevention, Screening and Early Intervention, Treatment, Recovery and Criminal Justice) are working in areas related to the general charge. These subcommittees which have broad membership which includes state and community partners as well as persons with lived experience, have been meeting over the past three years. These subcommittees have spurred a number of actions that have been taken to address the opioid epidemic. The subcommittees and their goals and progress to date are described in greater detail in the Opioid Annex on pages 75 through 84.

Emerging Trends in Substance Use

The State Substance Use Plan that will be presented is responsive to emerging trends that affect substance use service delivery in the State. In the previous report certain trends heavily impacted the substance use service system. This included increases in opioid-related admissions and overdose deaths. While this has remained a major focus of statewide substance use services over the past three years, there have been some signs that show overdose deaths and opioid-related admissions may have begun to plateau or decline. Opioid-related admissions into CT's treatment system actually declined in FY 2018, falling from approximately 31,000 in FY 17 to approximately 29,000 in FY18. Admissions related to opioids for the first 6 months of FY 19 also reflect a continued decline when compared to the same period in FY 18.

Similarly, overdose deaths have declined slightly in calendar year 2018, a positive sign that statewide efforts to address the epidemic may be working. At the same time a new concern has surfaced which shows that fentanyl, a more potent opioid is now involved in over 70% of all opioid-related overdose deaths. Fentanyl is more inexpensive to manufacture and is reported to be present in much of what is being sold as "heroin". Other substances have also shown to be contaminated with fentanyl increasing the overdose risk for persons using any illicit drug.

Data for FY 18 from DMHAS' data collection system shows that opioids account for 41% of all substance use treatment admissions while alcohol is reported to be the primary drug involved in approximately 34% of these admissions. Admissions related to marijuana comprise about 11% of substance use treatment admissions. One noteworthy trend that requires continued monitoring is that is that cocaine and crack admissions now account for almost 7.5% of admissions to the substance use treatment system. It is important to note that there was a 12% increase in cocaine/crack admissions from FY 17 to FY 18 and this trend bears further monitoring.

A positive trend that has emerged over the past 3 years relates to federal funding that has been made available to address the opioid epidemic. DMHAS alone has been awarded approximately \$33,000,000 in discretionary funds over the past 3 years. These funds are supporting a number of initiatives across the state that will be discussed in greater detail in the Opioid Annex. Over the past three years various trends have impacted the substance use prevention and treatment system in Connecticut.

IMPACT OF AFFORDABLE CARE ACT

The Affordable Care Act (ACA) was introduced during the last reporting period. The introduction of ACA has created changes in how substance use services are delivered and funded, and has increased the number of individuals that are eligible to receive these services. For example, in Connecticut, Medicaid Expansion to Low Income Adults has increased the number of clients that are now eligible for Medicaid. Access Health CT, Connecticut's insurance exchange has significantly reduced the number of people in the state who do not have insurance. While the Medicaid substance use benefit available to these individuals has not changed over that period, more individuals continue to be eligible to receive substance use services.

Plan Development

The 2019 State Substance Use Plan is organized under the same key strategy areas which were included in the 2016 State Substance Abuse Plan. Each strategy area lists a number of action steps that will be taken over the next three years to address substance use issues. The plan and the Opioid Annex cuts across all state agencies involved in substance abuse treatment and prevention and is heavily influenced by recent trends in Connecticut. Many action steps continue to relate to the opioid crisis as much attention has been focused on trying to reverse this epidemic. However, many action steps continue to focus on managing and maintaining a comprehensive substance abuse system which focuses on prevention and health promotion and treatment of substance use disorders. Each strategy area will be followed by a summary of the accomplishments that have occurred over the past three years

6 Key Strategies for a Comprehensive and Coordinated State Substance Use Plan

1

STRATEGIES RELATED TO PREVENTION AND EDUCATION

- Prevent substance use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals. Reduce stigma associated with seeking treatment.

2

STRATEGIES RELATED TO TREATMENT

- Expand access to broad spectrum of substance use services.
- Increase the use of evidence-based treatments (EBP's) including methadone maintenance and buprenorphine

3

STRATEGIES RELATED TO RECOVERY

- Increase the use of peers and natural supports.
- Maintain recovery supports.

4

STRATEGIES RELATED CRIMINAL JUSTICE

- Implement criminal justice reforms that will increase diversionary options.
- Increase the availability of substance use treatment, especially medication-assisted treatment in jails and prisons.
- Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail

5

STRATEGIES RELATED TO COLLABORATION AND COST EFFECTIVENESS

- Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.

6

STRATEGIES RELATED ACCOUNTABILITY AND QUALITY CARE

- Ensure that providers deliver high quality services.
- Use data to improve care throughout the system.

Strategy 1: Strategies Related to Prevention and Education

<p>❖ Achieve quantifiable decreases in substance use and use, and suicide and suicide attempt rates statewide through the skilled delivery of timely, efficient, effective, developmentally appropriate, and culturally sensitive evidence-based prevention strategies, practices, and programs.</p>	
<p>Action Step: Provide data collection, management, analysis, and dissemination; survey development and implementation; technical assistance and training on data and evaluation-related topics; house the State Epidemiological Outcomes Workgroup; and serve as a clearinghouse for epidemiological and evaluation-related services for prevention through the Center for Prevention Evaluation and Statistics</p>	<p>Action Step: Develop, enhance, implement, and integrate sustainable, comprehensive, culturally competent, evidence-based suicide prevention, intervention and response strategies statewide to reduce non-fatal suicide attempts and suicide deaths through the CT Suicide Advisory Board and the Garrett Lee Smith Youth Suicide Prevention-CT Networks of Care for Suicide Prevention Initiative</p>
<p>Action Step: Increase youth access to behavioral healthcare and supports for early childhood development, and reduce substance use and exposure to violence through an enhanced, integrated and coordinated state behavioral health infrastructure through the Safe Schools Healthy Students Initiative</p>	<p>Action Step: Support prevention efforts within the state by building the capacity of individuals and communities to deliver alcohol, tobacco and other drug use prevention services directed at schools, colleges, workplaces, media and communities through the Governor’s Prevention Partnership</p>
<p>Action Step: Identify and engage youth and young adults who have or are at risk for behavioral health disorders and connect them to high quality care through the Now is the Time – Healthy Transitions, CT Seamless Transitions & Recovery Opportunities for Network Growth (CT STRONG) Initiative</p>	<p>Action Step: Educate tobacco merchants, youth, communities and the general public about the laws prohibiting the sale of tobacco products to youth under the age of 18 through the Tobacco Merchant & Community Education Initiative</p>
<p>Action Step: Provide leadership on substance use prevention through engagement of senior college administrators and implementation of evidence based policies, practices and strategies through the CT Healthy Campus Initiative</p>	<p>Action Step: Increase the rate at which young adults encountered by Crisis Intervention Teams (CIT) are connected to appropriate treatment and support services and diverted from arrest through the Specialized CIT for Young Adults Initiative</p>
<p>Action Step: Conduct activities focusing on the prevention of community problem substance misuse or use utilizing the five-step Strategic Prevention Framework (SPF) through CT SPF Coalitions, and the Partnerships for Success Initiative</p>	<p>Action Step: Enforce State laws that prohibit youth access to tobacco products by inspecting retailers across the state in order to maintain a retailer violation rate at or below 20 percent through the Synar Program</p>
<p>Action Step: Prevent youth access to tobacco by enforcing Federal laws that prohibit sales of tobacco products to minors and restrict advertising and labeling through the FDA CT Tobacco Compliance Program</p>	<p>Action Step: Disseminate information via print and electronic media on substance use, mental health and other related issues through the Connecticut Center for Prevention, Wellness and Recovery</p>
<p>Action Step: Assist prevention providers/local communities in assessing prevention needs and coordinating resources to address these needs through Regional Behavioral Health Action Organizations</p>	<p>Action Step: Deliver training and technical assistance to substance use and mental health practitioners through the Training and Technical Assistance Service Center</p>

<p>Action Step: Develop and implement municipal-based alcohol and other drug prevention initiatives through Local Prevention Councils</p>	<p>Action Step: Prevent non-prescription opioid use and the progression from use of prescription opioids to the use of readily accessible and inexpensive heroin and fentanyl using multi-faceted prevention strategies through the State Targeted Response and State Opioid Response initiatives</p>
<p>Action Step: Decrease alcohol consumption for 12-20 year olds and/or prescription drug and illicit opioid misuse and use in 12 to 25 year olds as well as address other community identified substance use priorities through the Partnership for Success initiative</p>	<p>Action Step: Increase awareness of the dangers of sharing medication for individuals age 18 and older, and the risks of overprescribing for prescribers and others in the medical community through the Strategic Prevention Framework for Prescription Drugs initiative (SPF Rx)</p>
<p>Action Step: Assess regional behavioral health needs; develop regional priority reports that identify services gaps; pursue resources and coordinate community efforts to prevent and treat substance use, mental health and gambling disorders via the Regional Behavioral Health Action Organizations</p>	

Accomplishments

With an eye towards best practices, data driven decision making and a more streamlined system of strong collaborations, over the past three years, the prevention division has strategically realigned and expanded its infrastructure. It has done this by: using the strategic prevention framework planning model to provide accountability-based, developmentally appropriate and culturally sensitive services; establishing the Center for Prevention Evaluation and Statistics (CPES) as a core component of the infrastructure to facilitate data driven decision-making; building strong collaborations at the local and state levels; and leveraging additional resources to support prevention efforts.

Behind these service improvements and expansions are community-based agencies funded to promote healthy lifestyles for Connecticut’s citizens. This is achieved through programs that reduce negative factors that are known to cause illness and problem behaviors, and encourage positive factors that buffer individuals and promote good health.

SUICIDE PREVENTION AND MENTAL HEALTH PROMOTION

Suicide prevention and mental health promotion activities, while not solely targeted towards persons with substance use issues, are provided in Connecticut with substance abuse prevention funding and are therefore included in this report.. Through the CT Suicide Advisory Board co-chaired by the Departments of Mental Health and Addiction Services, Children and Families and the American Foundation for Suicide Prevention: engaged 44 sites in 34 systems in monthly learning communities on the Zero Suicide evidence-based program; developed and released poison and firearm suicide prevention materials; and posted suicide prevention signage on the Arrigoni Bridge through the Lethal Means Committee. With the federal Garrett Lee Smith (GLS)

youth suicide prevention funds: formed 5 Regional Networks of Care (RNCs) to implement suicide prevention and response strategies in local communities; developed, evaluated and disseminated “Gizmo’s Pawesome Guide to Mental Health” for elementary youth to support their mental health and wellness. Twenty schools with over 2,000 students were chosen to participate in a pilot of the curriculum and the Guide has since been distributed nationwide. GLS funds were also used to support 20 school systems to adopt evidence-based practices and programs kindergarten through 12th grade for suicide prevention and mental health promotion.

The Specialized Crisis Intervention Team (CIT) for Young Adults (SCYA) initiative ended in 2018. 796 young adult clients age 18-29 were served through crisis intervention assessment, engagement, case management and follow up services. Wallet Cards were developed and disseminated to police departments with a tear-off card for officers to give to young adults and families with the peer connection QR reader, suicide hotline, and toll free SCYA Resource/Referral Line. A total of 954 officers participated in 15 CIT trainings over the grant period. A Young Adult Coordinator position was created at NAMI-CT, and 5 young adult groups were developed and were sustained statewide.

The Connecticut Safe Schools/Health Students Diffusion Project, (CSSHSDP) wrapped up in 2018. Evidence based trainings and practices have been implemented in all three of the school district partners in the project. These included: PBIS, Ruler, Youth Mental Health First Aid, Boys Town, Effective School Solutions, and Restorative Practices. The school districts continued partnering with community resources to offer more comprehensive services to students. A one-day conference with over 300 attendees was offered to diffuse the best practices and lessons learned. Targeted supports were provided to 6 schools around their systems for tiered behavioral supports and a website was created to host conference materials and all resources compiled during the CSSHSD grant.

The CT STRONG State Level Transitions Teams with members from over 20 state and community agencies served as the advisory for the CT STRONG grant and met twice a year. 3 community teams (New London, Milford & Middletown) served 120 youth annually by providing wrap around services and supports for youth who have, or are at risk for developing a serious mental health disorder. Focal Point, a journal of Portland State University, published an article on the preliminary outcomes of the CT STRONG grant in May of 2019. The five year, SAMHSA funded grant, concludes September 2019.

TRAINING AND TECHNICAL ASSISTANCE SUPPORTS

1. Center for Prevention Evaluation & Statistics (CPES)

CPES provides coordination and leadership for the State Epidemiological and Outcomes Workgroup (SEOW). The SEOW meets four times a year and its membership consists of representatives of state agencies, academic institutions and private organizations with an

interest in epidemiological data relative to substance use consumption, consequence and related data. The SEOW re-launched the data portal in February of 2019. The new and expanded portal has increased data offerings and expanded functionality. CPES conducted the Community Readiness Survey (CRS) in 2018. The CRS is implemented every two years and the information collected has generated community readiness profiles for the state and sub-regions. It is also utilized for planning and to obtain funding and resources at the state and local levels.

2. Governors Prevention Partnership (GPP)

The GPP provides leadership in the areas of positive school climate, bullying prevention, mentoring, the prevention of underage drinking and drug use and positive youth development. It provides oversight and coordination of the Youth Leadership Advisory Board which provides professional development and asset skill building for peer advocates and young adult leaders to strengthen their advocacy roles in Prevention and in their communities. GPP also connects with media outlets to increase public awareness of substance use by disseminating monthly press releases, blog posts and website updates.

3. CT Healthy Campus Initiative (CHCI)

Members of the CT Healthy Campus Initiative met 7 times per year to focus on substance use prevention and mental health promotion. 3 CT campuses were funded to implement the College AIM (Alcohol Intervention Matrix) to reduce substance use on their campus. 17 CT campuses received Opioid STR funding to implement public awareness and education activities related to Opioid Overdose, safe medication storage and disposal on their campuses.

4. CT Clearinghouse

During the period of July 2015 to September 2018, over 280,000 materials related to Opioid and prescription drug use were disseminated. Connecticut Clearinghouse staff provided trainings and education to professionals on a variety of evidence based curriculum including, ASSIST, Mental Health First Aid and QPR, and resources and staffing for at least five conferences, health fairs and symposiums annually.

5. Training and Technical Assistance Services Center (TTASC)

The TTASC provided leadership in the area of training and workforce development by supporting the Training & Technical Assistance Advisory Council, which meets twice annually. 12 Community Strategic Prevention Framework (CSC) and 8 Partnership for Success (PFS 2015) community coalitions were trained on the implementation of the Strategic Prevention Framework (SPF) 5 step process. A Coalition Vitality Assessment tool was created for use by coalitions to guide them in continued coalition development. Face to face training (Learning Communities) as well as web based training (explainer videos and hybrid webinars) were presented on topics related to substance use

prevention, substance use disorders and workforce development. During the period of 9-2017 to present 48 training events occurred with over 800 persons trained.

PRESCRIPTION DRUGS AND OPIOIDS

Under the SPF RX initiative the Change the Script opioid awareness campaign was developed and launched. 4 health districts in high burdened communities were funded to promote the campaign and conduct opioid awareness and education activities. A number of expansions and improvements were made to the CT Prescription Monitoring and Reporting System (CPMRS). Upwards of 4 million clinical alerts and notifications were sent to users and 34 hospitals and healthcare institutions have been able to link their patients' electronic health records to the CPMRS.

Through the STR and SOR initiatives, a number of strategies and activities addressing multiple targets in a variety of settings were implemented to prevent opioid misuse and non-medical use of prescription drugs. As a result: 2,600 opioid overdose reversal kits were distributed; 17 colleges implemented campus based public awareness/education events that served over 12,266 persons; parent trainings were held in English and Spanish across the state to teach parents how to effectively communicate with children on the dangers of drug use; 75 micro grants were awarded to communities to deploy the Change the Script campaign through materials, mall and public transportation signage, billboards and social media; and several in person and interactive web based training and a webinar were developed along with accompanying users guides on opioid education and awareness.

PREVENTION OF TOBACCO USE BY MINORS

The FDA Tobacco Compliance Program and the federal Synar mandate require the enforcement of federal and state laws that restrict the sale of tobacco products to minors. Inspections relative to these laws continued to be conducted by the prevention division. The Community and Retailer Education Steering Committee CRESC which informs materials on education and awareness of tobacco laws to retailers met quarterly in FYs 2016, 2017 and 2018. They created a tobacco retailer email listserv and launched the first and second edition of the newsletter the *Responsible Connecticut Retailer*. The new 27 awareness campaign was launched advising retailers to check the photo ID of anyone under the age of 27 years old when selling tobacco or Electronic Nicotine Delivery System (ENDS) devices, and an annual letter sent to all licensed retailers providing awareness and a new state notice sign. Over 2500 retailers have completed the online training course: *Tobacco Sales: Do The Right Thing*.

The retailer violations rates RVR for federal fiscal years 2018 (RVR 8.8%) and 2019 (RVR 9%) Annual Synar Reports, the first time the program had consecutive RVR's under 10%. A total of

5,472 unannounced compliance inspections were completed in 2016, 4,637 unannounced compliance inspections in 2017 and 6,081 unannounced compliance inspections in 2018. Under the FDA Tobacco Compliance Program, a total of 2,406 advertisement and labeling inspections (A&L) in 2016, 1191 A&L inspections in 2017 and 534 A&L inspections in 2018. In 2016, the FDA began conducting Electronic Nicotine Delivery Systems ENDS compliance inspections.

COMMUNITY PREVENTION ACTIVITIES

The eight community coalitions and 12 towns awarded under the PFS 2015 initiative have completed a needs assessment, strategic plan, implementation plan, evaluation plan, and sustainability plan. Strategies implemented include: Social Marketing Campaigns (Change the Script and individual town campaign), Enforcement (Alcohol Compliance Checks, Surveillance), Raising Awareness and Training/Education (Community events, presentations, PSAs) and Capacity building (coalition).

The coalitions funded under the CSC initiative successfully completed and evaluated school and local survey data which revealed decreases in teen use rates of alcohol, marijuana, and prescription drugs. They created information briefs and forums to inform their communities of the findings. Coalitions also completed Sustainability Plans to implement in the absence of state and federal funding. Coalition staffs have obtained professional credentials as Certified Prevention Specialist through ongoing education services provided by DMHAS.

Strategy 2: Strategies Related to Treatment

<ul style="list-style-type: none"> ❖ Expand access to broad spectrum of substance use services. ❖ Increase the use of evidence-based treatments (EBP’s) 	
<p>Action Step: Create statewide network of walk-in assessment centers and provide transportation to detoxification programs to rapidly assist clients to find appropriate treatment</p>	<p>Action Step: Maintain comprehensive substance use treatment system</p>
<p>Action Step: Provide specialized services to DCF involved parents with substance use problems</p>	<p>Action Step: Expand Clinic-Based MAT</p>
<p>Action Step: Increase capacity in substance use outpatient programs and in outreach programs to prescribe buprenorphine and naltrexone</p>	<p>Action Step: Apply for federal funding being made available to expand substance use services</p>
<p>Action Step: Maintain screening for substance use and early intervention after grant expiration. (SBIRT)</p>	<p>Action Step: Improve linkages from detoxification programs to follow-up care</p>
<p>Action Step: Implement a statewide toll free call line to connect callers to treatment options</p>	<p>Action Step: Increase adoption and expansion of EBP’s through learning collaboratives</p>

Accomplishments

COMPREHENSIVE TREATMENT SYSTEM

DMHAS is the state's lead agency for the prevention and treatment of alcohol and other substance abuse. As such, it provides a variety of [treatment services on a regional basis](#) to persons with substance use disorders, including residential detoxification, long-term care, long-term rehabilitation, intensive and intermediate residential services, methadone or chemical maintenance, outpatient, partial hospitalization, and aftercare. DMHAS' FY 18 budget for substance use services was approximately \$149,000,000 and blends state general funds with federal block grant funds. The DMHAS substance use treatment system includes approximately 51 providers with over 300 programs. In the same period (FY 18), DSS spent over \$95,000,000 for substance use services offered under Medicaid. The state as a whole spent almost 332 million in FY 18 for a range of substance use services.

CALL LINE

Rapid access to treatment is another essential component of a comprehensive strategy designed to address the opiate epidemic. Connecticut has responded to the opiate crisis by implementing a toll free number where services related to opiate addiction can be accessed. The toll free line is staffed 24/7 and links callers to a network of walk-in centers where somebody can receive a same day evaluation of their needs. The 24/7 call line is as follows: **1-800-563-4086**. They are receiving between 2,200 and 2,900 calls monthly. Call Line services have been enhanced over the past 3 years and now provide transportation to those individuals who need to be connected to detoxification or residential services. Two providers offer these transportation services statewide. Priority is given to transporting people to detox and residential treatment. Over 600 rides per month are provided.

WALK-IN EVALUATION CENTERS

Over 50 programs continue to conduct same-day evaluations in order to link the clients to the most appropriate level of care. These walk-in centers and their locations can be accessed at the following link: <http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=577738>

FOLLOW-UP CARE

Changing Pathways to Opioid Use Disorder Recovery

Many withdrawal management programs follow an abstinence-based medical detoxification protocol, discharging or transferring a client once the detoxification medication has been tapered to zero. The period after detoxification is an especially high-risk time for opioid-use relapse, as well as accidental overdose and/or death due to decreased physical tolerance. Thus, induction on MAT during withdrawal management and a seamless transition/warm hand off to follow-up care can save lives for individuals choosing to support their recovery with medication.

In October 2018, Beacon Health Options, under the auspices of the Connecticut Behavioral Health Partnership, along with InterCommunity Inc., and Hartford Healthcare's Rushford Center launched the Changing Pathways project. Changing Pathways uses a person-centered, multidisciplinary approach to incorporate MAT induction into withdrawal management care. The three essential components of the Changing Pathways model are:

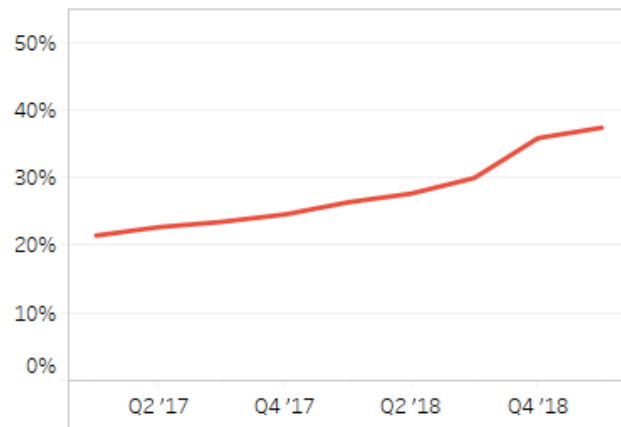
1. Frequent and thorough education of individuals with OUD on MAT
2. Offering individuals with OUD the option to be inducted on MAT during their withdrawal management/detox stay
3. Comprehensive discharge planning and seamless warm transfers to guarantee continuation of MAT post-discharge

These three essential components have numerous benefits for providers and individuals with OUD. MAT has been shown to reduce the risk of relapse and overdose, support individuals significantly in sustaining long-term recovery, and to allow individuals to better tend to other behavioral and/or medical issues they are facing compared to individuals who pursue treatment without medication.ⁱ

Initial results are promising:

- 🐛 Monthly induction rates were as high as 25% within the first eight months as compared to a baseline of 0-1% per month
- 🐛 Randomly selected chart reviews indicated that all clients choosing MAT were given MAT education
- 🐛 The 7-day readmission rate and the percent of members leaving Against Medical Advice (AMA) were lower than that of clients choosing traditional detoxification/withdrawal management
- 🐛 Additionally, statewide, the rate of connection to MAT post-discharge from withdrawal management for individuals with OUD increased from 27.6% in CY Q2 '18 (the three month period prior to implementing Changing Pathways) to 37.4% in CY Q1 '19

Discharges with a Connection to MAT Over Time
Statewide



CLINIC-BASED MAT

The support and expansion of Clinic Based Medication Assisted Treatment has been a priority in Connecticut as an alternative to office-based opioid treatment (OBOT) for those individuals who are without private insurance or the means to otherwise pay a private practitioner. Currently DMHAS is providing this service in 10 clinics across the state and 2 additional clinics are being brought on. CB-MAT is offered in traditional licensed outpatient clinics or Federally Qualified Health Centers that typically offer an array of other behavioral health, recovery and primary care supports. Clients have the benefit of accessing this menu of services all under “one roof”. The medications offered within state-funded CB-MAT programs are buprenorphine and naltrexone. Naloxone prescriptions or kits are available. Depending on the particular clinic, a multi-disciplinary team is available for clinical and recovery support that may include individual, group and family therapy; recovery coach services, employment support, psychiatric services, primary care and dental care. In the “Enhanced MAT” clinics, DMHAS has been able to support the hiring of a full-time Recovery Coach in addition to a full-time employment specialist.

FEDERAL GRANT OPPORTUNITIES

Each year DMHAS has approximately \$70 million in federal grant dollars coming into the system. Over the past three years, it ranged from \$65 million to \$72 million. Related to substance use services, three SAMHSA grants in particular were awarded including the Medication Assisted Treatment Expansion (MATx for \$3 million), the State Targeted Response (STR for \$11 million) and the MATx Supplemental grant for \$250,000.

REAL-TIME WEB-BASED ADDICTION SERVICES BED AVAILABILITY

In November 2017 DMHAS launched a real-time web-based addiction services bed availability system. This was funded through the federal MATx SAMHSA grant. DMHAS operated and funded programs update the site at least daily to inform the public on the current availability of

detox, residential treatment, recovery house, and sober house services. There are more than 1200 beds represented on this site.

EVIDENCE-BASED PRACTICES AND LEARNING COLLABORATIVES

DMHAS facilitates a number of learning collaboratives with providers to enhance addiction services, including collaboratives on Methadone, MAT, Residential Treatment, Recovery Houses, and Infectious Disease Education/Testing. DMHAS has a workforce development division that puts out a catalogue of trainings and DMHAS contracts with the CT Women’s Consortium (CWC) to facilitate trainings on addiction related topics. For example, a new training and implementation initiative through the CWC is on auricular acupuncture.

Strategy 3: Strategies Related to Recovery

<p>❖ Increase the use of peers and natural supports.</p> <p>❖ Maintain recovery supports.</p>	
<p>Action Step: Expand the use of peers in DMHAS funded or operated services</p>	<p>Action Step: Expand the use of peers in hospital emergency departments.</p>
<p>Action Step: Increase use of telephonic aftercare</p>	<p>Action Step: Provide short-term Supported Recovery Housing and other recovery supports</p>
<p>Action Step: Expand wellness programs</p>	<p>Action Step: Maintain high levels of consumer satisfaction</p>
<p>Action Step: Expand use of natural supports</p>	<p>Action Step: Continue to develop certified peer workforce</p>

Accomplishments

DMHAS has worked with Connecticut’s recovery community on a number of initiatives that support recovery. These activities include the development of peer supports, telephonic support following treatment, the use of recovery centers, use of peers in treatment programs, and programs oriented at wellness. These are described in further detail below.

CCAR RECOVERY COACH ACADEMY

As part of DMHAS’ contract with the Connecticut Community for Addiction Recovery (CCAR), CCAR provides Recovery Coach training to individuals who want to work with people with SUDs. Coaches work in a variety of settings (e.g., ED, methadone, outpatient). The training is a five day intensive curriculum.

CCAR TELEPHONIC AFTERCARE

As part of DMHAS' contract with the Connecticut Community for Addiction Recovery, CCAR provides telephonic aftercare to individuals who have been discharged from addiction treatment facilities. The service is also available to persons in recovery who feel that a regular check-in would be beneficial to them. Last year CCAR reports that they are calling over 1,000 persons a week and had over 12,500 conversations with persons in recovery over the course of the year. The Aftercare Program is seen as a cost effective method to provide support to persons in recovery and quickly link those individuals back to treatment when they may require additional treatment. It also helps connect persons in recovery with 12 step groups and other natural supports within the community.

WELLNESS AND INTEGRATED HEALTH

Connecticut's advocacy community offer a number of activities focused on wellness and holistic health. Examples include things like Toivo, CCAR's Recovery Centers, and wellness programs like those at Connecticut Valley Hospital. Toivo, by Advocacy Unlimited is an initiative that includes statewide classes, workshops, and a mind/body focused wellness center where people can engage in yoga, meditation, fitness activities, and other creative and expressive activities. DMHAS began a statewide Integrative Medicine Collaborative a couple years ago, including quarterly meetings and an annual conference that draws more than 400 participants.

SUPPORTED RECOVERY HOUSING

DMHAS contracts with Advanced Behavioral Health to maintain a network of short-term Supported Recovery Housing. Statewide there are 14 contracted Recovery House providers offering structured sober living in 47 locations which have over 200 beds. Approximately 1,300 individuals were served in the last year. The program provides short-term funding to support persons in recovery who may be transitioning out of treatment programs back into the community. The program provides temporary assistance until an individual can gain more permanent housing and work. DMHAS contracted Supported Recovery Houses were added to the DMHAS bed availability website in the fall of 2018.

RECOVERY CENTERS

CCAR's Recovery Centers are community anchors for recovery offering a range of supports including employment and housing services, training, and recovery social events. CCAR has three distinct Recovery Centers; Hartford, Windham, and Bridgeport. A range of supports are offered at these centers by persons in recovery.

RECOVERY COACHES IN EMERGENCY DEPARTMENTS

In March 2017, the CT Department of Mental Health and Addiction Services (DMHAS) partnered with the Connecticut Community for Addiction Recovery (CCAR) to launch an

initiative that pairs on-call recovery coaches with Emergency Departments in four hospitals in eastern Connecticut. The recovery coaches assist people who are admitted with opioid overdose and other alcohol or drug-related medical emergencies and connect them to treatment and other recovery support services. This program was expanded in September 2017 and again in 2018 through the support of federal grants which allowed eight additional hospitals to offer Recovery Coach Services to ED patients.

RECOVERY COACHES IN METHADONE MAINTENANCE PROGRAMS

DMHAS received funding in 2018 to support recovery coaches in 8 methadone maintenance programs. Prior to this expansion, DMHAS provided funding for 4 recovery coaches at community-based clinics across the state. These staff were introduced as a tool for increasing our ability to engage substance abuse clients in services.

OPIOID EDUCATION AND FAMILY SUPPORT GROUPS

Weekly opioid education and family support meetings are being provided in seven locations statewide. (New Haven; Hartford (2); Plainville; Willimantic; Torrington; New London). These meetings are designed for family members who have loved ones that are misusing opioids.

Strategy 4: Strategies Related to Criminal Justice

<ul style="list-style-type: none"> ❖ Implement criminal justice reforms that will increase diversionary options and the availability of substance abuse treatment in jails and prisons. ❖ Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail 	
<p>Action Step: Continue to support Law Enforcement Assisted Diversion (LEAD) programs, a pre-booking program that diverts to services as an alternative to arrest. Two programs were initiated in early 2018</p>	<p>Action Step: Transition offenders with drug convictions to community substance use programs</p>
<p>Action Step: Sustain the CSSD-operated Treatment Pathways Program in three courts to divert persons with substance use disorders from jail and into treatment services</p>	<p>Action Step: Increase housing opportunities for ex-offenders</p>
<p>Action Step: Implement diversionary services for individuals arrested for crimes related to substance use</p>	<p>Action Step: Increase employment training and job opportunities for ex-offenders</p>
<p>Action Step: Provide substance use services to persons who are incarcerated</p>	

Accomplishments

Many individuals that are involved with the criminal justice system have struggled with substance use and may be at-risk for continued use when they return to the community. Others have been arrested for low-level crimes that were related to substance use. Connecticut has developed strong collaborations between DMHAS, DOC, Judicial Branch CSSD, and DCF that focus on diverting individuals, where appropriate from prison or jail or focus on community re-entry after being released from prison.

SECOND CHANCE INITIATIVES

Legislation signed by Governor Malloy in June 2015 reduced penalties for drug possession and eliminated mandatory sentencing requirements. Funding was approved in that year's budget for three initiatives that are part of the "Second Chance Society" including funding for the following programs: I-BEST, an employment program for ex-offenders in the Hartford area, Connecticut Collaborative on Re-Entry, a successful housing program aimed at individuals that repeatedly cycle in and out of the homeless service and correction systems, and a School-Based Diversion Initiative aimed at reducing suspension, expulsions, and school-based arrests in grades K-12.

DOC METHADONE MAINTENANCE PILOT

The Methadone Maintenance Program began as pilot program in October of 2013 and has since expanded to the 4 jails and in 1 sentenced facility for the male offenders and is also available in our only female facility. Clients are provided methadone treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. In 2018, 845 patients were treated with methadone maintenance at 6 DOC facilities. Clients are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release

COLLABORATIVE CONTRACTING WITH DOC AND JUDICIAL BRANCH CSSD

DMHAS is currently involved in collaborative contracting projects with the Judicial Branch CSSD and DOC. This project combines funding and jointly purchases intensive, intermediate, and recovery house beds from DMHAS-contracted substance use providers. A certain number of beds are reserved for clients from DOC or CSSD. The beds are used for diversion from jail and re-entry to the community.

DMHAS FORENSIC SERVICES

The DMHAS Division of Forensic Services funds community agencies to provide services to people with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism.

The Women’s Jail Diversion, Jail Diversion Substance Abuse (JDSA), Alternative Drug Intervention programs provide a full complement of clinical and support services to criminal court defendants with substance use disorders. The Pretrial Intervention Program is a suspended-prosecution diversion program for first-time DUI offenders and drug possession offenders that provides alcohol and drug education groups or referral to a substance use treatment program. Transitional Case Management is a re-entry program that provides pre-release engagement and discharge planning and post-release OP substance abuse treatment and support services for men.

LEAD INITIATIVE

Law Enforcement Assisted Diversion is a new program that was developed with the community to address low-level drug crimes in Hartford and New Haven. It is a pre-booking diversion program that allows officers to redirect low-level offenders engaged in drug activity to community-based services instead of jail and prosecution. LEAD participants begin working immediately with case managers to access community-based treatment and support services – including housing, healthcare, job training, substance use treatment and mental health support -- instead of processing them through traditional criminal justice system avenues. A unique coalition of law enforcement agencies, public officials, and community groups collaborated to create this pilot program. These groups make up LEAD’s Policy Coordinating Group, which governs the program.

Strategy 5: Strategies Related to Collaboration and Cost Effectiveness

❖ Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.	
Action Steps: Improve quality of care through the expansion of data sharing	Action Steps: Increase inter-agency collaboration for treatment services
Action Steps: Increase inter-agency collaboration for prevention services	Action Steps: Maximize federal and state funding and avoid costly duplication of efforts

Accomplishments

State agencies are involved in multiple collaborations that focus on inmates, community re-entry and jail diversion, substance-using parents, and specialized supports for adolescents. Some of these collaborations are described under other strategies but they will be briefly reviewed below.

COLLABORATIVE CONTRACTING WITH DMHAS, DOC, AND JUDICIAL BRANCH CSSD

DMHAS is involved in collaborative contracting projects with the Judicial Branch CSSD and DOC. This project combines funding and jointly purchases intensive, intermediate, and recovery house beds from DMHAS-contracted substance use providers. A certain number of beds are reserved for clients from DOC or CSSD. The beds are used for diversion from jail and re-entry to the community.

JAIL DIVERSION AND RE-ENTRY PROGRAMS

The DMHAS Division of Forensic Services funds community agencies to provide services to people with mental illness and/or addictions who are justice involved. These programs are designed and operated in collaboration with criminal justice agencies to divert adults from jail, assist with reentry from jail/prison, and reduce recidivism.

RECOVERY SPECIALIST VOLUNTARY PROGRAM (RSVP)

The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody, and where substance use was a significant contributing factor in the removal. This is a joint DCF/DMHAS program. This program was eliminated in FY 2018.

DOC METHADONE MAINTENANCE PILOT

DOC, in collaboration with DMHAS, implemented a pilot program at New Haven Community Correctional Center in October of 2013, offering methadone maintenance to offenders who enter the facility already on a verified dose of methadone. A second program was added at Bridgeport Community Correctional Center in November 2014. Clients are provided treatment, as well as continued dosing, for their term of incarceration followed by re-entry planning services to continue the treatment upon release. This was expanded to the York, Osborne and Corrigan facilities.

ADOLESCENT SUBSTANCE USE SERVICES

DCF has maintained its focus on providing substance use services located in communities throughout the state that are accessible to all youth, and are evidence-based and family-focused. DCF's network of adolescent substance use treatment programs from SFY 2016 through SFY 2018 included:

- 30 Multidimensional Family Therapy (MDFT) in-home teams across 13 providers statewide; with X of these providers also offering the RAFT protocol described below

- 6 Multisystemic Therapy (MST) in-home teams across 3 providers covering nearly the entire state
- 2 Multisystemic Therapy Family Integrated Transitions (MST-FIT) in-home teams delivered by 1 provider covering eight DCF area office catchment areas
- 1 Multisystemic Therapy Transition Age Youth (MST-TAY) in-home teams across 2 providers covering 10 DCF area office catchment areas
- 6 Adolescent Community Reinforcement/Assertive Continuing Care (ACRA/ACC) clinic-based teams across 4 providers statewide
- 1 Multidimensional Family Therapy (MDFT) residential program

SUICIDE PREVENTION

A number of state agencies are involved in Suicide Prevention efforts including DCF, DMHAS, CSSD, Education, and DPH. Other stakeholders are involved in these efforts to reduce suicides and to develop a coordinated and supportive response when suicides occur. While these services may focus on individuals with mental health concerns, suicide prevention efforts are also directed at persons with substance use problems who may feel suicidal.

PHARMACIST ONLINE NARCAN TRAINING

DCP developed an online training for pharmacists. The training was informed by experts from other state agencies that participated in the development and review of the training tool.

Strategy 6: Strategies Related to Accountability and Quality Care

<p>❖ Ensure that providers deliver high quality services.</p> <p>❖ Use data to improve care throughout the system.</p>	
<p>Action Step: Ensure providers submit timely and accurate data</p>	<p>Action Step: Establish performance measures for all SUD levels of care and benchmark performance annually</p>
<p>Action Step: Implement and enhance the DMHAS provider performance measurement system</p>	<p>Action Step: Monitor emerging needs and trends by compiling and reviewing Annual Statistical Data</p>
<p>Action Step: Increase the % of SUD clients that have continuous treatment exposures that exceed 90 days</p>	<p>Action Step: Utilize data systems to identify and address health disparities</p>
<p>Action Step: Ensure services are well utilized</p>	

Accomplishments

DATA SYSTEMS

The Department uses two systems to capture substance abuse data. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers and was implemented in 2009. The second system WITS collects client level data from state-operated facilities. This system was implemented in mid-May 2014. Both systems capture a broad range of data including demographics, admission and discharge info, diagnostic information and the services individuals receive within our programs. These new data systems have greatly enhanced the department's ability to collect and report on the all clients served within our system and track measureable outcomes.

PROVIDER QUALITY REPORTS

The data described above feeds our Performance Measurement System. The Department of Mental Health and Addiction Services (DMHAS) introduced Provider Quality Dashboard Reports as part of a performance evaluation system in 2009. This system uses contractually specified performance measures for each mental health and substance use level of care (i.e., detoxification, intensive residential, outpatient) and benchmarks for performance. The quality reports are issued quarterly and posted to the DMHAS website. These reports can be found at the following link: <http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=489554>.

The FY 15 annual performance measures are benchmarked and can be found at the following link:

http://www.ct.gov/dmhas/lib/dmhas/eqmi/SA.LOC.FY15_Performance_Measure_Goals_and_Statewide_Avge.pdf

The link shows each performance measure for substance use levels of care, the goal, and the state average for each measure. This allows DMHAS' Quality and Monitoring Departments to review system averages as well as those of individual providers.

OUTLIER DATABASE

DMHAS launched a companion database to the Provider Quality Reports in 2013 called the Outlier Database. This database allows DMHAS staff to easily compare provider and program performance and is used to focus on quality improvement efforts. In early spring 2016, the database began to include functionality that allowed DMHAS to stratify agency and program performance based on race and ethnicity. While just launched, this innovation will help DMHAS and provider agencies to identify and address health disparities that may exist within the system.

ANNUAL STATISTICAL REPORT

DMHAS developed an Annual Statistical Report that was first published in December 2014. That report examined two fiscal year's data. A second report was released in December 2015 which reported on Fiscal Year 15 activity. The report is now being produced on an annual basis.

The report includes information on clients served, demographics, substance use trends and service utilization data. The report was intended to annually capture essential information about service delivery in the DMHAS behavioral health system. The SFY 18 Annual Statistical Report can be found at the link listed below:

<https://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreport2018.pdf>

PRESCRIPTION DRUG MONITORING PROGRAM

The State's Department of Consumer Protection has already taken steps that partially address some of the action steps identified above. The state implemented a Prescription Monitoring Program (PMP) in 2008. The PMP was designed to collect prescription data for Schedule II through V drugs into a central database which can be used by medical providers and pharmacists in the active treatment of their patients. Recently enacted legislation (October 1, 2015) requires health care professionals to check the PMP prior to prescribing opioid medications for greater than a 72-hour period. Additional provisions require that pharmacists enter controlled substance prescription data after July 1, 2016 immediately or no later than 24 hours. This will improve the data as previous requirements specified that data must be entered within a one week period. New legislation limited initial prescriptions for opioids to 7 days.

CONTINUOUS TREATMENT EXPOSURE

National research has shown that continuous treatment episodes that exceed 90 days or more result in better outcomes. This measure cuts across all substance abuse levels of care. DMHAS first reported on this measure in our last report. DMHAS examined clients that were active or admitted during a fiscal year to determine the percentage that remained in treatment with no interruption for greater than 90 days. The information for FY 16, 17, and 18 is as follows:

FY 16: 56%

FY 17: 56%

FY 18: 56%

ANNUAL CONSUMER SATISFACTION SURVEY

DMHAS administers a Consumer Satisfaction Survey which typically receives over 25,000 respondents. The instrument was developed by states across the country that were looking for a tool that allowed them to compare results to national data. DMHAS consistently receives high marks on this survey and typically exceeds national outcomes.

Other State Agency Substance Abuse Initiatives and Accomplishments

➤ Department of Children and Families (DCF)

DCF remains committed to serving youth and families in their communities using evidence-based treatment and promising practices that integrate treatments for substance use and mental health, and that improve family functioning. DCF funds a wide array of substance use services including outpatient, intensive in-home and residential treatment services for youth, as well as specialized services for caregivers who are involved with child protective services. The majority of the Department's community-based services for adolescent substance use are evidence-based and equipped to address problems related to the use of any substance, including opioids and prescription drugs.

Caregiver substance use programs funded by DCF are home-based. These services aim to prevent removals of children from their homes, or support reunification of the family when a removal has occurred. This is accomplished through intensive services that address substance use and the multiple correlates that affect child well-being including child and parent trauma, mental health, parenting and attachment, housing, and vocation.

Table 1. DCF Substance6+9 Use Expenditures by Service Type, SFY15 and SFY18.

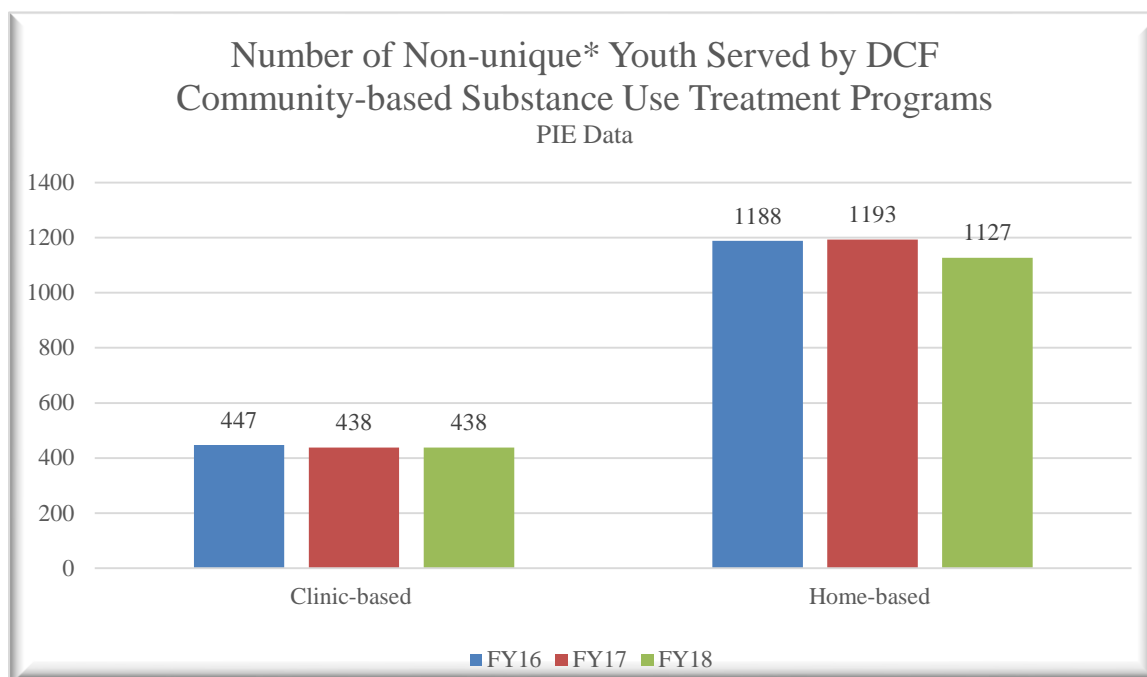
Service Type	FY2015 Expenditure	FY2018 Expenditure
Adolescent Outpatient treatment (Individual, Family and Group)	1,668,587.00	1,730,226.00
Adolescent Home-based treatment services	13,581,515.00	16,042,684.00
Adolescent Residential treatment	2,665,449.00	4,045,448.00
Adolescent Evidence-based Practice Quality Assurance	754,406.00	855,570.00
ADOLESCENT SERVICES TOTAL	\$ 17,383,268.00	\$22,673,928.00
Recovery Support Programs (RSVP and RCM)	1,637,942.00	1,241,770.00
MST-Building Stronger Families	1,658,949.00	2,610,017.00
Family Based Recovery	2,894,460.00	3,983,397.00
MST-BSF Consultation & Quality Assurance	341,840.00	334,840.00
CAREGIVER SERVICES TOTAL	\$ 6,533,191.00	\$8,170,033.00
TOTAL Substance Use Expenditures	\$23,916,459.00	\$28,178,513.00

DCF's uses data-driven planning to design and monitor its service system. All substance use treatment programs receiving DCF funds are required to use an evidence-based assessment called the Global Appraisal of Individual Needs (GAIN-Q3). Since SFY09 the Department also has collected standardized information from substance use providers through the Provider Information Exchange (PIE) portal. Data from the GAIN-Q3 and PIE systems enhance providers and DCF's ability to identify the population served, conduct needs assessment, compare client information across programs, implement systematic monitoring of outcomes, analyze program-specific goals and meet its statutory obligation to report on programs to the legislature.

ADOLESCENT SUBSTANCE USE SERVICES

DCF has maintained its focus on providing substance use services located in communities throughout the state that are accessible to all youth, and are evidence-based and family-focused. DCF's network of adolescent substance use treatment programs from SFY 2016 through SFY 2018 included:

- 30 Multidimensional Family Therapy (MDFT) in-home teams across 13 providers statewide; with X of these providers also offering the RAFT protocol described below
- 6 Multisystemic Therapy (MST) in-home teams across 3 providers covering nearly the entire state
- 2 Multisystemic Therapy Family Integrated Transitions (MST-FIT) in-home teams delivered by 1 provider covering eight DCF area office catchment areas
- 1 Multisystemic Therapy Transition Age Youth (MST-TAY) in-home teams across 2 providers covering 10 DCF area office catchment areas
- 6 Adolescent Community Reinforcement/Assertive Continuing Care (ACRA/ACC) clinic-based teams across 4 providers statewide
- 1 Multidimensional Family Therapy (MDFT) residential program

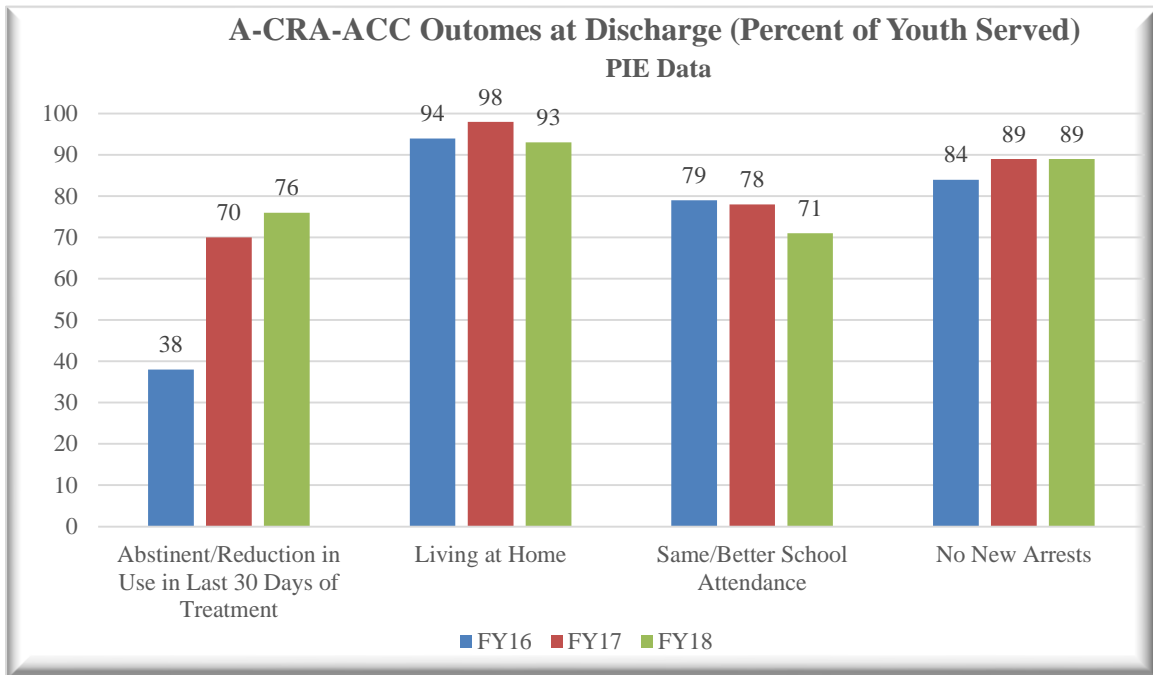


*Youth may have been served by multiple programs during the reporting period.

Outpatient Substance Use Services

ADOLESCENT COMMUNITY REINFORCEMENT APPROACH WITH ASSERTIVE CONTINUING CARE (A-CRA-ACC) is a three-month clinic-based outpatient behavioral therapy for adolescents age 12-17 inclusive with a substance use disorder diagnosis, and their caregivers. A-CRA is a behavioral intervention that replaces environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery. A-CRA works with adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together as a family. When recovery goals are achieved, adolescents are transitioned to ACC where they receive recovery support and case management in their home or community for three more months. A-CRA-ACC has shown success keeping adolescents living at home and engaged in school, reducing substance use, and preventing new arrests.

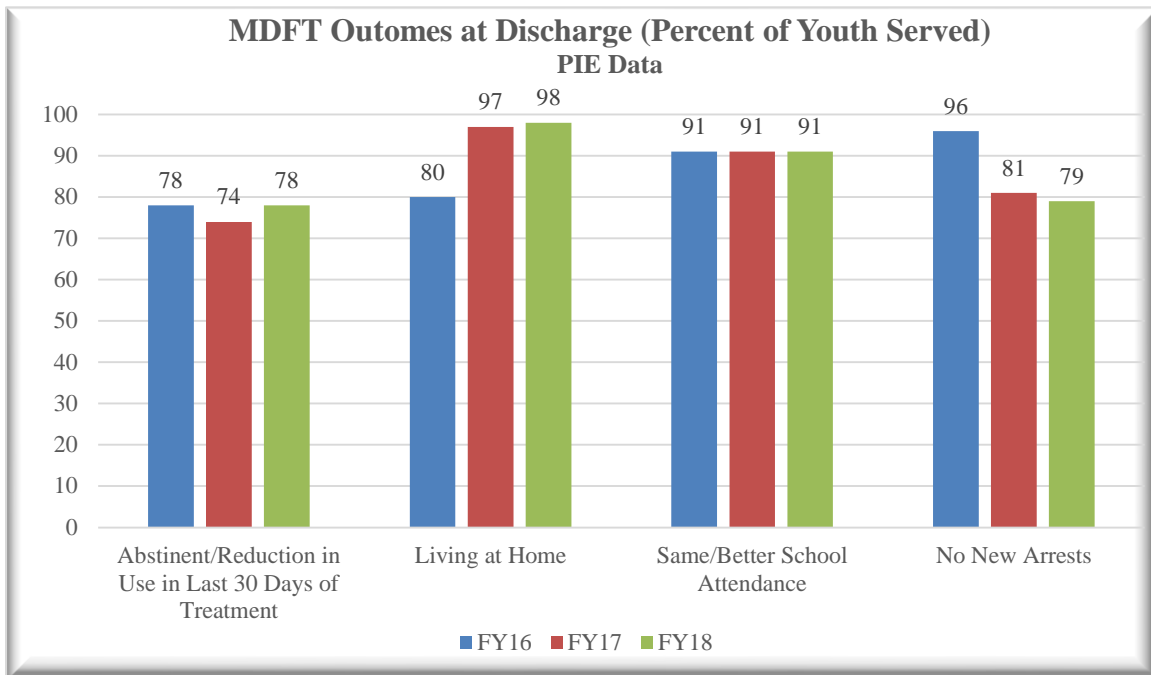
A-CRA-ACC Distinct Clients Served: 447 (FY16); 438 (FY17); 438 (FY18)



Intensive In-Home Substance Use Services

MULTIDIMENSIONAL FAMILY THERAPY (MDFT) is a family-based intensive in-home treatment for adolescents, 9-18 years of age, with significant behavioral health needs, either alcohol or drug related problems, or who are at risk of substance use problems. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health disorders, and school and family problems, and helps to prevent out-of-home placements of children. MDFT services are typically provided three times a week for four to six months (average length of stay is five months). During this time MDFT provides individual, caregiver, and family therapy, and case management services to each family in their home. During this reporting period, MDFT quality assurance and model fidelity were provided by Advanced Behavioral Health in Middletown CT. MDFT has shown success keeping adolescents living at home and engaged in school, reducing substance use, and preventing new arrests.

MDFT Distinct Clients Served: 931 (FY16); 914 (FY17); 889 (FY18)

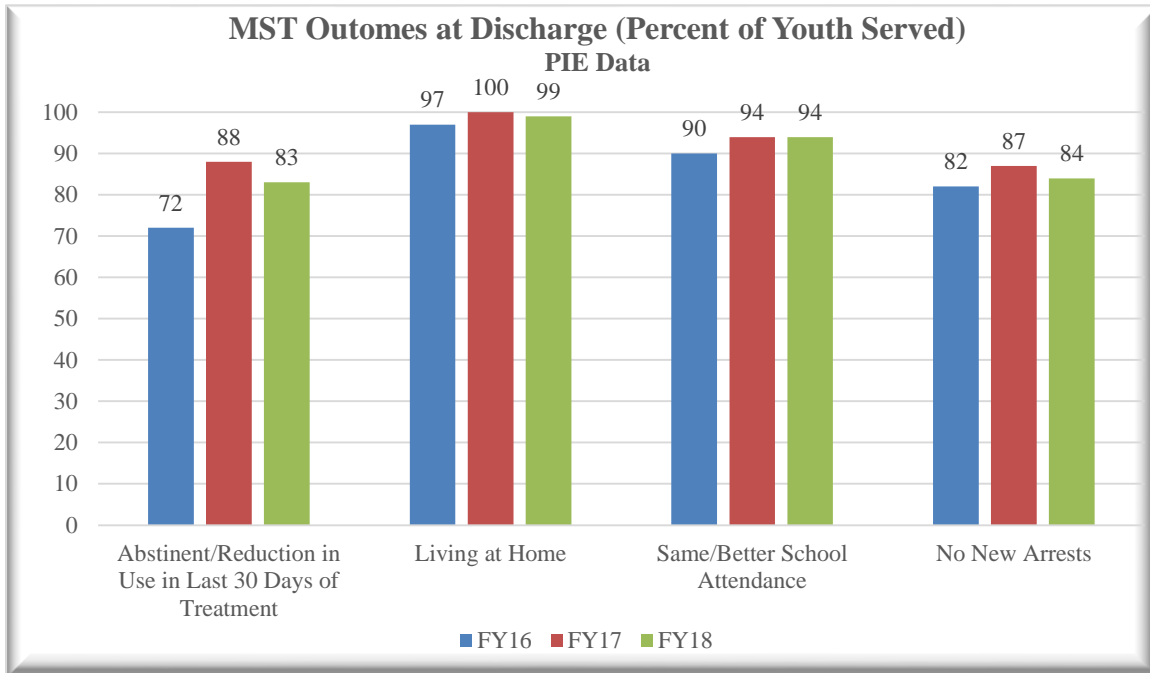


MDFT RE-ENTRY AND FAMILY TREATMENT (MDFT RAFT) is an enhanced MDFT approach for youth involved with parole, particularly youth who resided at the CT Juvenile Training School (CJTS), who have problems related to substance use and who are re-entering their communities after a year or more in a controlled environment. The RAFT approach is embedded within existing MDFT teams. RAFT aims to shorten lengths of stay in secure facilities and admissions to out of home placement, reduce costs associated with out of home placements, stimulate faster re-entry by eliminating or reducing step-down to residential programs, and improve youth outcomes related to substance use, illegal activity, family relationships and educational and vocational engagement.

Initially RAFT began services with youth and their families an average of 30 days prior to anticipated or scheduled release from the controlled environment. Program outcome data indicated that longer pre-release services improved successful re-entry for youth and their families. As a result, the protocol was changed so that referrals were made at least 60 days prior to anticipated or scheduled release from the facility. The longer pre-release services were determined to better prepare both the family and the youth for return home and successful re-entry into the community. Pre-release services are provided to youth in secure settings, and with their families in their homes. Upon release, MDFT-RAFT services are provided to youth and families together in their homes. The typical length of service, service intensity, and quality assurance of MDFT RAFT is similar to standard MDFT. Clients served and outcomes for MDFT RAFT are included in the rates for standard MDFT noted above.

MULTI-SYSTEMIC THERAPY (MST) is an intensive family- and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders. The environmental systems MST typically addresses include homes and families, schools and teachers, neighbourhoods, and friends. MST typically serves adolescents 12-17 years inclusive who have problems related to substance use, risk of substance use problems, or conduct disorders. MST services usually include two to three home visits each week over a three to five month period. MST has shown success keeping adolescents living at home and engaged in school, reducing substance use, and preventing new arrests.

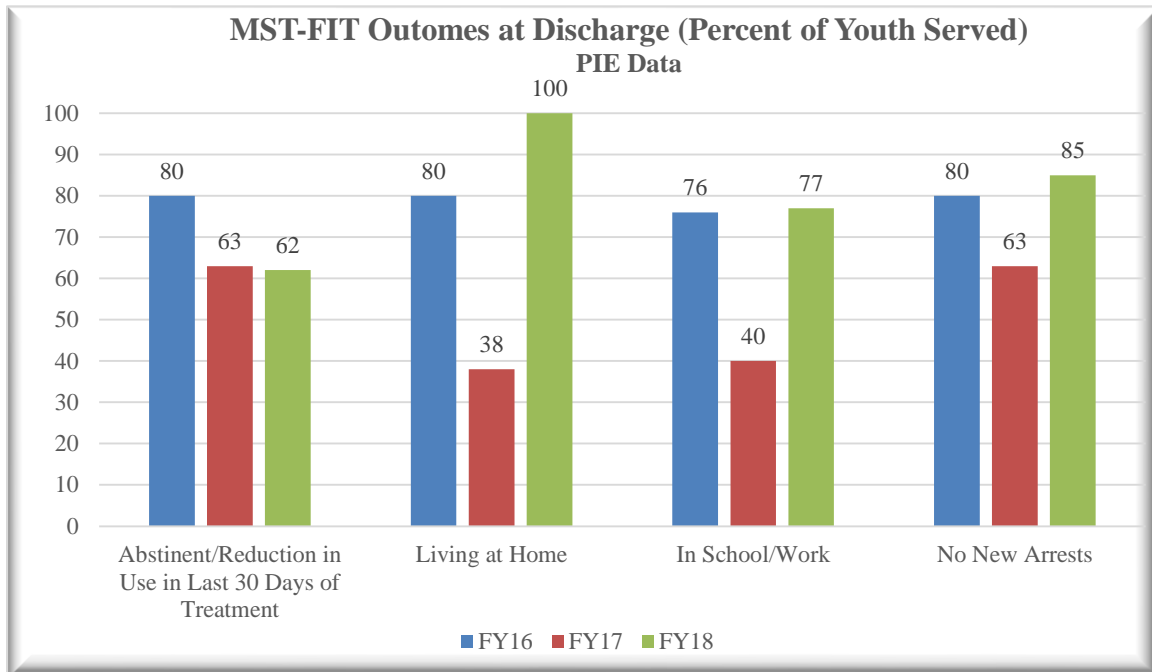
MST Distinct Clients Served: 211 (FY16); 219 (FY17); 204 (FY18)



MST FAMILY INTEGRATED TRANSITIONS (MST-FIT) is a re-entry service for youthful offender’s age 12-17.5 years who are placed in secure facilities, and their families. Integrated individual and family services are provided during the 60-day period prior to anticipated or scheduled re-entry to the community from residential or juvenile justice facilities. Pre-release services are provided to youth in the secure facilities, and with their families in their homes. Upon release MST-FIT services are provided to youth and their families in their homes. MST-FIT combines three evidence-based interventions targeting multiple determinants of antisocial behavior and systemic factors that create the context for problematic behavior. MST-FIT aims to shorten lengths of stay in secure facilities and admissions to out of home placement, reduce costs associated with out of home placements, stimulate faster re-entry by eliminating or reducing step-down to residential programs, and improve youth outcomes related to substance use, illegal activity, family relationships and educational and vocational engagement. MST-FIT services typically are provided two to three times weekly during a period of six months. MST-FIT quality assurance and model fidelity are provided by the model developers from the University of Washington in

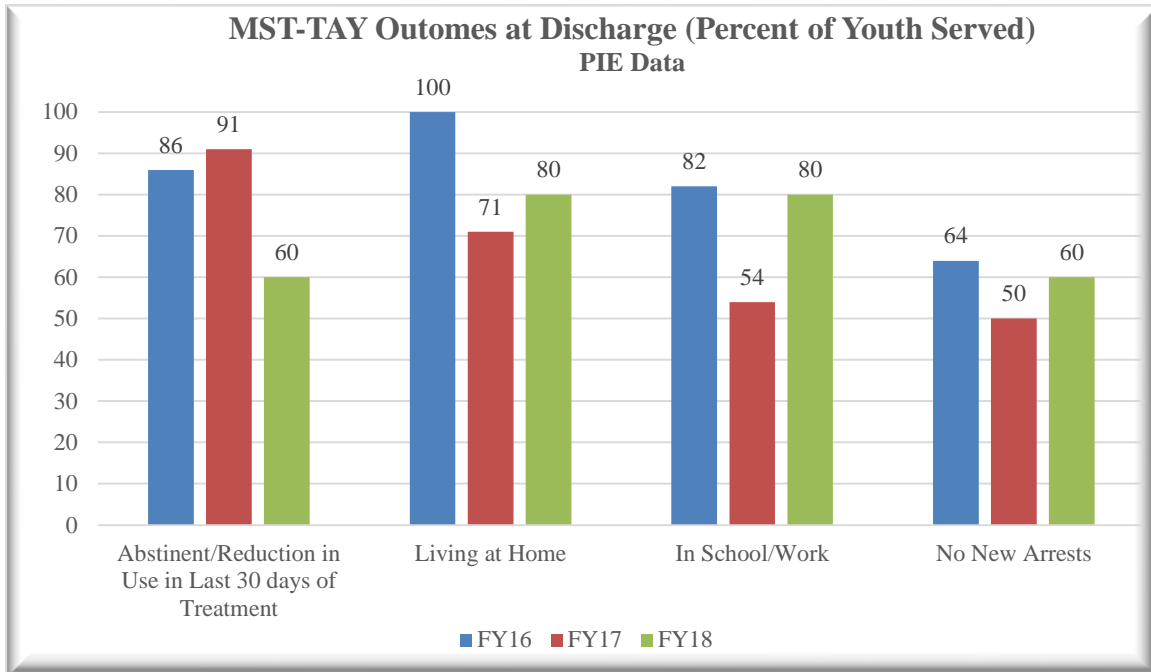
Seattle, WA. MST-FIT has shown success keeping youthful offenders living at home and engaged in school, reducing substance use, and preventing new arrests.

MST-FIT Distinct Clients Served: 28 (FY16); 29 (FY17); 20 (FY18)



MST TRANSITION AGE YOUTH (MST-TAY) is an intensive home-based service for older adolescents age 17-20 years inclusive who are involved with the juvenile or criminal justice system, and who have a serious mental health condition with or without a substance use disorder. MST-TAY services focus on building skills of independent living and addressing problems that impact healthy functioning as an emerging adult. The program aims to improve youth outcomes related to substance use, illegal activity, and educational and vocational engagement. MST-TAY treatment services typically last four to eight months, in conjunction with up to 14 months of life coaching services. MST-TAY quality assurance and model fidelity are provided by the model developers from the Oregon Social Learning Center in Portland, OR. MST-TAY has shown success keeping older adolescents living at home and engaged in school, and reducing substance use.

MST-TAY Distinct Clients Served: 18 (FY16); 31 (FY17); 14 (FY18)



DCF Residential Substance Use Treatment

MULTI-DIMENSIONAL FAMILY THERAPY RESIDENTIAL PROGRAM AT CT JUNIOR REPUBLIC is an 8-bed, short-term (4-6 months), family-centered Multidimensional Family Therapy (MDFT) residential program that opened in late summer 2016. The program serves males, ages 14-18, who are committed to the Department of Children and Families and who are experiencing substance use problems. This program integrates the MDFT model into all aspects of residential and clinical programming and provides an expansive array of educational, vocational, clinical, and residential programming.

In addition to the MDFT residential program, DCF has rate agreements with other residential programs to meet the heterogeneous treatment needs of youth requiring this level of care.

Caregiver Substance Use Services

There is strong recognition statewide and nationally that parental substance use problems are a key factor adversely affecting children’s immediate and future health and development. This is particularly true for children in the child welfare system. Over the past decade, DCF has continued to enhance and grow services designed to mitigate the impacts of parental substance use on children to increase their safety, well-being, and permanency.

PROJECT SAFE is a legislatively mandated collaboration between DCF and DMHAS that evolved into a joint contract between the state agencies and Advanced Behavioral Health (ABH), an Administrative Services Organization. Project SAFE provides DCF social workers access to a

centralized referral system for substance use services for adult caregivers involved with child protective services. Project SAFE services include screening (urine toxicology and hair testing), treatment evaluations, outpatient treatment (partial hospitalization, intensive outpatient, and group, individual and family counseling) and access to specialty residential programs for women and children through ABH. Funding for Project SAFE is braided; DCF funds substance use screenings and evaluations while DMHAS funds are used to support access to adult treatment services. Funds from both state agencies are used to support management by ABH of Project SAFE referrals and payments for treatment services.

Project SAFE Percent of Referred Clients Receiving Treatment Services (FY 12-FY 18)

	# Referred for Treatment	# Referrals Receiving Treatment	% Referrals Receiving Treatment
FY 13	2,214	1,204	54.38%
FY 14	2,284	1,185	51.88%
FY 15	2,231	1,141	51.14%
FY 16	1,085	Not Available	Not Available
FY 17	1,063	225	21.17%
FY 18	949	194	20.44%

During this reporting period DCF, in partnership with DMHAS, began a program improvement initiative for Project SAFE. This initiative was in response to observed multi-year declines in Project SAFE referrals and caregiver participation in services. The process included convening meetings of DCF social work staff and Substance Use Specialists, and Project SAFE adult treatment providers to discuss their experiences, identify client needs, and solicit ideas for program improvements. DCF also hosted a LEAN event with Project SAFE stakeholders (i.e., ABH, DCF, DMHAS, providers) to identify areas where program efficiency could be improved. This process identified improvement areas that led DCF to redesign the program and procure new services in late 2018.

RECOVERY SUPPORTS FOR CAREGIVER SUBSTANCE USE

Recovery support and intensive case management services were added to Project SAFE in 2009 to help families enter treatment and navigate the multiple systems with which they are often connected.

RECOVERY CASE MANAGEMENT (RCM)

Recovery Case Management (RCM) is an intensive recovery support and case management service for DCF involved families with problems related to substance use, and whose child(ren) are at risk of removal due to a parent or caregiver’s substance use. RCM aims to prevent out of home placement of children by child protective services by rapidly engaging caregivers into

treatment services and helping the family to build community and natural supports for recovery. RCM typically involves at least weekly contact for six to nine months.

RECOVERY SPECIALIST VOLUNTARY PROGRAM (RSVP)

The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody, and where substance use was a significant contributing factor in the removal. RSVP is modeled after the STARS program in Sacramento, CA which is implemented within a drug-court system and has shown promising results. The aims of RSVP are to facilitate caregiver engagement and retention in treatment, to promote abstinence and recovery from substance use; to better coordinate with treatment providers and the court to improve the time to permanency for children; and to develop a practice model that can be replicated. RSVP services typically involve at least weekly contact over an eight-month period.

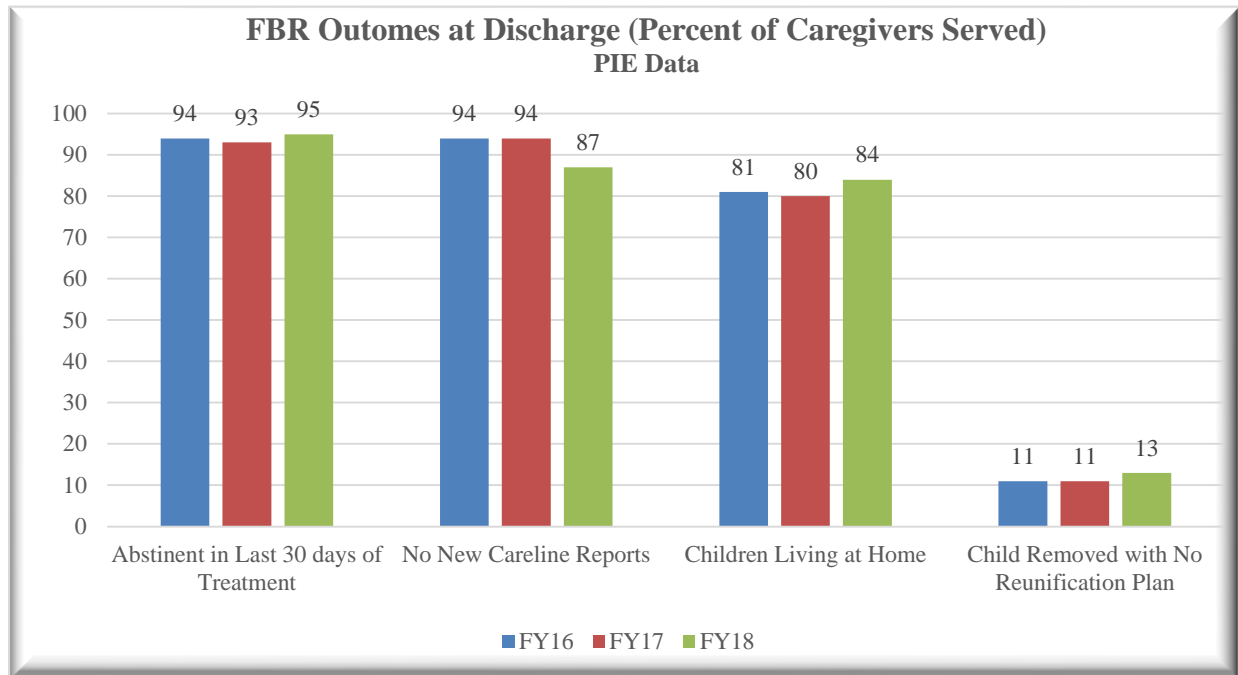
INTENSIVE IN-HOME TREATMENT FOR CAREGIVER SUBSTANCE USE AND CHILD MALTREATMENT

DCF has maintained an array of evidence-based intensive in-home services for caregivers with substance use problems who are also connected to the Department. These services target the Department's most vulnerable children and families including families with very young children, families who have had their children removed because of problems related to substance use, or families whose children are at high risk for removal related to caregiver substance use.

FAMILY BASED RECOVERY (FBR)

The Family-based Recovery Model (FBR) is an attachment-based substance use treatment for parents of children under three years of age who are involved with DCF child protective services. The model integrates two treatment modalities that focus on attachment and substance use recovery. The two models are Coordinated Intervention for Women and Infants (CIWI), an attachment-based parent-child therapeutic approach developed at the Yale Child Study Center (Yale CSC); and Reinforcement-Based Treatment (RBT), a contingency management substance use disorder treatment developed at Johns Hopkins University. FBR aims to promote safe, secure, drug-free family environments where young children can live with their parents; to facilitate parenting skills that promote optimal child development; and to develop an evidence-based practice model that can be replicated. FBR in-home services typically occur three times a week for an average of six to seven months. FBR treatment provides engagement and psychotherapy with the caregiver, a weekly relapse-prevention group, and case management services to enhance the caregiver's recovery. FBR quality assurance and model fidelity are provided by the model developers at FBR Services of the Yale Child Study Center in New Haven, CT. FBR has shown success keeping children living at home, reducing caregiver substance use, and preventing new Careline reports.

FBR Distinct Clients Served: 285 (FY16); 271 (FY17); 279 (FY18)



MULTI-SYSTEMIC THERAPY-BUILDING STRONGER FAMILIES (MST-BSF)

Multi-systemic Therapy-Building Stronger Families (MST-BSF) was developed through a collaboration between DCF, Wheeler Clinic and Johns Hopkins University with support from the Annie E. Casey Foundation to address the problem of co-occurring parental substance use and child maltreatment. This program integrates an innovative evidence-based treatment for adult substance use (i.e., Reinforcement-Based Therapy [RBT]) with an evidence-based treatment of child abuse and neglect (i.e., Multi-systemic Therapy for Child Abuse and Neglect [MST-CAN]). MST-BSF is a comprehensive integrated treatment intervention that addresses the individual, family, peer, school, and community-level problems that brought the family to the attention of child protective services. MST-BSF works closely with a family’s natural support systems to achieve abstinence, reduce risk to children, and sustain treatment gains without ongoing child welfare involvement. MST-BSF targets families with children between the ages of 6-17 years of age and addresses the needs of each family member, including any trauma issues and case management services. MST-BSF aims to promote safe, secure, drug-free family environments where children can live with their parents or be quickly reunified. The typical length of service is six to nine months and the service intensity is generally three weekly in-home visits. MST-BSF quality assurance and model fidelity is provided by the model developers at MST Services in Charleston, SC. MST-BSF has shown success keeping children at home, and reducing both caregiver substance use and new Careline reports.

MST-BSF Distinct Clients Served: 72 (FY16); 124 (FY17); 128 (FY18)

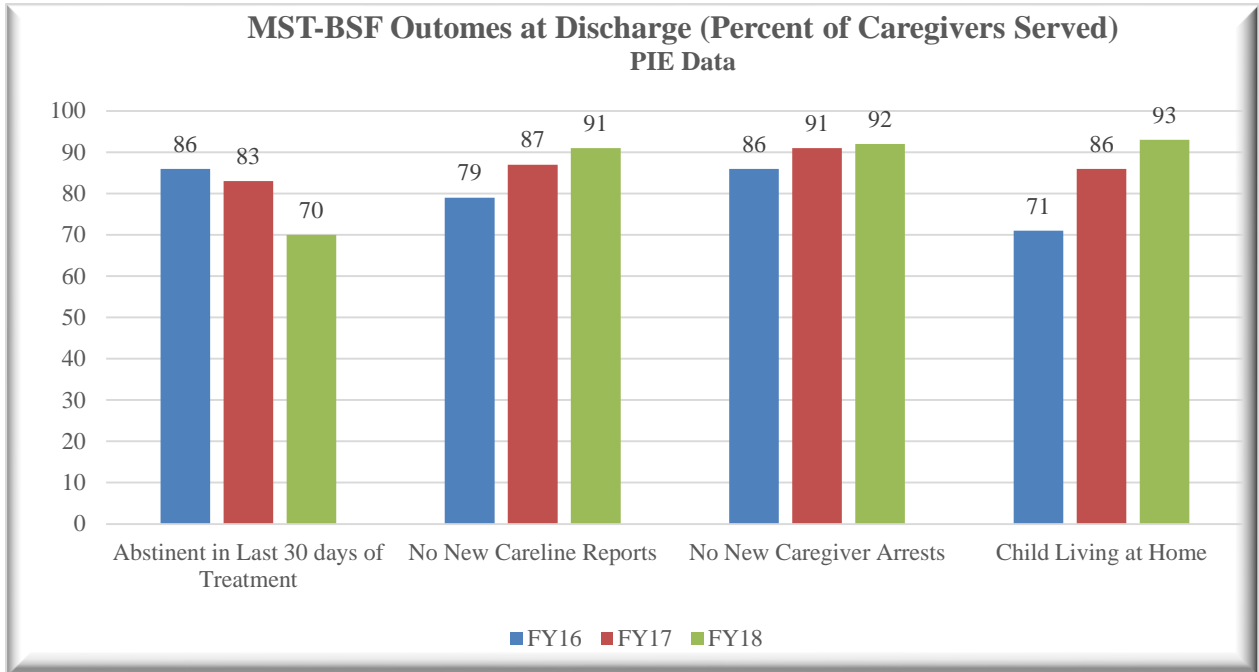


Table 2: Statewide Distribution of Substance Use Services by DCF Region and Area Office

R	Area Office	Substance Use Services									
		MDFT	ACRA/ ACC	FBR	MST-PSB	MST-TAY	MST	MDFT- RAFT	MST- FIT	MST-BSF	RSVP / RCM
1	Bridgeport	X	X	X	X	X	X	X			X
	Norwalk	X	X	X	X						X
	Stamford	X	X	X	X						X
2	New Haven	X	X	X	X	X	X	X	X	X	
	Milford	X	X	X	X	X	X	X	X		
3	Middletown	X	X	X	X	X			X		RCM only
	Norwich	X	X	X	X	X	X			X	X
	Willimantic	X	X	X	X		X				X
4	Hartford	X	X	X	X	X	X	X	X	X	X
	Manchester	X	X	X	X	X	X		X	X	X
5	Waterbury	X	X	X	X	X	X	X	X	X	
	Danbury	X	X	X	X						
	Torrington	X	X	X	X				X		
6	New Britain	X	X	X	X	X	X	X	X	X	X
	Meriden	X	X	X	X	X		X		X	X

DCF Federally-sponsored Substance Use Initiatives & Special Projects

ADOLESCENT SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (A-SBIRT)

Funding from SAMHSA/CSAT supports DCF's continued partnership with DMHAS, UConn Health, and the CT Clearinghouse to maintain A-SBIRT services in community settings using the S2BI/CRAFFT tool. In addition to supporting ongoing training on the S2BI/CRAFFT screening tool and brief intervention approach, the A-SBIRT project has expanded screening for substance use problems in the Mobile Crisis service to also include Care Coordination programs. In addition to supporting A-SBIRT in Mobile Crisis and Care Coordination, DCF has offered ongoing training to DMHAS Regional Behavioral Health Action Organizations, youth service bureaus, schools, and youth prevention organizations throughout the state.

CONNECTICUT RECOVERY ORIENTED SUPPORT SYSTEM (CROSS) FOR YOUTH

CROSS was established by DCF in October 2017 with SAMHSA State Targeted Response (STR) funding from DMHAS. Wheeler Clinic serves as the Coordinating Center for CROSS activities. The CROSS program has begun to develop a statewide network of Alternative Peer Group (APGs) for substance use recovery using the evidence-based SMART Recovery model. This network is directed by a Youth Coordinator at Wheeler Clinic who identifies community partners to implement SMART Recovery, coordinates training and regular network meetings, and is developing a sustainability plan for recovery supports. Since the project started, local partners have held 405 SMART Recovery youth groups, 50 SMART Recovery "Friends and Family" groups, and 200 Alternative Peer Group meetings.

THE CONNECTICUT SUBSTANCE EXPOSED INFANT (CT SEI) INITIATIVE

DCF is leading the CT SEI Initiative, in partnership with DMHAS. Wheeler Clinic serves as the Coordinating Center. The CT SEI program was developed to build a statewide infrastructure to address substance exposed infants, particularly infants exposed to opioids in utero. Since its inception, the initiative has established a dedicated position at Wheeler Clinic to identify and address policy gaps in SEI prevention, screening, early intervention and treatment efforts for affected infants and their families. These policies are intended to reduce bias, disparities and inequalities in access to SEI care and needed support services. Recently the SEI program drafted a **statewide plan** to coordinate responses to SEI among health care providers, and to identify the necessary continuum of services for vulnerable families, including prevention, early intervention and intensive intervention services.

FAMILY STABILITY PROJECT (FSP); A RANDOMIZED CONTROLLED TRIAL OF FAMILY BASED RECOVERY

The Family Stability Project (FSP) is a four-year Social Impact Bond (SIB) project between DCF, Social Finance, Inc., UConn Health Center, and the Kennedy School at Harvard. FSP is an outcomes evaluation of the Family Based Recovery (FBR) promising practice model that uses a randomized controlled trial methodology to assess program efficacy. FBR provides intensive in-home treatment to

DCF-involved caregivers with substance use disorders and their children (age 0-3). The FBR treatment aims to prevent repeat child maltreatment and placement of children out of home. FSP expands the reach of FBR by increasing program capacity to serve an additional 500 families over project period, and making the service available to families with children up to age six. FSP is in year two of the four year project period. During this reporting period, FSP enrolled a total of 312 families: 187 families into FBR, and 125 families into community care.

IMPROVING ACCESS CONTINUING CARE AND TREATMENT (IMPACCT) PROJECT

During this reporting period, DCF completed a two-year planning grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) by developing a three-year comprehensive statewide strategic treatment and communications plan to improve treatment for adolescents (age 12-18) with substance use disorders with or without co-occurring mental health disorders. This strategic plan served as the basis for an application for continued funding from CSAT to support implementation. Two key features of the strategic plan and implementation proposal are the establishment of a financial mapping protocol to track expenditures and third-party reimbursement of adolescent substance use services, and the development of an **opioid treatment program for youth and young adults called the ASSERT Treatment Model (ATM)**. The IMPACCT financial map report is included as an addendum to this report. ATM integrates evidence-based family therapy (MDFT), Medication Assisted Treatment (MAT) and Recovery Management Checkups and Support (RMCS) to youth up to the age of 21 who have opioid use problems. The implementation period is 9/30/2018 – 9/29/2022.

RANDOMIZED CONTROLLED TRIAL OF RECIDIVISM IN MST-TAY SERVICES

Through SFY2018, DCF continued to collaborate with Drs. Maryann Davis (University of Massachusetts Medical School), Ashli Sheidow (Oregon Social Learning Center), and Mike McCart (Oregon Social Learning Center), on a grant from the National Institute of Mental Health (NIMH; #R01MH108793) to conduct a randomized controlled trial of Multisystemic Therapy for Emerging Adults (MST-EA) through 2020. MST-EA, referred to in Connecticut as MST-Transition Age Youth (MST-TAY) is being evaluated for recidivism reduction and mental illness outcomes, as well as other functional outcomes. The 4-year trial currently is enrolling participants. In SFY19, the program transferred from DCF to JB-CSSD. This is the first randomized controlled trial ever conducted in the U.S. or internationally that focuses on reducing recidivism in emerging adults.

➤ **Judicial Branch Court Support Services Division**

MULTI-SYSTEMIC THERAPY (MST)

MST is intensive, evidence-, family- and community-based treatment program for serious, chronic, and violent juvenile offenders. It blends clinical treatments including cognitive behavioral therapy, behavior management training, family therapies and community psychology. The overriding goal of MST is to

keep adolescents who have exhibited serious clinical problems—drug use, violence, severe emotional disturbance—at home, in school and arrest free.

CHILD AND YOUTH FAMILY SUPPORT CENTER (CYFSC)

CYFSCs are multi-modal centers that provide targeted services for status offenders and medium risk delinquent children ages 11-17. CYFSCs conduct intakes, assessments, and provide cognitive-behavioral interventions, and case management services to address basic needs and pro-social activities, and discharge planning. Services are gender- specific and trauma-informed. MET/CBT/FSN is the substance use curriculum used.

MULTI-DIMENSIONAL FAMILY THERAPY (MDFT)

MDFT is a comprehensive, family-centered treatment program for adolescent and young adult ages 11-18 with drug use and related behavioral and emotional problems. MDFT addresses the areas of adolescent and parent functioning known to create problems while enhancing the factors that solve problems, improve relationships, and restore positive development. CSSD has also implemented the same program through a MOA with the department of Children and Families.

INTERMEDIATE RESIDENTIAL (IR)

Brief (4 month) out-of-home Treatment service targeting youth with substance use, behavioral health or co- occurring needs. MDFT is clinical model, and is provided to the client in the program and to the family as well. MDFT is also offered following discharge from the program in the home community. There is a boys' program and a girls' program.

COURT BASED ASSESSMENT (CBA)

Psychological and substance use evaluations as ordered by the court to determine service that best match treatment needs of child and family.

ADOLESCENT COMMUNITY REINFORCEMENT APPROACH (A-CRA)

Evidence-based behavior therapy for substance using adolescents and caregivers; identified population is 12-17 years old with substance use and meet ASAM criteria for outpatient level of care.

DMHAS COLLABORATIVE (VIA MOA)

Substance use treatment and prevention for men and women ages 18 and older.

ADULT BEHAVIORAL HEALTH SERVICES (ABHS)

Services include a continuum of behavioral health outpatient treatment services. The primary treatment modality is cognitive behavioral treatment with skills training and practice. Services include: Integrated substance use and mental health evaluations, individual and group substance use, co-occurring, mental

health, anger management and relapse prevention; intensive outpatient treatment substance use testing, medication evaluations and medication management. Clinics serve male and female clients ages 18 or older.

ALTERNATIVE IN THE COMMUNITY (AIC)

The Alternative In the Community (AIC) and associated transitional housing are center based programs that administer validated assessments, provide case management services including addressing clients basic needs, cognitive behavioral skill building group interventions that emphasize individual accountability and teach cognitive skills that enable clients to think and behave in a more pro-social manner. Group interventions include substance abuse, cognitive skills, employment services and job development that are based on the clients risk and needs. Group services and transitional housing are gender specific.

➤ **Department of Public Health**

PRACTITIONER LICENSING AND INVESTIGATIONS SECTION (PLIS)

- The Department of Public Health is responsible for investigating complaints against licensed health and routinely investigates licensed prescribers who are alleged to have inappropriately prescribed medications. If violations of the standard of care related to prescribing are identified, prescribing practitioners are subject to licensure discipline by their respective board. Discipline may include, but is not limited to: a license reprimand, civil penalties, requirements for additional education related to prescribing, probation with a monitor to review prescribing practices, and reports to the Department.
- The Department of Public Health investigates complaints regarding licensed health care practitioners who may be impaired due to substance use disorder. These practitioners may be removed from practice until they are deemed safe to practice. Once a practitioner is deemed safe to practice, they may return to work under a consent order with terms that include, but are not limited to: restrictions on practice settings, no access to narcotics, random urine screens reported to the Department, requirements to participate in therapy, requirements to attend 12-step meetings, and employer reports. The Department monitors the licensee adherence to terms and may further restrict the licensee's practice if terms are violated. The penalty for violating terms of a consent order may lead to license revocation or surrender. These efforts are to protect public safety while supporting the licensee's recovery.

- The Department works closely with the HAVEN program, a confidential alternative to public discipline, for licensees who meet specific criteria for participation. The Department may refer individuals with substance use disorder to the HAVEN program. The HAVEN program may refer individuals ineligible for its program to the Department. Eligibility for HAVEN includes no prior licensure discipline, no patient harm caused, and no felony convictions. The HAVEN program monitors its participants similarly to the Department.
- Hospitals and other licensed practitioners are mandated to report potentially impaired practitioners to the HAVEN program or DPH pursuant to 19a-12e of the Connecticut General Statutes. The Department and the HAVEN program have seen significant increases in reports of impaired practitioners law was enacted in 2015.

OFFICE OF EMERGENCY MEDICAL SERVICES (OEMS)

- Since 2017, the CT DPH/OEMS has hosted conferences for Connecticut’s first responders and emergency medical service providers at hospitals throughout the State of Connecticut. “The Opioid Overdose Epidemic – The EMS Role” is a four hour conference which consists of a core group of presenters with an add-on of hospital opioid programs and community opioid resources.

Below is a representation of topics covered and usual speakers:

- | | |
|----------------------------------|-------------------------------|
| ○ Registration | DPH Regional Coordinators |
| ○ Welcome | Director DPH/OEMS |
| ○ History of the Opioid Epidemic | Hospital EMS Coordinator and |
| ○ OEMS Medical Director | |
| ○ Science of Addiction | Hospital or Community Partner |
| ○ New England High Intensity | HIDTA personnel |
| ○ Drug Trafficking Area (NE | |
| ○ HIDTA) | |
| ○ Stigma | Hospital or Community Partner |
| ○ EMS Treatment | Hospital EMS Coordinator and |
| ○ OEMS Medical Director | |
| ○ EMS Provider Safety | OEMS Medical Director |
| ○ Harm Reduction | Community Partner |
| ○ Opioid Assistance Program | Hospital or Community Partner |
| ○ ED MAT Program | Hospital |
| ○ Data & Initiatives | Director DPH/OEMS |
| ○ Wrap up, Panel and Questions | Panel of all presenters |

This opioid conference was developed for EMS providers and can be replicated as requested throughout the five EMS regions.

The conference goals are to increase EMS provider awareness to:

- reduce the stigma that exists around opioid addiction
- take an active role in education of victims and families of victims in the use of Naloxone to prevent overdose deaths
- provide information regarding treatment options

The following *Opioid Overdose Epidemic: The EMS Role* conferences were presented:

1. September 20, 2017 at UCONN , 92 attended
2. January 30, 2018 at St. Francis Medical Center, 69 attended
3. May 30, 2018 at the CT EMS EXPO,
4. November 14, 2018 at Danbury Hospital, 33 attended
5. Scheduled April 18, 2019 at Waterbury Hospital.

- A PowerPoint presentation with voice over was developed for EMS responders in the state. This self-study course was designed to prepare EMS responders to intervene in opioid emergencies in order to reduce patient death through effective medical interventions and use of community resources. This is available statewide on our educational portal: *Train Connecticut*. It offers one (1) hour of continuing education credit.
- A wallet foldable card was developed, mass produced, and distributed to EMS providers and agencies to be left at the home of, with family/friends of, or in the pocket of a person transported to the hospital who has overdosed. It contains information on how to obtain Naloxone, the five key points to prevent a fatal overdose, and the phone number for the Department of Mental Health & Addiction Services Hotline for help finding treatment. These cards are continuously made available to all CT EMS providers and agencies through the Regional Coordinators and Regional Councils.
- A tri-fold brochure was developed, printed and has been distributed to all 5 Regional Councils which contains information regarding the role of EMS as it relates to opioid and substance abuse/addiction. This informational brochure was made with provider education in mind and contains information such as CT OD death statistics, EMS Treatment, EMS Safety, information regarding how to access the *Train Connecticut* online education and the Opioid Hotline phone number. The Regional Councils and Regional Coordinators have disseminated them to EMS as well as to local community activist groups.

HIV PREVENTION PROGRAM

- **Community Naloxone Distribution Activities-** the Overdose Prevention Education and Naloxone (**OPEN**) **Access CT** Program continues to be a successful addition to current syringe services programs (SSPs) that are under contract with DPH. Programs offer free HIV/HCV screening, harm reduction education, substance use treatment referrals, overdose (OD) prevention training and OD kits. The funding source is state AIDS funding and at this time provides funds to purchase HIV/HCV kits, OD kits and syringes services supplies. In 2018, a

Memorandum of Agreement between DMHAS and DPH was initiated to enhance community naloxone distribution for person who uses injection drugs. Through this collaborative, a total of \$190,000 will be supported annually for 3 years to purchase OD kits to distribute to persons in the community at risk for injection drug use. Participants will be trained on OD prevention, harm reduction strategies, and how to access substance treatment referral services. This initiative is federally funded through the Substance Abuse and Mental Health Services Administration's State Opioid Response grant and will cover three regions in CT that are most impacted by injection drug use and opioid related deaths. DPH is collaborating with various community-based organizations across the state to implement this initiative throughout the next 3 years.

- **Overdose Prevention Activities-** In 2018, the HIV Prevention Program's **OPEN Access Program** conducted over 529 individual-level OD trainings for clients participating in SSPs, in addition over 39 group-level community trainings occurred, in which 537 people attended and received OD kits. The community-level trainings target a variety of providers (i.e., first responders, DOC staff, substance treatment staff, emergency medical staff, OD survivors and their family members). To date, DPH has expanded SSPs from 3 programs in 2017, to five programs in 2018. There are plans to further expand SSPs in 2019 to in regions of the state where there are limited services for people who use drugs. This will be completed through a request for proposals process in 2019.
- **Data Collection-** At the request of the Commissioner, the HIV Prevention staff, in partnership with the Statewide Overdose Prevention Workgroup, developed a uniform data collection form to standardize how people collect and report on OD related deaths in CT. The purpose of the form is to gain a better understanding of the types of providers collecting OD data and determine a centralized mechanism for reporting OD, naloxone administration, OD reversals, and highlight maps for prevention interventions in real-time.
- HIV Prevention staff participated in the 2018 Overdose Prevention Conference as part of the harm reduction panel.
- **Fentanyl Testing Initiative-** A fentanyl testing initiative was implemented in 2018 to raise awareness of the risk for fentanyl-laced opioids. In collaboration with community partners, the initiative will provide free fentanyl testing strips to SSPs in CT. A fact sheet was developed to better educate providers and the community on the risks of OD due to fentanyl. The fact sheet can be found at: tinyurl.com/fentanyltestct

TOBACCO PROGRAM

- **Prevention Activities**-DPH implemented evidence-based programs that incorporate interventions into local communities through policy, systems, and environmental changes. These programs are working with youth groups to perform activities that include visiting and talking to retailers about the placement and sale of tobacco products.
- **Tobacco Use Cessation Activities**-The tobacco use cessation telephone Quitline is operated 24 hours a day 7 days a week under a contract with DPH. Through PHHS Block Grant Funds, DPH is also offering a few face-to-face tobacco use cessation programs at certain locations. Although tobacco use cessation services are covered under health insurance policies pursuant to the Affordable Care Act, select policies do not yet cover these services so these programs try to cover gaps.
- **Training Institute**-DPH provides training for community partners based on needs and updated research, and develops and shares resource materials to assist with various community initiatives.
- Funding provided for these activities includes:
CDC funding for tobacco control program \$824,868

OFFICE OF INJURY AND VIOLENCE PREVENTION

The Department of Public Health conducts the following overdose surveillance and prevention activities:

- **Tracking of nonfatal and fatal drug overdoses** currently through three primary data sources:
 1. The EpiCenter syndromic surveillance system – allows for analysis of real-time emergency department data on suspected drug, opioid, and heroin overdoses and establishment of an early warning system to detect increases in drug overdoses by city or town, region, and statewide.
 2. CT Violent Death Reporting System (CTVDRS) – State Unintentional Drug Overdose Reporting System (SUDORS) module
 3. CT Office of the Chief Medical Examiner (OCME) complex toxicology testing results
- **Disseminating opioid-related data** to all local health departments and districts in Connecticut as well as providing data to sister agencies, including DMHAS, DCF, and DCP among other partners such as the New England High Intensity Drug Trafficking Areas (HIDTA).
- **Building State DPH Laboratory capacity to test for synthetic opioids** (fentanyl and its analogues) and benzodiazepines.

- **Enhancing and maximizing the use of the Connecticut Prescription Drug Monitoring Program (PDMP)** by opioid prescribers and pharmacists, in partnership with the Connecticut Department of Consumer Protection (DCP).
- **Implementing a statewide media campaign, ‘Change the Script,’** in partnership with Connecticut Departments of Mental Health and Addiction Services, Consumer Protection, and Children and Families, with a focus on prevention, treatment, and recovery and directing CT residents to: drugfreect.org, as a centralized resource. Purchasing additional media buys for **local dissemination of the CDC Rx Awareness campaign** messages to run in tandem with the statewide campaign.
- **Implementing community interventions** - Identified high burden communities and contracted with six (6) local health departments and districts (Bridgeport, Hartford, Ledge Light, New Haven, Quinnipiack Valley, and Waterbury) to implement prevention strategies identified in the CT Opioid Response (CORE) Plan.
- Funding a **DPH Opioid Services Coordinator to work with the Department of Correction** to plan and develop a model for ongoing and sustainable medication-based treatment for the medically appropriate DOC population with opioid use disorder (OUD).
- Planning and implementing an annual **Opioid and Prescription Drug Overdose statewide conference** for public health stakeholders and partners that addresses data and surveillance, prevention strategies, prescriber and provider training and education, harm reduction, and Adverse Childhood Experiences (ACEs) and trauma, as well as progress around treatment and recovery topics.

Funding provided for these activities includes Centers for Disease Control and Prevention (CDC) grant dollars totaling over \$9 million between March 1, 2016 and August 31, 2019.

1. CDC Prescription Drug Overdose Prevention for States Cooperative Agreement
Project Period: 3/1/2016 - 8/31/2019
Federal Funding Amount: \$1,703,853 annually
2. Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality Cooperative Agreement
Project Period: 9/1/2017 - 8/31/2019
Federal Funding Amount: \$441,754 annually
3. Cooperative Agreement for Emergency Response: Public Health Crisis Response 2018 Opioid Overdose Crisis Supplement
Project Period: 9/1/2018 – 8/31/2019
Federal Funding Amount: \$3,981,976

Note: CDC has provided a forecast notice about a future funding opportunity entitled, ‘Overdose Data to Action,’ (anticipated release February 2019) that would allow the DPH to continue as well as expand these efforts, beginning September 1, 2019.

➤ Department of Consumer Protection (DCP)

The Department is tasked with promoting access to safe and effective pharmaceutical care services in Connecticut and protecting consumers against fraud, deception, and unsafe practices in the distribution, handling, and use of pharmaceuticals and medical devices. The Program has statutory responsibility to set standards for the control of prescribing, dispensing, and administration of pharmaceuticals by health care providers as well as distribution of pharmaceuticals by health care facilities (e.g. hospitals, clinics, long-term care) and other entities (e.g. manufacturers, distributors, community-based programs).

MAJOR SUBSTANCE USE INITIATIVES AND ACCOMPLISHMENTS

The DCP' substance initiatives fall into 4 major categories: the Connecticut Prescription Monitoring Program (PMP), increasing access to Naloxone, safe storage and disposal of over the counter and prescription medications, and the implementation of Connecticut's Medical Marijuana Program. In addition, DCP provides educational programs to support each of these efforts.

PRESCRIPTION MONITORING PROGRAM

The Connecticut Prescription Monitoring and Reporting System (CPMRS) was designed to collect prescription data for Schedule II through V drugs into a central database which can be used by medical providers and pharmacists in the active treatment of their patients. On October 1, 2015 legislation was passed requiring health care professionals to check the CPMRS prior to prescribing controlled substances for greater than a 72-hour period. Additional provisions required that pharmacists enter controlled substance prescription data after July 1, 2016 immediately or no later than 24 hours. This improved the timeliness of the data as previous requirements specified data must have been entered within a one week period. Connecticut now shares data with 31 states, Washington DC, Puerto Rico and the Military Health Systems.

Also, DCP has conducted educational campaigns targeting both prescribers and pharmacists on drug-seeking behavior and how to use the CPMRS effectively. In recent years, the Program has focused its efforts on educating the general public on safe storage and proper disposal of over-the-counter and prescription drugs. DCP has been publishing statistical information obtained from CPMRS to support the activities of DCP and sister agencies concerning prescription drug misuse and abuse. The statistics information can be found on our website <https://portal.ct.gov/DCP/Prescription-Monitoring-Program/CTPMP-Statistics>.

In addition, the Program has trained 112 law enforcement agencies on how to use the CPMRS to conduct prescription fraud investigations. As part of our efforts, law enforcement educational campaigns have been utilized to increase awareness of the CPMRS and the prescription fraud problem in Connecticut.

COMMUNITY DRUG TAKE BACK PROGRAMS

Another important initiative of DCP has been the establishment of a prescription drop box program. There are now over 95 boxes in operation between the state police and municipal police which have collected over 165,000 pounds of unwanted medications since 2012. DCP has been involved with Community Drug Take-Back Days and provided documentation on the DCP website on how to setup such an event. DCP also conducts educational campaigns for the general public about prescription drug abuse and safe storage and disposal of over-the-counter and prescription medications. Drop box locations can be found using the interactive map on our website <https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Local-Drug-Collection-Boxes>.

MEDICAL MARIJUANA PROGRAM

DCP has established and implemented Connecticut's Medical Marijuana Program. The Program utilizes a pharmaceutical model for the manufacturing and dispensing of medical marijuana and marijuana products. Dispensary facilities are also required to upload dispensing information into the Connecticut Prescription Monitoring and Reporting System (CPMRS) at least once per day.

ACCESS TO NALOXONE

DCP passed legislation allowing pharmacists to prescribe and dispense Naloxone after completing a certifying training course. DCP implemented an online continuing education training course last summer and has also collaborated with major chains regarding an existing training tool they use for the same purpose. To date almost 600 pharmacies have at least one pharmacist certified and can now prescribe Naloxone in the state. Pharmacies that have at least one pharmacist that can prescribe naloxone can be found on our interactive map <https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Naloxone-Prescribing-By-Pharmacists>. DCP also allowed pharmacies who have a trained pharmacist to hold naloxone prescribing events away from the pharmacy thereby improving access to naloxone.

➤ **Connecticut Office of Policy and Management**

RESIDENTIAL SUBSTANCE USE TREATMENT FOR STATE PRISONERS

Grant funds are sub-granted to the Connecticut Department of Correction to use as follows:

Enhance the provision of residential substance abuse treatment services (RSAT) to offenders in prison; Increase overall completion rates in RSAT; Maintain individual treatment gains made in prison within the community; and Ensure staff has training and knowledge about best practices and sufficient training hours to maintain certification required to deliver substance use treatment services.

Type of Programs to be Implemented: Prison-based Substance Use Treatment.

Description of Strategies: The majority of grant funds will continue to support (1) FT Correctional Substance Use Counselor to provide counseling and prepare participants for reentry. The balance will fund the following: professional development and technical assistance in evidence-based practices for DOC Addiction Services staff; provide partial payment for up to 10 staff to attend substance use certification training; purchase supplies such as substance abuse curriculum aids; and travel for two individuals to attend the BJA grantees conference.

Major Deliverables: Provide in-prison substance use treatment services, and to establish links to after care for offenders completing in-patient treatment.

Coordination Plans: The RSAT program is coordinated by Correctional Counselor Supervisor Deborah Henault with the DOC Health and Addiction Services Division.

➤ Department of Corrections

SYSTEM OF CARE

The Department of Correction provides comprehensive treatment services utilizing a graduated system of substance use treatment programs. The agency's Addiction Services Unit (ASU) screens, assesses and provides treatment to greater than 80% of the individuals who enter the correctional system. A range of treatment options are available to meet the offenders' treatment needs. Programs range from brief treatment focusing on re-entry and reintegration; intensive outpatient (IOP), with cognitive behavioral therapy curriculum to residential substance use treatment in a modified therapeutic community setting. The Addiction Services Unit provides aftercare programming designed to provide a continuum of care and recovery maintenance. The Addiction Services Unit also provides services to the specialize population to include the young adult offender, youthful offenders, women, Driving Under the Influence (DUI) offenders, methadone maintenance and temporary violation as an incremental sanction in Time Out Program for parolees at risk for violation of parole.

Major Initiatives and Accomplishments:

DUI OFFENDERS

Connecticut General Statute, CGS 18-100h permits the Department of Correction to offer provisional release. This discretion allows eligible offenders convicted of Driving Under the Influence and related convictions to be released on Home Confinement. Offenders are screened upon admission by Addiction Services staff to determine eligibility. Following the initial screening, eligible offenders are then given an in-depth DUI assessment to determine treatment need. The DUI treatment programs offer an elevated range depending on the level of care needed for the offender. Offenders are required to complete the treatment program prior to be released on DUI Home Confinement release. DOC Community Release

Unit (CRU) renders decisions for all DUI HC releases. Cases approved for home confinement are transferred to the DOC division of Parole and Community Services DUI Unit, a specialty parole unit to begin the release process.

IN-PRISON ADDICTION TREATMENT

The DOC Addiction Services Unit provides in-prison treatment services to several thousand offenders annually. These services include brief treatment, intensive outpatient, therapeutic community treatment, youth specific intensive outpatient treatment, gender specific treatment, DUI specific treatment, Time Out Program (TOP) for at risk parolees and medication assisted treatment. Recent TOP improvements include MAT induction and maintenance, curriculum enhancements and process facilitation.

COMMUNITY AFTERCARE

DOC is the sub-grant recipient of the Residential Substance Abuse Treatment (RSAT) grant from OPM. DOC has enhanced its ability to provide continuity of care from in-prison to community care for offenders following their participation in residential substance use treatment programs. These services include behavioral health treatment in addition to recovery supports such as employment and housing assistance, transportation and other services.

NALOXONE (NARCAN) PROJECT

DOC has recognized the ongoing opioid epidemic and has implemented new approaches in the drug and alcohol treatment and education. Addiction Services counselors and supervisors have been trained as trainers in naloxone (Narcan) administration. Ongoing trainings have been offered to the custodial staff to help them have a better understanding of substances, treatment modality and how to administer Narcan in the event they confronted in an emergency overdose situation.

In addition, Addiction Services staff have provided trainings agency wide on recent drug trends to include fentanyl. Other agencies such as Connecticut State Police, Department of Public Health and High Intensity Drug Trafficking Areas (HIDTA) have provided training to the wider staff of DOC employees. Through the training efforts additional resources have been made available on the shared agency drive for all staff to access.

Naloxone kits have been maintained and distributed through ongoing efforts of Addictions Services Unit and through partnerships with agencies such as Department of Public Health and Department of Mental Health and Addiction Services. Naloxone kits have been distributed to all correctional facilities and to the parole offices.

MEDICATION ASSISTED TREATMENT

The Methadone Maintenance Program began as pilot program in October of 2013 and has since expanded to the 4 jails and in 1 sentenced facility for the male offenders and is also available in our only female facility. Clients are provided methadone treatment, as well as continued dosing, for their term of

incarceration followed by re-entry planning services to continue the treatment upon release. In 2018, 845 patients were treated with methadone maintenance at 6 DOC facilities. (See figure 1 below.)

TOBACCO CESSATION AND PREVENTION

Over the past several years, the Tobacco and Health Trust Fund Board provided funding to the DOC to develop tobacco education and cessation support programs in several jails. In 2016, DOC expanded this program to provide similar programs in the DOC funded halfway houses. Smoking prevalence data was collected as part of this project. The results show that correctional populations have 4 to 5 times higher smoking prevalence rates than the general population, and female prisoner rates were even higher. This indicates that the criminal justice population has not benefitted from the national public health efforts to reduce the health consequences of tobacco, as has the general population. Tobacco Cessation efforts have been integrated into the ASU treatment portfolio and daily care continues, as well as care in halfway houses.

RECOVERY COACHING

Working with CCAR (Connecticut Community for Addiction Recovery) the ASU trained approximately 25 staff and 10 inmates at Osborn Correctional Institution in recovery coaching. This provides important professional development opportunities for staff and enables inmates to utilize these skills in their day to day recovery in the OCI therapeutic community. In addition, the inmates now have employment opportunities in recovery coaching upon release.

➤ **Department of Education**

The Connecticut State Department of Education (CSDE) offers several substance use prevention supports through programs that address the issue directly and through meeting the social-emotional, developmental and behavioral health needs of students.

The following programs have been implemented throughout the 3-year reporting period (fiscal years 2016-2018) and will continue to be administered by CSDE pending available appropriations. The funding levels listed are from fiscal year 2018:

AFTER-SCHOOL GRANT PROGRAM: \$4,418,571

The After-School Grant Program was established by the Connecticut General Assembly for creating high quality after-school programs. After-school programs are defined as programs that take place when school is not in session and provide recreational activities, parent involvement, wellness components and educational enrichment designed to complement academic programs for students in Grades K-12.

These programs, located in elementary or secondary schools or community-based facilities, provide a range of high-quality services to support student learning and development. In addition to tutoring, mentoring, homework help and academic enrichment initiatives, programs also provide youth development activities, violence and pregnancy prevention programming, substance use prevention, counseling, project-based learning, art, music, and technology education programs, service learning and character education. Between 28 and 32 programs are funded annually.

FAMILY RESOURCE CENTERS: \$5,790,000

Family Resource Centers (FRCs) provide access, within a community, to a broad continuum of early childhood and family support services that foster optimal development of children and families. FRCs offer parent education and training, family support, preschool and school age childcare, teen pregnancy prevention, substance use prevention, positive youth development services and family day-care provider training. School-based FRCs collaborate with many resources in their communities, including child-care providers, School Readiness Councils, local United Way chapters and service providers of the Departments of Social Services and Children and Families. There are currently 58 FRCs funded through the CSDE annually.

LEADERSHIP, EDUCATION, ATHLETICS IN PARTNERSHIP (LEAP): \$312,311

The LEAP Program implements year-round community and school-based programming with a multi-tiered mentoring model designed to achieve positive academic and social outcomes for children living in high poverty urban neighborhoods. Since 1992, LEAP has led the movement to provide children and youth with opportunities to thrive in all areas of their lives. LEAP programming addresses the whole-child, with activities in reading, math, arts, health, athletics and interpersonal skill building.

NEIGHBORHOOD YOUTH CENTERS: \$438,866

Exclusively served through Boys and Girls Clubs, the Neighborhood Youth Center (NYC) Grant Program focuses on character development as the cornerstone of positive youth growth. Boys and Girls Clubs focus on capturing the interests of young people, improving their behavior and increasing their personal expectations and goals. The CSDE supports 17 sites through the Connecticut Alliance for Boys and Girls Clubs and one individual community-based club (Bridgeport).

PRIMARY MENTAL HEALTH PROGRAM: \$345,283

The Primary Mental Health Program is an evidence-based program that helps children in pre-k through third grade adjust to school, gain confidence and social skills, and focus on learning. Through play, the Primary Mental Health Program addresses children's school adjustment difficulties and increases their chances for success. Through a competitive bidding process, the CSDE currently supports 18 Primary Mental Health Program sites throughout the state.

YOUTH SERVICE BUREAUS (YSBs): \$3,066,527

As outlined in Connecticut General Statutes (C.G.S.) 10-19m, YSBs are the coordinating unit of community-based services to provide comprehensive delivery of prevention, intervention, treatment and follow-up services. YSBs deliver services ranging from counseling, therapy, employment and training counseling, recreational and enrichment activities, juvenile justice system diversion, outreach programs, substance use prevention, awareness and education and other preventative and positive youth development programs for families, children, and delinquent, pre-delinquent, pregnant, parenting and troubled youth. The CSDE currently supports 102 YSBs serving 146 communities.

SCHOOL-BASED DIVERSION INITIATIVE (SBDI): \$840,000

In collaboration with the Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS) and the Child Health and Development Institute (CHDI), the CSDE implements SBDI in school districts with high incidences of student arrest and disciplinary sanctions. SBDI is a school-level initiative that engages teachers, staff, administrators, and school resource officers through consultation, expert training, and capacity building activities. SBDI is an effective strategy to increase access for students and families to mental health prevention supports and treatment services in the school and local community. Thirty-seven schools and thirteen districts have implemented SBDI to date.

The following program is in its final year of operation and will not be continued as is, although many of the strategies will be incorporated in other general forms of support to schools (e.g., attendance supports and alternative school programming):

SCHOOL CLIMATE TRANSFORMATION GRANT: \$705,707

The School Climate Transformation Grant is a five-year federal award that was established to assist state agencies in developing, enhancing and expanding statewide systems of support for, and technical assistance to, local education agencies (LEAs). LEAs receive support for implementation of an evidence-based, multi-tiered behavioral framework (MTBF) [e.g., Positive Behavior Interventions and Supports (PBIS)] for improving behavioral outcomes and learning conditions for all students.

The following program is federally funded from September 2018 through September 2023:

PROJECT ADVANCING WELLNESS AND RESILIENCY IN EDUCATION (AWARE): \$1,774,332 ANNUALLY

In October 2018, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a five-year grant to the CSDE to improve capacity within three school districts to improve

services and supports for students with mental and behavioral health needs. In partnership with the Department of Children and Families (DCF), Project AWARE will serve the communities of Middletown, Naugatuck and Windham by increasing staff knowledge of indications of student distress; skills to engage with the student; and knowledge of appropriate services for those students who will benefit from structured supports. Furthermore, the school districts will develop improved formal and reciprocal relationships with community service providers for their region. District staff will receive training on and implementation of the Adolescent Brief Intervention and Referral to Treatment (A-SBIRT) tool and other cognitive-behavioral intervention practices.

- **Total Funding from Fiscal Year 2018: \$15,917,265**
- **Total Estimated Annual Funding for Fiscal Years: 2019-2021: \$16,985,890**

➤ **Department of Veterans Affairs**

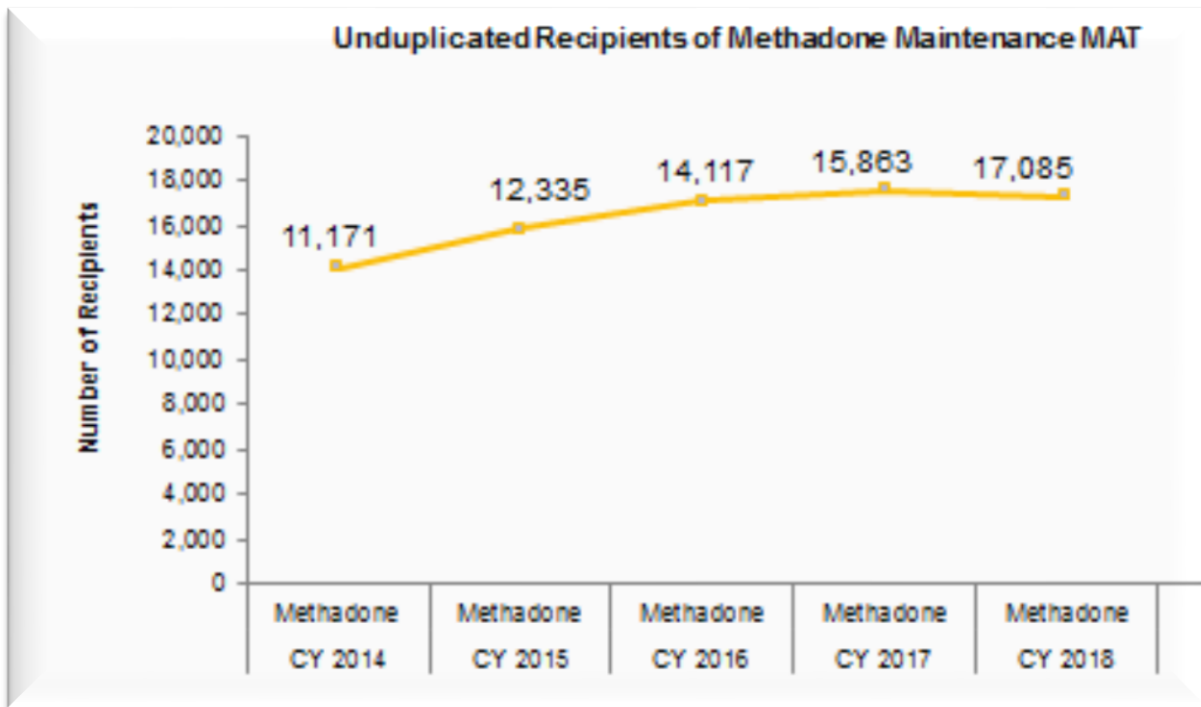
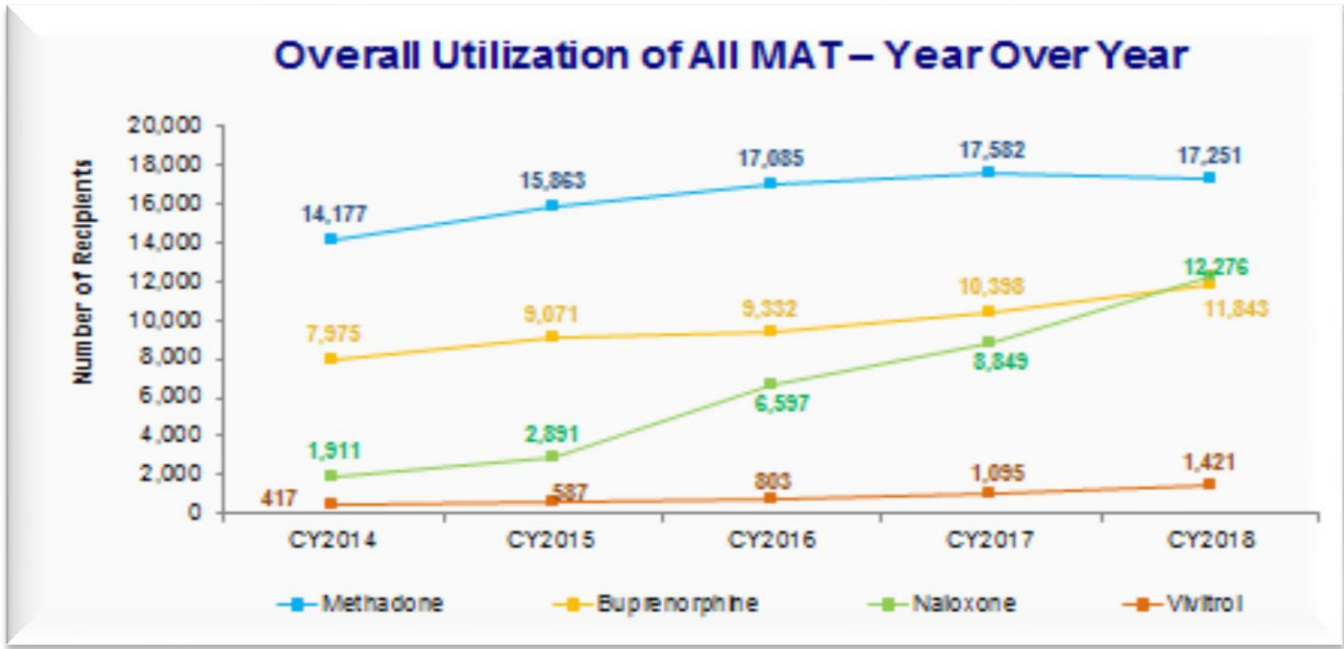
INTENSIVE OUTPATIENT PROGRAM

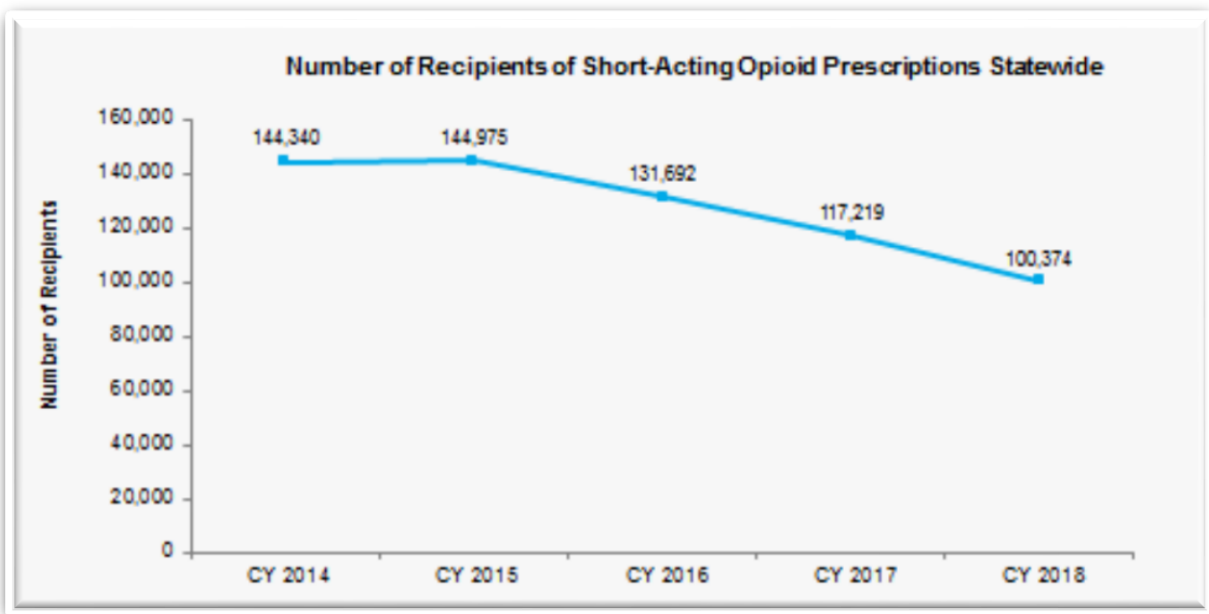
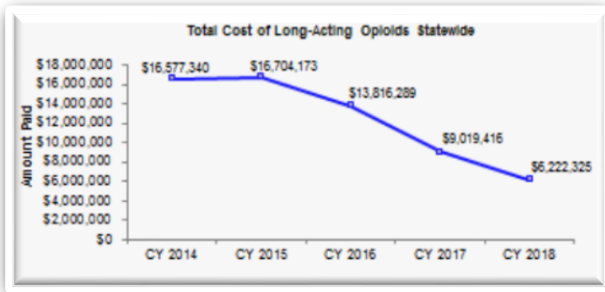
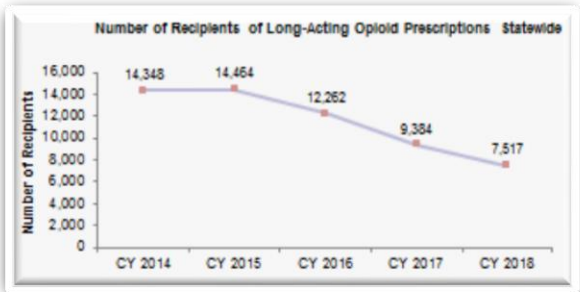
The Veterans Recovery Center (VRC) is located on the grounds of the Connecticut Department of Veterans Affairs (DVA) under the auspices of the Connecticut Department of Mental Health and Addiction Services (DMHAS). The VRC is designed to assist and support DVA Veteran Residents, Connecticut Veterans and National Guard Service members with substance use disorders with their recovery needs. The VRC offers outpatient services consisting of an individualized plan of counseling sessions with a substance use counselor, recommended attendance at Community AA/NA meetings, and random urine monitoring and breathalyzers upon request from VRC staff. Additionally, we offer the Recovery Education Program (REP) which consists of a brief educational group format. Admissions are voluntary.

➤ **Department of Social Services**

The Department of Social Services (DSS), the state Medicaid agency, provides comprehensive substance use treatment services for individuals eligible for Medicaid across numerous levels of care, including, but not limited to Methadone Maintenance, Routine Outpatient, Intensive Outpatient, Partial Hospitalization and Acute Detoxification services. In Fiscal Year 2018, DSS spent approximately \$95 million on substance use treatment services for individuals eligible for Medicaid of which, \$55 million was for methadone maintenance.

DSS, along with our state agency partners, is also committed to addressing the opioid crisis. The following graphs show the use of Medication Assisted Treatment as well as the trends of long acting and short acting opioid prescriptions under Medicaid.





State Spending for Substance Use Services in Connecticut

Connecticut spends almost \$321,000,000 on substance use services within the state. Each state agency submitted their expenditures for substance use spending for fiscal year 2018. The data is shown in the table below.

Agency (FY 18 data)	Total
DMHAS	\$149,200,000
DSS*	\$95,269,039
JUDICIAL CSSD	\$30,759,121
DCF	\$28,178,513
DOC	\$5,428,221
DPH	\$4,472,421
DCP	\$2,166,230
DVA	0
OPM	\$290,344
SDE	\$15,917,265
TOTAL	\$331,681,154

*DSS expenditures are for Calendar Year 2018

*Department of Mental Health and Addiction Services
Triennial Report 2019 Opioid Annex*

*Miriam E. Delphin-Rittmon, Ph.D.
Commissioner
Nancy Navarretta M.A. LPC, NCC
Deputy Commissioner*

DMHAS Triennial Report Subsection Responding to the Opioid Epidemic

Introduction

Connecticut, like all of the other New England states and indeed, most states in the country began to see a significant increase in opioid use in fiscal year 2011. The surge in heroin and other opioid use has been described by the Centers for Disease Control and Prevention (CDC) as an epidemic (CDC, 2018). This is reflected in growing numbers of overdose deaths attributable to opioid use; it is also echoed in increases in admissions, specifically related to opioid use, to Connecticut's treatment system. Many of these overdose deaths involve the use of multiple substances. Overdose deaths involving fentanyl comprise a particularly troubling trend; at 50-100 times the strength of heroin, fentanyl is a potent opioid that is being mixed with or substituted for heroin, leaving unwitting users at much higher risk for fatal overdose. Additionally, fentanyl has been found combined with other illicit drugs, such as cocaine-yielding dangerous results, including clusters of overdose by unwitting users. Notably, New Haven was the site of a significant overdose event in the summer of 2016 involving fentanyl (CDC, 2016).

Connecticut has responded to this crisis with comprehensive, multi-agency strategies that include treatment, prevention, education and training, new legislation and policy initiatives. Additionally, the state has applied for and received private and federal funding targeting the opioid crisis. Experts from Yale University have collaborated with the Alcohol and Drug Policy Council to develop a comprehensive plan to coordinate the state's efforts.

Connecticut's Opioid Epidemic

Heroin is the primary substance involved in Connecticut's opioid crisis, although fentanyl and prescription opioids such as hydrocodone, oxycodone, codeine, morphine, and diverted methadone are also present. Fentanyl, a synthetic opioid, is 50 to 100 times the strength of heroin and is increasingly being mixed with or substituted for heroin (CDC, 2018). This practice places both users and others in close proximity at greater risk due to the greater strength and toxicity of the drug. Overdose deaths related to opioids escalated over the 2015-2017 time period. Calendar year 2018 data shows a slight decrease in deaths compared to 2017 suggesting that this trend may be slowing, in large part due to escalating prevention, treatment, and law enforcement efforts.

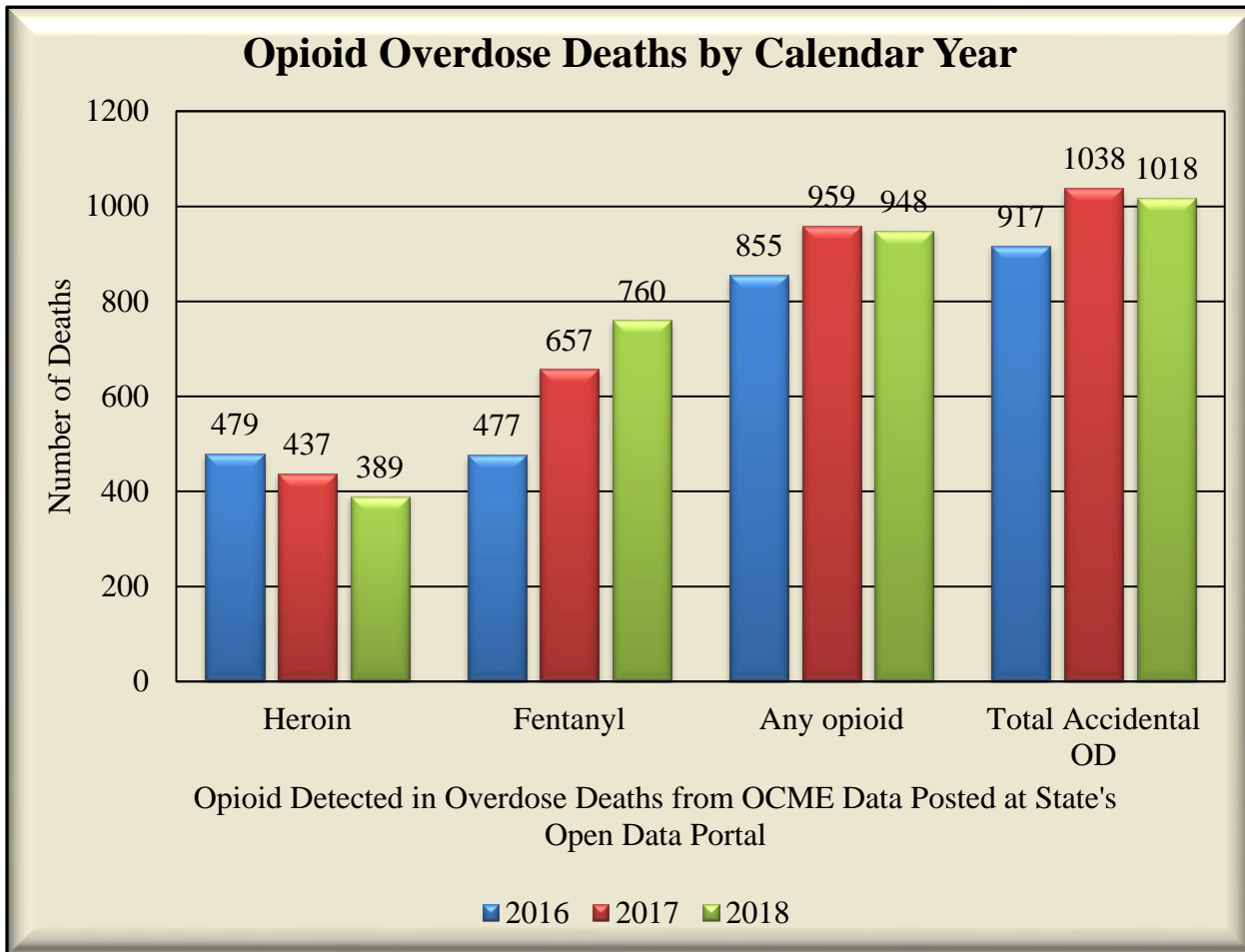


Figure 1

Opioid overdose deaths had been steadily rising in Connecticut but did show a slight decrease in Calendar Year 18. Office of the Chief Medical Examiner (OCME) data documents significant poly-substance involvement (OCME, 2018). Opioids were detected in 92% to 93% of the overdose deaths reported in the last three calendar years. Figure 1 shows a sharp upward rise in fentanyl-related deaths between 2016 and 2018, while the share of heroin deaths has declined during the same time. Shockingly, there were 3.5 times as many fentanyl-related deaths on 2017 (657) than there were in 2015 (184). Nearly three-quarters (74%) of all overdose deaths in CY 2017 and CY 2018 involved fentanyl and its analogues, such as carfentanil.

DMHAS evaluation staff has investigated deaths related to combinations of benzodiazepines and opioids; a preliminary analysis shows that benzodiazepines were involved in 599 (31%) deaths over the past two-year period (CY16-CY17). Opioids and benzodiazepines were both present in 568 of the overdose deaths (29% of total deaths and 95% of benzodiazepine related deaths), highlighting the dangers of co-prescribing these medications. In comparison, opioids and benzodiazepines were both present in 23% of total deaths and 87% of benzodiazepine deaths over CY13-CY15.

OCME has reported that there were 1,018 overdose deaths in CY 18, a slight reduction from CY 17 when 1,038 overdose deaths were reported to OCME. This statistic should be closely monitored because it may be an indication that overdose deaths may have plateaued.

The Connecticut treatment system has seen a decline in opioid-related admissions for the first time in 7 years. Prior to FY 2018, the DMHAS treatment system was experiencing annual increases in opioid-related admissions. That trend began in FY 11. Heroin and other opioid-related admissions had been in a slow decline from 2006 through 2010. However, admissions increased slightly in 2011 and have been steadily increasing until fiscal year 2018. In FY2017, admissions peaked at over 30,000 (DMHAS, 2018). Opioid-related admissions increased by 23% from 24,416 in FY 14 to 30,062 in FY 17. The average number of admissions increased from 1.81 per client in FY14 to 2.04 admissions at the peak in FY2017. However, between FY17 and FY18 (July 1, 2017 – June 30, 2018), we have observed a modest 5% decrease in opioid-related admissions to the DMHAS system. This may represent a leveling-off of the crisis, although it is too early to make definitive statements at this time. See Figure 2 for more detail on the number of unduplicated clients and opioid-related admissions to the DMHAS treatment system.

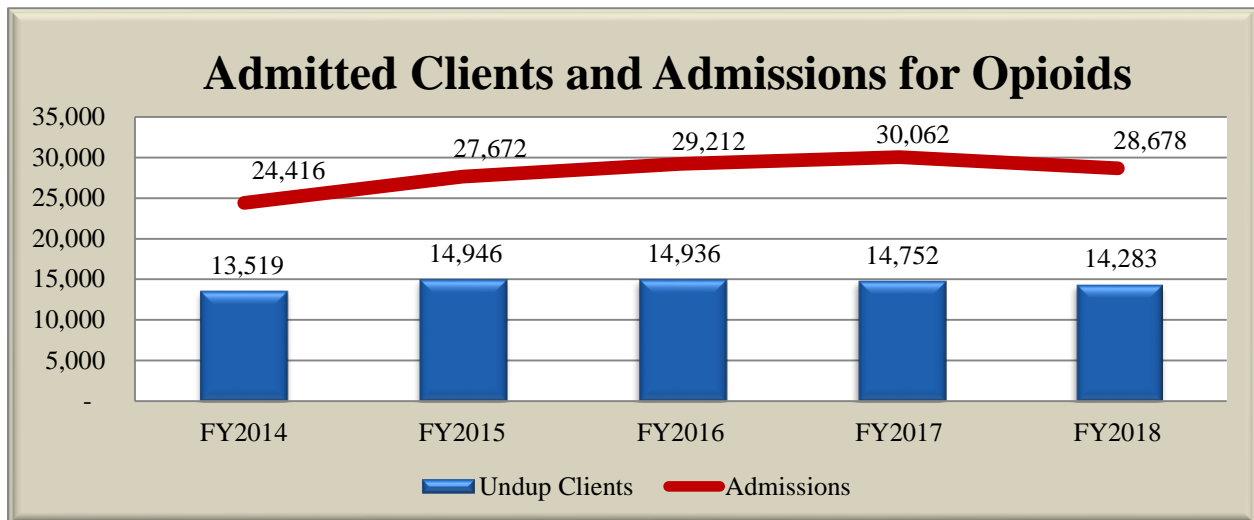


Figure 2: Admitted Clients and Admissions for Opioids, FY14-FY18 (*Data from DMHAS EDW; all funding sources)

When individuals are admitted to DMHAS substance use services, they report their “primary drug” of use. For a number of years, alcohol had been the most frequently reported primary drug at admission. Since FY 15, opioids have replaced alcohol as the primary drug reported at admission within the SA treatment system. In FY 18, heroin, along with prescription opioids, accounted for just over 40% of all SA treatment admissions.

Primary Drug at Admission (SA Programs)

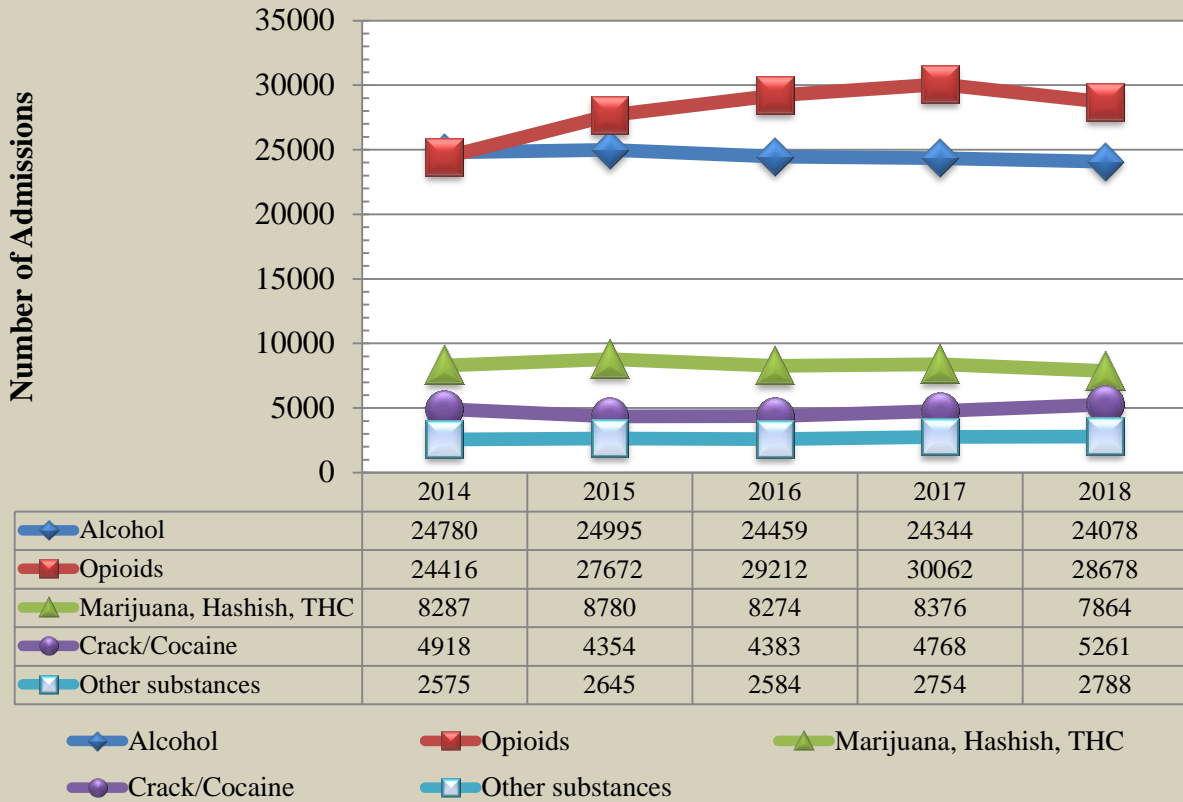


Figure 3: Primary Drug at Admission, FY14-FY18 (*Data from DMHAS EDW; includes all funding sources)

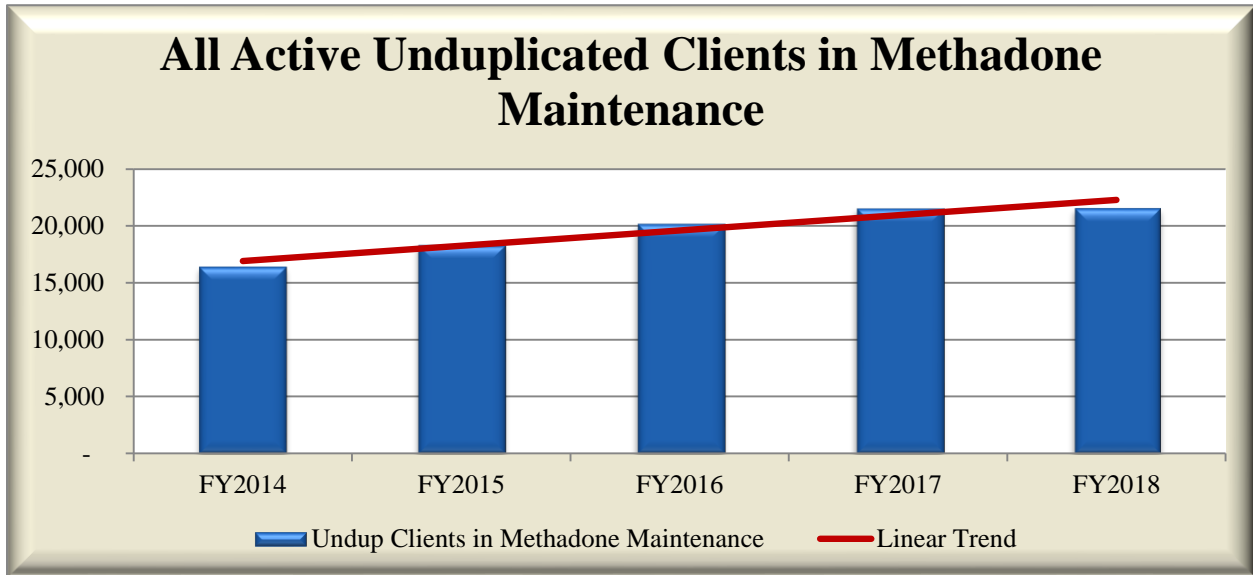


Figure 4: Unduplicated Clients in Methadone Maintenance, FY14-FY18
 (*Data from DMHAS EDW; includes all funding sources)

The impact of the opioid crisis has been evident in certain treatment levels of care. In FY 14, DMHAS served 16,445 in methadone maintenance programs and that number grew to 21,553 in FY 18, a 31% increase. Below, the graph illustrates the yearly increases in admissions and unduplicated clients served in methadone maintenance programs.

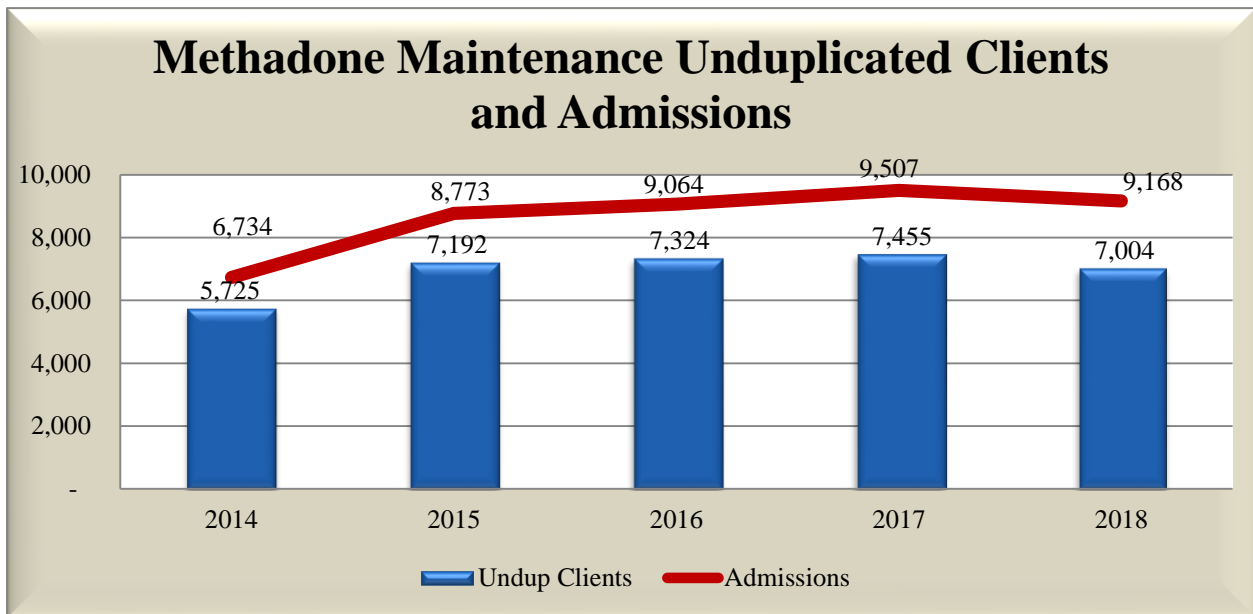


Figure 5: Yearly Admissions and Clients in Methadone Maintenance, FY14-FY18
 (*Data from DMHAS EDW; includes all funding sources)

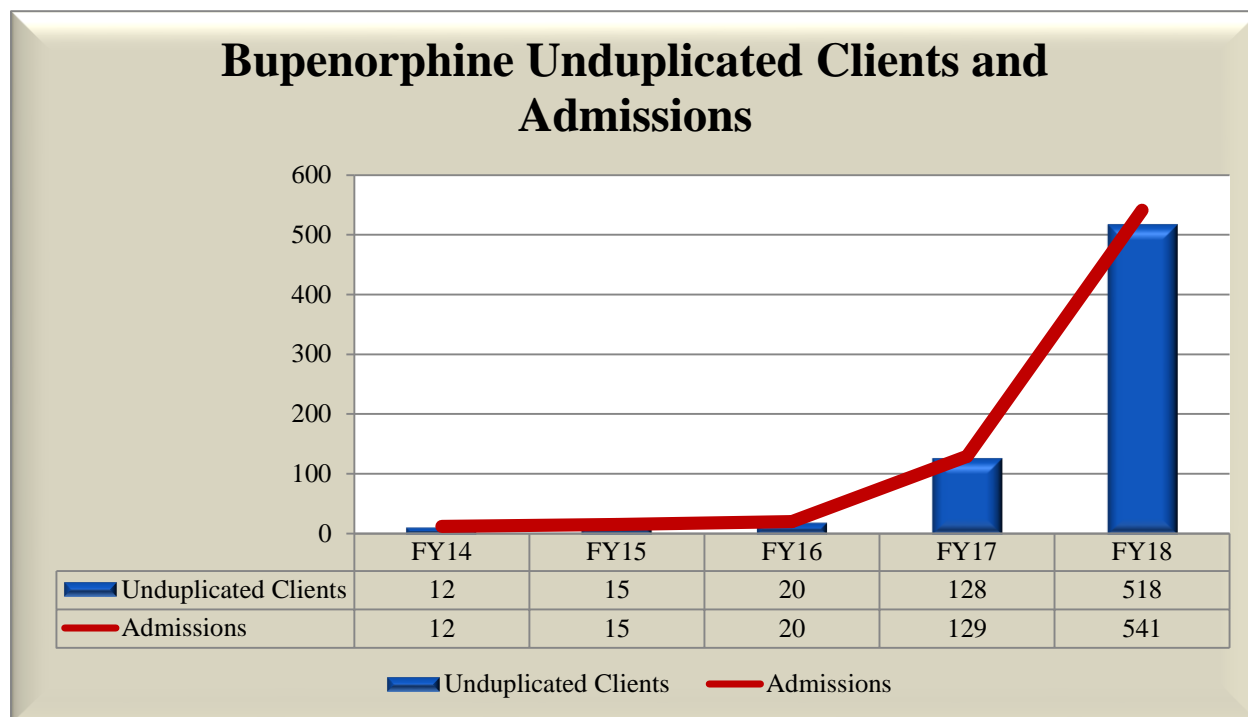


Figure 6: Yearly Admissions and Clients in Buprenorphine Programs, FY14-FY18
 (*Data from DMHAS EDW; includes federally funded MAT programs)

Over the past two fiscal years there has been a significant increase in the number of clients and admissions to buprenorphine programs. Unlike methadone which must be provided in highly structured clinics, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed in physician’s offices. These programs provide persons with opioid disorders an additional evidence-based option for the treatment of opioid dependency, significantly increasing treatment access (SAMHSA). DMHAS began developing these specialized programs in FY 16 using federal grants focused on the opioid crisis. From FY16 to FY17 there was a 540% increase in clients and admissions with an additional 305% increase from FY17 to FY18. The increase in clients may explain some of the FY17-FY18 decreases in the number of clients utilizing Methadone Maintenance programs; more clients are using alternative treatment options to Methadone Maintenance. DMHAS only began tracking this data in 2016 but it appears to show that efforts to increase treatment options for persons with opioid disorders are succeeding. Recent data provided by Beacon Health Options for just the 4th quarter of 2018 shows over 7,200 Medicaid clients had received buprenorphine during that period. This statistic appears to demonstrate that efforts to increase options for MAT are being successful.

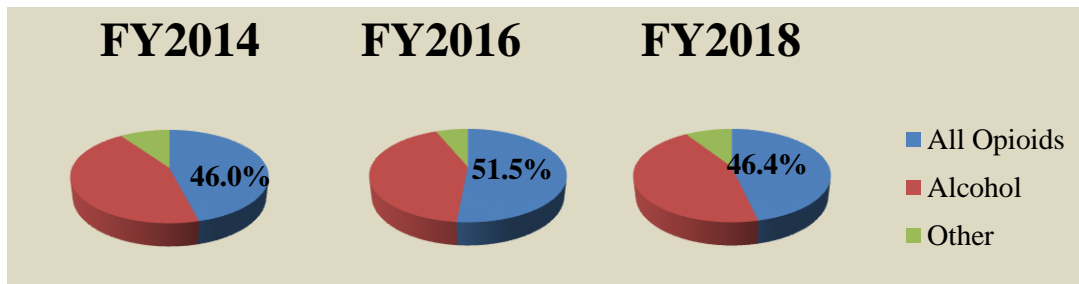


Figure 7: Primary Drug at Admission in Detoxification Programs, FY11-15
 (*Data from DMHAS EDW; includes all funding sources)

Detoxification programs had 15,641 admissions in FY 18; approximately **46%** of all detoxification program admissions in FY18 were related to heroin or other opioids. In FY17, this percentage was 52% - an increase of 17% from FY11's rate of 35%. Greater emphasis is being focused on connecting these clients to medication-assisted treatment. DMHAS has received State Targeted Response (STR) and State Opioid Response (SOR) grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). These funds will increase the availability of medication assisted treatment (primarily buprenorphine/naloxone) treatment in Connecticut.

Some demographics associated with opioid users are also changing. While the largest number of admissions continues to originate in our most populated cities, most cities in Connecticut are represented in admissions to our treatment programs. There was an 8% overall increase in the number of unduplicated clients and a 23% increase in the number of admissions across the FY14-17 timeframe.

Another changing demographic relates to the age of individuals using opioids. From FY14 to FY18, there has been a 50% reduction in the number of 18-24 year old clients with opioid-related admissions. The largest increase in clients is in the 55 and older age group, with 57% more clients admitted in FY18. Clients in the 25 to 54 age ranges (25-34, 35-44, & 45-54 years old) compose the majority of clients using opioids; the number of clients in each group peaked in FY17. From FY17 to FY18, the number of total clients for this larger group decreased by about 7%.

There have been some minor fluctuations in admissions to treatment within gender and racial categories; however, generally speaking, the trends have remained stable.

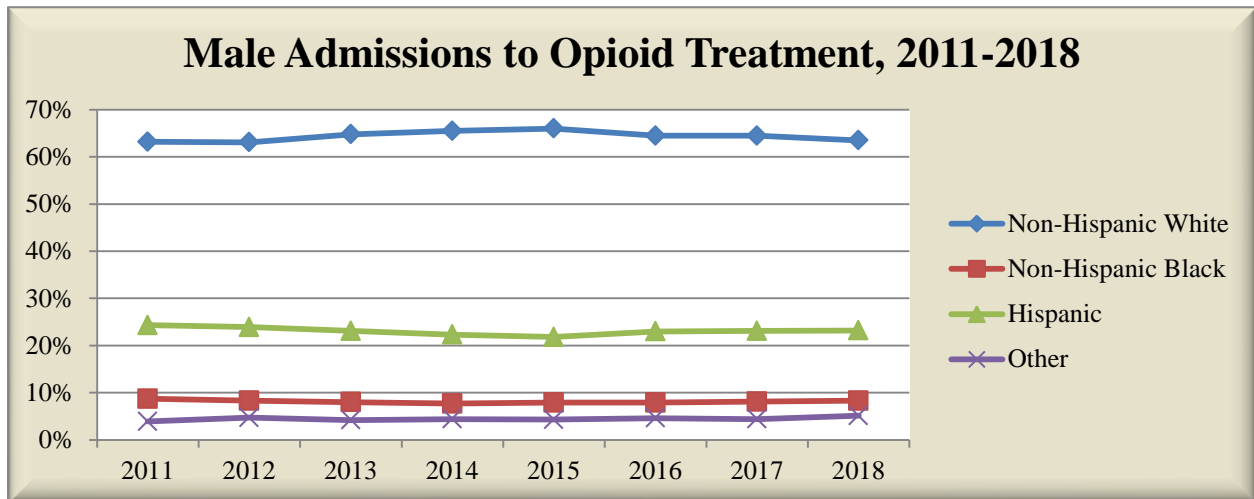


Figure 8: Male Admissions to Opioid Treatment, 2011-2018

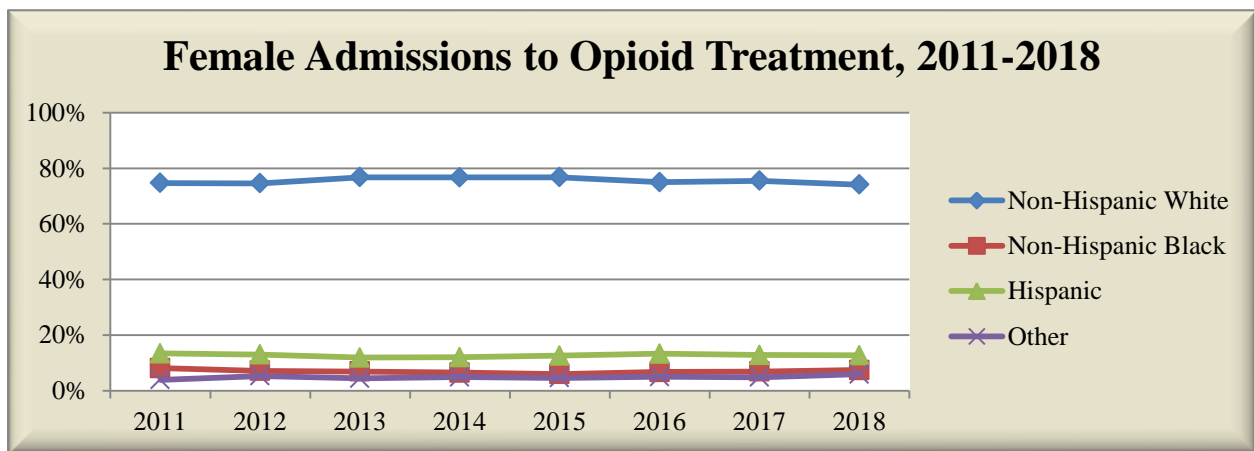


Figure 9: Female Admissions to Opioid Treatment, 2011-2018

THE STATE’S RESPONSE

As mentioned in the Introduction, changing the trajectory of the opioid crisis requires multi-pronged strategies that target various components of this crisis. These strategies include treatment, prevention, education and training, new legislation and policy initiatives. Below, we summarize our progress with these strategies since our last report.

CONNECTICUT ALCOHOL AND DRUG POLICY COUNCIL

The CT Alcohol and Drug Policy Council (ADPC), co-chaired by the DMHAS and DCF Commissioners were legislatively mandated in 1997. It was 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 and included representatives from all three branches of State government (Executive, Judicial, Legislative), individuals in recovery and family members, and private service providers. It has four working sub-committee which include prevention, treatment, recovery and criminal justice sub-committees. In 2015 Governor Malloy charged the ADPC with coordinating Connecticut’s efforts related to substance use in light of the opioid crisis. The ADPC current recommendations and activities include:

- Development of core competencies for medical practitioner education for safe prescribing and pain management
- Provide training and forums addressing opioid education, stigma, other barriers
- Provide safe storage and disposal education
- Connect electronic health records to the Prescription Drug Monitoring Program
- Get naloxone in schools and on college campuses
- Expand training on and use of SBIRT
- Expand use of Medication Assisted Treatment in DMHAS Local Mental Health Authorities
- Identify and address regulatory barriers

Many of the goals related to the opioid epidemic have been addressed by the Alcohol and Drug Policy Council. A summary of their accomplishments can be found in the table below. The goals are cross-cutting and are a comprehensive compilation of activities that have been undertaken by state agency partners as well as partners in the private sector. They are presented as a summary of all of the activities that have been initiated and in many instances completed under the umbrella of the ADPC which is now co-chaired by Commissioner Delphin-Rittmon of DMHAS and Commissioner Dorantes of DCF.

CT Alcohol and Drug Policy Council Recommendations and Progress to Date

Prevention Subcommittee Goals	Progress to date	Status
<p>Identify core competencies for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff).</p> <p>Measures:</p> <ul style="list-style-type: none"> • Number of individuals attending the Scope of Pain trainings • Decrease in the number of opioids prescribed 	<ul style="list-style-type: none"> • A list of core competencies was developed by Dr. Daniel Tobin, Assistant Prof. of Medicine, Yale Univ. School of Medicine and Medical Director of the Adult Primary Care Center at Yale New Haven Hospital. These competencies are the objectives of the lectures he delivers to both prescribers and non-prescribing medical staff and is suggested for use in measuring current pain management programs for medical trainees and providers. • To date, six Scope of Pain trainings have been delivered to prescribers and non-prescribers across the state including the most recent on 	<p>Original goal Completed. Trainings are ongoing with 527 individuals trained to date.</p>

	November 29th in Hartford. Additional trainings are being planned throughout the state.	
<p>Create a Statewide Prevention and Education Communication Strategy which will:</p> <ul style="list-style-type: none"> • Raise awareness of and provide education on the dangers of opioids and reduces 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 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. Assist with the identification of necessary resources to do so. <p>Measures:</p> <ul style="list-style-type: none"> • # of website hits 	<ul style="list-style-type: none"> • The 6 health districts awarded a PDO grant are receiving quarterly report cards with data on age, gender, race ethnicity, residence and where overdose deaths have occurred in order to target their interventions. • The drugfreect.org website continues to be utilized approximately 1,800 times/day, and is in the process of being redesigned. • National Prevention Week is scheduled for May 12-18, 2019. The planning committee is coordinating an educational forum at the New Britain Museum of American Art, a Health & Wellness Fair at the State Capitol, a prevention video conference and numerous local community events. • There are a total of four completed Remembrance Quilts that are available for display. Additional quilt square making events are being planned. • 4 health districts from across the state have been trained to implement comprehensive prescriber, school and community social marketing education campaigns which will include medication storage and disposal information. • The Subcommittee reviewed a series of CDC-produced factsheets and posters directed at patients and families. Identified materials were mailed to more than 1,000 healthcare agencies. • On November 21, 2017 a press release was issued jointly by the DCP and DMHAS encouraging the public to check their medicine cabinets and dispose of and/or secure medications for the safety of their guests. • The DCP has: created a new “How to dispose of your medications” for YouTube; licensed additional law enforcement drop boxes; drafted language for drop boxes in pharmacies; provided brochures for distribution including “Secure Your Meds” and “Safe Storage and Disposal of Prescription Medication.” • Brochures, posters, print ads, online ads, radio scripts, handbills, social media and on-line ads have been developed for the Change the Script campaign. A targeted campaign is being finalized for prescribers to increase their utilization of the CPMRS. Plans are for a 	<p>Goal is <u>Completed</u> and activities are ongoing</p> <p>Goal is <u>Completed</u>, activities are ongoing</p> <p><u>Completed</u></p> <p>Completed</p>

<ul style="list-style-type: none"> • Increase in calls to the toll free number • Increased number of individuals being trained • Increase in the volume of unused prescription medication collected <p>Number of quilting events</p>	<p>statewide kickoff of the campaign in February 2018.</p> <ul style="list-style-type: none"> • The “Change the Script” campaign materials continue to be broadly disseminated and evaluated statewide. New messaging for a variety of target audiences is being developed. The campaign will also be integrated with the statewide “One Word, One Voice, One Life” suicide prevention campaign since they share common risk factors. 	
<p>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.</p> <p>Measures:</p> <ul style="list-style-type: none"> • Number of institutions participating in integration • Number and types of campaign materials distributed • Increase in the number of CPMRS users 	<p>A total of Thirteen (13) new CPMRS users have signed up, they consist of: Griffin Hospital; 1 inter-tribal organization (United South and Eastern Tribes); 9 provider groups (Paradigm Medical Care, LLC/The Eye Care Group/Recovery and Health Source LLC/Dental Health Associates/Norwich Smiles and Family Dentistry/Physicians Alliance of CT, LLC/ Lester S. Kritzer, MD/Paul H Deutsch/Branford Pediatrics); Southwest Community Health Center and Community Mental Health Affiliates.</p> <p>The following large healthcare systems have already integrated the CPMRS into their EHR systems: CT Children’s Medical Center and Yale New Haven Health network. The DrFirst software has integrated the CPMRS and is being used by Stamford Hospital and Bristol Hospital. The following provider groups are also connected via DrFirst: Vanja Kondev MD, Paul Hanna DMD PC, Pathways Center, and Interventional Spine and Sports. Walmart became the first retail pharmacy to integrate the CPMRS with 34 stores.</p> <p>There are currently 2,800 campaign materials that have been distributed throughout the state of Connecticut. The material distribution efforts have been ongoing through fairs and presentations.</p> <p>The campaign efforts have yielded an additional 2,994 CPMRS users; these include Prescribers, Pharmacists and Delegates, from February 2018 through September 2018. The campaign efforts also include compliance letters which have been going out in waves since December 2017.</p>	<p><u>Partial Completion</u></p>
<p>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</p> <p>Measures</p> <ul style="list-style-type: none"> • Increase in the number of school personnel who carry naloxone 	<p>Data has been gathered from CSUs, community colleges and private colleges and universities.</p>	<p><u>Not Completed</u></p>

<p>2/20/18</p> <ul style="list-style-type: none"> • Make available age-appropriate, evidence-based opioid curricula in public schools K-12 	<p>The committee researched how some other states have addressed the opioid use disorder in their health curricula.</p> <p>Using examples from other states, the SDE will revise their Healthy and Balanced Living Curriculum Framework in fall 2019 to include opioid education standards and indicators.</p> <p>A letter was sent to all school superintendents on September 25th regarding awareness of the opioid crisis and other substances, legislative requirements for instruction, maintaining naloxone, and the pending naloxone survey. School nurse supervisors were also informed of the survey in a training workshop on September 28th 2018</p> <p>Through the federal SOR grant DMHAS is contracting with SERC to bring awareness of the dangers of opioid use directly into the classroom for students in grades K-12.</p>	<p><u>Partial Completion</u></p>
<p>2/20/18</p> <ul style="list-style-type: none"> • Provide guidance and encourage the stocking of naloxone and reporting of naloxone use in schools. 	<p>A naloxone survey to assess: whether districts stock naloxone in formulary; if not why; who can administer naloxone and any product training received was distributed on November 30, 2018 to school nurses statewide. Results will be compiled and shared with the PSEI subcommittee meeting for consideration of further action.</p> <p>A letter was sent from the SDE to school superintendents in September 2018 advising them to partner with community agencies to develop response plans for cases of toxic drug use. The letter further requested that they consider maintaining naloxone and ensuring proper training on its use. The letter also included a list and description of substance use resources.</p>	<p><u>Completed</u></p>
<p>2/20/18</p> <ul style="list-style-type: none"> • Expand naloxone education and availability for high risk populations 	<p>The RBHAOs have determined priority populations in each region and are working with some health districts to provide naloxone education and distribution.</p> <p>Additional opportunities to expand naloxone availability to the public have been met through the SOR federal grant. A total of 12,000 Narcan kits will be available for distribution in FY 2019 through the following: DMHAS, DOC, DPH, CT Hospital Association and the RBHAOs.</p>	<p><u>Completed</u></p>
<p>Tasks from HB7052</p> <ul style="list-style-type: none"> • One page fact sheet- Opioids :risks, symptoms, services and strategy for dissemination • Feasibility of Marketing campaign and monthly PSAs-Opioids: risks, symptoms, services (including opioid antagonists) 	<ul style="list-style-type: none"> • A one-page fact sheet on the risks of OUD and resources available to address it is being finalized and reviewed for posting on the DMHAS website by October 1st. • A statewide media campaign called <i>Change The Script</i> targeting users, their families and friends, prescribers and the general public is being developed for deployment this fall. It is being designed for customization by local 	<p>Deliverable on or before October 1, 2017- <u>Completed</u></p> <p><u>Completed.</u> Deliverable on or before January 1, 2019 – Campaign development is completed. Soft launch in communities and across the state</p>

<ul style="list-style-type: none"> 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 	<p>agencies to build on the growing awareness of the opioid misuse problem and move individuals and communities toward taking appropriate action.</p> <p><i>HB-7052 Recommendation for Safe Disposal</i> <i>A registered nurse employed by a home health care agency will be educated consistent with the information provided by the Department of Consumer Protection's website on approved disposal methods for all controlled substances. The home health care agency will retain documentation verifying that the registered nurse has received such education. Upon a patient's death, the RN will work proactively with the decedent's designated representative or responsible family member to destroy or remove all controlled substances belonging to the decedent from the dwelling.</i></p> <ul style="list-style-type: none"> The VNOD form was developed by DPH and reviewed and approved by the DCP and DMHAS. It is currently being reviewed by their legal department in preparation for posting on the DPH website on October 1 2017 	<p>occurred January 2019. Official launch planned for the end of February 2018.</p> <p>Deliverable on or before February 1, 2018</p> <p><u>Completed</u></p> <p><u>Completed</u></p>
Treatment Subcommittee Goals	Progress to date	Status
<p>Promote screening, brief intervention and referral to treatment for opioid misuse (e.g. SBIRT) across the lifespan:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Trainers, Kognito licenses and UCONN training institute available-ongoing SAMHSA State Youth Treatment Implementation (SYT-I) proposal includes A-SBIRT trainings for various sectors. DMHAS STR and DCF ASSERT Awards include resources for SBIRT implementation and expansion. Dollars going to Beacon Health Options and UConn. SBIRT training offered at July 2017 opioid conference. 	<p><u>Completed.</u> Maintain/Expand through DMHAS STR grant (A-SBIRT data infrastructure improvements and trainings) and DCF ASSERT grant (A-SBIRT training for a wide range of audiences)</p>

<p>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:</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Urine toxicology guidelines to be drafted by subcommittee for distribution to ECCs (can also be used beyond ECCs); please see October 2017 meeting packet for draft. • The original recommendation to “require” ECCs to use urine toxicology screening upon all admissions was explored by the committee and ultimately decided against because of the possible misuse of it and resulting alienation from treatment that could happen. 	<p><u>Partial Completion</u> Guideline document created and dissemination started.</p>
<p>Require the 13 DMHAS operated/funded Local Mental Health Authorities (LMHA) to provide Buprenorphine treatment on-site, including psychosocial and recovery support services. Psychosocial services require a comprehensive assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate. The assessment should include the individual's stage of readiness and receptivity to the recommendations.</p>	<ul style="list-style-type: none"> • 12/16- One time DMHAS funding for LMHAS • 12/16-DMHAS Learning Collaborative begun including sharing of policies • Related-9/16 SAMHSA MATX funding expansion at 4 sites (2 LMHAS) • DMHAS Prevention-Treatment-Recovery Conference 7/17- 8 hrs. FREE DATA training offered • Note: DCF ASSERT grant award includes expansion of MAT to youth aged 16-21 • Sept 2017 DMHAS Prescriber MAT Learning Collaborative expanded to include all LMHA prescribers. <ul style="list-style-type: none"> ▪ DMHAS expands MAT Learning Collaborative to include 7 STR funded sites 	<p><u>Completed.</u> Maintain/Expand through involvement with Project ECHO opportunities and PCSS-MAT and NP/PA MAT</p> <p>MAT Learning Collaborative with 13 LMHAS and 7 STR sites is fully operational.</p>

<p>Establish a workgroup to identify and address regulatory barriers that limit access to care. Some examples include: 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.</p> <p>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 <u>specific to ADPC and governor’s charge</u> -Involve DSS in discussion of Medicaid rules related to incarcerated individuals; clarify any mis-information regarding benefits</p>	<ul style="list-style-type: none"> • Have explored multiple topics and invited speakers regarding the following topics: <ul style="list-style-type: none"> ○ children’s behavioral health program licensing; ○ integrated mental health/substance abuse program license; ○ scope of practice for LADCs. ○ Mobile MAT ○ Increasing co-occurring capability of programs (e.g., licensing, funding, IMD rules) 	<p><u>Not completed</u></p>
<p>2/20/18 Increase access to substance use services (i.e. increasing access to lifespan MAT and co-occurring programming)</p>	<p>DCF has implemented a youth/young adult OUD treatment program through a SAMHSA Federal Grant (ATM program). The program combines MAT, family co-occurring treatment, and recovery checkups.</p> <p>Ongoing Waiver trainings to increase the number of MAT prescribers</p>	<p><u>Partial Completion</u></p>
<p>Task from HB7052 Feasibility of establishing a publicly accessible electronic information portal-bed availability for detox, rehabilitation, outpatient MAT</p>		<p>Deliverable on or before January 1, 2019 <u>Completed</u> for detox, rehabilitation and certified/credentialed sober homes. Launched 11/20/17</p>
<p>Recovery and Health Management Subcommittee Goals</p>	<p>Progress to date</p>	<p>Status</p>
<p>The ADPC will adopt the “Recovery Language” document developed by the Recovery and Health Management Committee to ensure that all members of the Council and members of the sub-committee are familiar with some alternatives to traditional terminology and can promote the use of such terminology.</p> <p>Revision (update)being drafted</p>	<p>A “Recovery Language” document was developed by the original sub-committee and adopted by the full Council</p>	<p><u>Completed</u></p> <p><u>Completed</u> A revision to the original document was adopted.</p>

<p>NEW 6/2018 The ADPC will adopt the “<i>Recovery Friendly Community Guidelines</i>” that have been promulgated and piloted in a minimum of two locations by the sub-committee.</p>	<p>Draft guidelines complete. Pilot communities in process of being identified.</p> <p>Approved by Council 6/19/18</p>	<p><u>Not Completed</u></p>
<p>Criminal Justice Subcommittee Goals 9/18/17 new</p>	<p>Progress to date</p>	<p>Status</p>
<p>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 corrections system. In doing so, equitable opportunity to access MAT is offered to inmates regardless of facility.</p>	<ul style="list-style-type: none"> • MAT New Haven jail (2013)-ongoing, 35 - 40 patients daily, including 1 Subutex induction. • MAT Bridgeport jail (2014)-ongoing, 35 - 40 patients daily. • MAT Hartford jail (2018)-ongoing, 20 - 25 patients daily. • MAT York CI expansion (initially, pregnant women on methadone). Expansion to other patients 2018, ~ 80 methadone and ~ 20 Subutex patients daily. Purchase and installation of automated methadone dispensing equipment underway (funded by SOR/DMHAS). • MAT in Osborn CI, (2018 with STR funding), 30 - 35 patients daily and have inducted approximately 5 on methadone. Osborn is receiving sentenced patients from the three jails, and treating TOP (time out program) patients as well. • Step Forward program in New Britain with STR funding 2017. 100 clients admitted pre-release, 52 admitted post-release. • Build a statewide re-entry MAT Network 	<p><u>Completed- ongoing</u></p> <p><u>Completed-ongoing</u></p> <p><u>Completed-ongoing</u></p> <p><u>Completed- ongoing</u></p> <p><u>Completed ongoing</u></p> <p><u>Completed ongoing</u></p> <p><u>Partially Completed</u></p>
<p>NEW 10/2018 Develop a plan for Police Preventative Deflection and Police Assisted Diversion for persons with problem substance use that can be quickly implemented when funding becomes available.</p>		<p><u>Not Completed</u></p>
<p>Tasks 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.</p>	<ul style="list-style-type: none"> • Workgroup met 9/28/17; will begin gathering information on programs in CT and elsewhere • Met 10/19/17 and 11/13/17, next meeting 11/27/17 • Preliminary ideas presented at ADPC December meeting 	<p>Deliverable due on or before February 1, 2018. <u>Completed</u></p>

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.

Connecticut Opioid Legislation and Policy Initiatives

Connecticut has taken a number of steps over the past **seven (7)** years to make Naloxone more widely available. Legislation was first introduced in 2011 and each successive legislative session has introduced new pieces of legislation that have made Naloxone more accessible. A Good Samaritan law was introduced in 2011 that protected people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia. Legislation enacted in 2012 allowed prescribers (physicians, surgeons, Physicians’ Assistants, APRNs, dentists, and podiatrists) to prescribe, dispense or administer Narcan to any person to prevent or treat a drug overdose and the prescriber is protected from civil liability and criminal prosecution. The protection from civil liability and criminal prosecution was extended to the person administering the Narcan in response to an overdose in 2014. Legislation enacted in 2015 allows pharmacists who have been trained/certified to prescribe and dispense Narcan directly to customers requesting it.

In 2016 opioid related legislation imposed a 7-day limit on opioid prescriptions, allowed licensed health care professionals to administer naloxone without fear of civil liability and required each municipality to have a designated first responder(s) trained on and equipped with naloxone. The legislation also required pharmacies to enter information about all controlled substances dispensed into the CT Prescription Drug Monitoring and Reporting System (operated by the CT Department of Consumer Protection). In 2017 opioid related legislation required electronic prescriptions for controlled substances and provided a vehicle to allow patients to refuse opioids through a directive. It also expanded the requirement for pharmacists to provide information about the risk of addiction to opioids and allowed data sharing among State agencies.

Most recently, PA 18-166 allowed prescribers to develop agreements with organizations wishing to train and distribute Narcan. This legislation established new reporting requirements, established a framework for expanding distribution and availability of Narcan, enacted limitations on prescribing controlled substances, and commissioned a feasibility study for opioid intervention courts.

6

Key Strategies for a Comprehensive and Coordinated Response to the Opioid Epidemic

- 1 STRATEGIES RELATED TO RESCUE**
 - Reduce overdose deaths by expanding the availability of naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives
- 2 STRATEGIES RELATED TO PREVENTION AND EDUCATION**
 - Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals.
- 3 STRATEGIES RELATED TO TREATMENT**
 - Expand access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine and naltrexone.
- 4 STRATEGIES RELATED TO CRIMINAL JUSTICE**
 - Implement criminal justice reforms that will increase the availability of MAT in jails and prisons.
 - Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution.
- 5 STRATEGIES RELATED TO LAW ENFORCEMENT**
 - Foster improved coordination between law enforcement and Connecticut's treatment system in order to divert individuals arrested for opioid related crimes into treatment.
 - Enforce laws related to trafficking of heroin and other opioids.
- 6 ACCOUNTABILITY AND QUALITY CARE**
 - Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need.

Strategy 1: Strategies Related to Rescue

<p>➤ Reduce overdose deaths by expanding the availability of Naloxone (Narcan) to first responders, law enforcement, treatment providers, community organizations, and families in order to reverse overdoses and save lives.</p>	
<p><u>Action Step:</u> Continue to expand the statewide network of pharmacists that are trained and willing to prescribe and dispense naloxone</p>	<p><u>Action Step:</u> Widely disseminate the names and locations of pharmacists that have completed the Dept. of Consumer Protection training program and are willing to prescribe and dispense Narcan.</p>
<p><u>Action Step:</u> Provide in-person training to law enforcement, first responders, treatment providers, community organizations and families regarding proper use of Narcan.</p>	<p><u>Action Step:</u> Continue to expand the numbers of Emergency Medical Technicians and other first responders that carry Narcan</p>
<p><u>Action Step:</u> Continue to make online training regarding Narcan available to the general public.</p>	<p><u>Action Step:</u> Continue to educate opioid users, family members, and the general public about Narcan.</p>
<p><u>Action Step:</u> Distribute Narcan through syringe exchange programs.</p>	<p><u>Action Step:</u> Ensure that all insurance carriers reimburse pharmacists for prescribing Narcan.</p>
<p><u>Action Step:</u> Apply for federal funding being made available to expand overdose prevention training.</p>	<p><u>Action Step:</u> Continue to ensure Narcan is available in schools and universities in CT</p>

Strategy 2: Strategies Related to Prevention and Education

<p>➤ Prevent opioid use through education aimed at teens, parents, school and university faculty and staff, and other caretakers including medical professionals</p>	
<p><u>Action Step:</u> Use the state’s network of Regional Behavioral Health Advocacy Organizations (RBHAO’s) to host community forums throughout the state to educate the public regarding risks of opioid use, benefits of Narcan and how to access it, and community resources available for the treatment of opioid use.</p>	<p><u>Action Step:</u> Apply for federal funds being made available to prevent opioid use and overdose deaths associated with heroin and other prescription opioids.</p>
<p><u>Action Step:</u> Continue to Inform the public about risks of opioid use and prescription drug use through videos, social media, websites, PSA’s, and posters and billboards</p>	<p><u>Action Step:</u> Continue efforts through the state’s prevention and treatment network to de-stigmatize addiction which is often a barrier to help-seeking.</p>
<p><u>Action Step:</u> Continue to disseminate educational materials regarding opioids for students, parents, and school personnel.</p>	<p><u>Action Step:</u> Expand community disposal sites for unused and expired prescription medications.</p>

Strategy 3: Strategies Related to Treatment

<ul style="list-style-type: none"> ➤ Expand access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine, and naltrexone. ➤ Rapidly link opioid users to treatment 	
<p><u>Action Step:</u> Create a statewide network of walk-in assessment centers to rapidly assist opioid users to find appropriate treatment.</p>	<p><u>Action Step:</u> Establish and implement protocols to attempt to rapidly engage into treatment those individuals that were rescued from an overdose</p>
<p><u>Action Step:</u> Continue the statewide toll free call line to connect callers to treatment options and make transportation available for individuals seeking treatment.</p>	<p><u>Action Step:</u> Maintain and expand as necessary the statewide network of methadone maintenance programs.</p>
<p><u>Action Step:</u> Increase capacity for outpatient programs to prescribe buprenorphine and naltrexone through clinic-based MAT.</p>	<p><u>Action Step:</u> Improve linkages from detoxification programs to MAT</p>
<p><u>Action Step:</u> Continue to apply for federal funding being made available to expand access to MAT.</p>	

Strategy 4: Strategies Related to Criminal Justice

<ul style="list-style-type: none"> ➤ Implement criminal justice reforms that will increase the availability of MAT in jails and prisons. ➤ Reduce barriers and adverse consequences faced by prisoners who may be dealing with opioid addiction or have drug convictions related to opioid use or distribution 	
<p><u>Action Step:</u> Continue the Law Enforcement Assisted Diversion (LEAD) programs in Hartford and Bridgeport and seek additional funds to expand the program.</p>	<p><u>Action Step:</u> Continue to maintain and expand methadone services in the correctional system.</p>
<p><u>Action Step:</u> Continue to transition offenders with drug convictions to community substance use programs.</p>	<p><u>Action Step:</u> Continue diversionary services for individuals arrested for crimes related to opioid use. Expand where possible.</p>
<p><u>Action Step:</u> Increase employment training and job opportunities for ex-offenders.</p>	

Strategy 5: Strategies Related to Law Enforcement

➤ Foster improved coordination between law enforcement and Connecticut’s treatment system in order to divert individuals arrested for opioid related crimes.	
Action Step: Provide DMHAS access line number to state and local police departments.	Action Step: Ensure law enforcement personnel have access to Narcan and are trained to administer the drug

Strategy 6: Accountability and Patient Care

▪ Ensure that medical professionals screen for opioid misuse and dangerous combinations of prescription medications, establish limits for opioid prescriptions, and regularly review patients that are receiving prescription painkillers to assess continued need	
Action Step: Provide continuing education training to medical professionals regarding risks involved in using painkillers and dangers associated with co-prescribing (i.e. opioids and benzodiazepines).	Action Step: Require medical professionals to query the state’s Prescription Monitoring Program when initially prescribing opioids and at regular intervals for patients receiving pain medications for chronic conditions.
Action Step: Continue to Require pharmacies to enter data into the State’s PMP as prescriptions are filled (real time data entry) in order to ensure PMP is complete and up-to-date.	Action Step: Increase efforts to identify mechanisms for sharing data across state agencies

Conclusion

This Annex was designed to formalize key strategies and to highlight the major efforts that have been ongoing as Connecticut attempts to address the opioid epidemic. The summary table included on p. of the Annex shows the goals that were set by the ADPC in the areas of prevention, treatment, recovery and criminal justice (across the lifespan) and the considerable amount of progress that has been achieved. The information in the table shows the state’s overarching strategy to reduce opioid addiction and overdoses and the role state agencies and private partners within the state are playing. Much remains to be accomplished but there are signs that the state’s plan is impacting the epidemic. Overdose deaths have declined, rather than increased in CTY 2018 and overall admissions to the DMHAS treatment system that are related to opioids have undergone a similar decrease in FY 18. The strategies delineated in this section will serve as a guide for activities over the next 3 years and will be the basis for a comprehensive plan that will build on the state’s efforts.



DMHAS Triennial Report Subsection
Women's Services

Introduction

In recognition of the unique experiences and challenges that women in need of substance use disorder treatment services face, DMHAS provides specialized and comprehensive programs for women and their children. These include residential treatment, outpatient treatment, and specialized care management for women transitioning from a residential setting to community-based recovery services. DMHAS supports a coordinated, effective system of family-based recovery and health services for pregnant and parenting women (PPW) with substance use disorders, especially opioid use disorders.

The number of women seeking treatment from DMHAS funded programs has increased by nearly 3.5 percent since FY2014 and decreased by 5.7% from FY 2017 to FY 2018 (Table 1). In 2018, 186 women were admitted to DMHAS PPW residential services programs, with an average length of stay of 110 days. While approximately 2.2 percent of women participating in all treatment modalities in 2018 were pregnant on admission, 44.1 percent of women in PPW residential treatment were pregnant on admission. Of the latter, 29.4 percent had children with them on admission. Of the women who did not have their children with them upon admission, 45.4 percent had their children upon discharge.

Table 1: Substance Use Treatment Admissions - Women

Year	Total Admissions	% change over previous year	Percent Pregnant	Percent Unknown
2014	11,721		3.06	8.86
2015	12,860	9.72%	3.29	10.79
2016	13,126	2.07%	2.80	10.30
2017	12,873	-1.93%	2.78	10.67
2018	12,136	-5.73%	2.19	13.88

In response to the needs of this population DMHAS has established a women's behavioral health system that offers recovery oriented care for women and their children with comprehensive services that are trauma informed, gender-responsive, and culturally competent. DMHAS funds seven pregnant and postpartum substance use disorder residential programs and seven outpatient programs, including three specialty women's outpatient programs where women can bring their children. All of these programs prioritize admission for pregnant women, admit them within 48 hours, and are geographically located around the state to ensure access to service. All of the programs can accommodate women on medication assisted treatment. While programs are located statewide in many communities to allow a woman to remain "local", she is also eligible for programs outside her immediate area, based on availability. The treatment programs are

located in both urban and rural settings, thereby offering unique experiences, opportunities and features.

Click [here](#) for the *DMHAS Women and Children's Services Webpage*

Residential substance use disorder treatment for Pregnant and Parenting Women in the seven facilities has a total capacity of 67 women with child(ren). Residents receive twenty hours of treatment per week attending to issues of trauma, intimate partner violence, 12 step support groups, individual, group and family counseling, relapse prevention, psychoeducation groups on mental health/co-occurring disorders, as well as information on infant mental health, NAS, attachment and bonding, parenting, and sexuality and reproductive health. Infants/children reside with their mother and participate in Early Head Start programming. Women also receive specialized care management addressing transition to community-based recovery.

DMHAS Funded Programs

Agency	Program	Location
Liberation Programs	Families in Recovery Program	Stamford
Connection, Inc.	Hallie House	Middletown
Connection, Inc.	Mother's Retreat	Groton
APT Foundation	Amethyst House	New Haven
Community Health Resources	New Life	Putnam
InterCommunity	Coventry House	Hartford
Wellmore Behavioral Health	Women & Children's Program	Waterbury

Given the importance of prenatal care and substance use disorder treatment and the importance of early development in children, pregnant and postpartum women are deemed a priority population with regard to treatment access. Women with dependent children are also considered a priority population for specialized treatment as opposed to treatment as usual. Research over the past decade indicates that successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers in the child welfare system.

Demographic Information on Substance Use Disorder Residential Programs for Pregnant and Postpartum Women FY 2018

Total Number of Admissions	186
Total Number of Women Waitlisted for Treatment	0
Average Length of Stay (days)	104
Health on Admission	
Pregnant on Admission	44.9%
Co-occurring MH and SU Disorder	43.6%
Substance Use Disorder Only	16.1%
Chronic medical and Co-occurring Disorder	33.9%
Ethnicity Information at Discharge	
White	79.9%
Black	15.8%
Hispanic-Puerto Rican	2.7%
Hispanic-Other	0.54%
Other	0.54%

DMHAS Oversight – Department staff conducts Trauma and Gender Fidelity reviews at each of the substance use disorder PPW residential program agencies. Trauma and Gender (TAG) fidelity reviews gauge the extent to which a program or agency has developed a culture of trauma-informed, gender-responsive care. Trauma-informed is defined as a culture that incorporates knowledge about trauma—its prevalence, impact, and the complex paths to recovery and healing—into every aspect of the program’s contacts, activities, relationships, and physical settings. Gender-responsive is defined as creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women/girls as well as men/boys and that addresses and responds to their respective strengths and challenges. Department staff maintains regular contact with private non-profit behavioral health service contractors and conduct oversight through formal and informal site visits to ensure quality service implementation and program management. Department staff also provides technical assistance and oversee evidence-based trauma and gender responsive initiatives for women and family members affected by substance use.

Outpatient (OP) & Intensive Outpatient (IOP) Substance Use Disorder (SUD) Treatment for Pregnant and Postpartum Women

– Outpatient and Intensive Outpatient Treatment vary in intensity and flexibility based on client needs. OP and IOP service provision includes comprehensive assessments, psychiatric assessment, individual, couples and family therapy, parenting and child development training, specialized groups for relapse prevention, trauma and co-occurring disorders, 24 hour crisis coverage, childcare, and discharge planning for aftercare services. Programs promote participation in self-help recovery groups and other community connections such as those with the faith-based community. Standard outpatient services are non-residential substance use disorder treatment modalities including individual,

group and family counseling and support services. Intensive Outpatient Services consist of non-residential treatment for a minimum of three (3) hours per day, provided for a total of not less than nine (9) and up to twenty (20) hours of structured programming per week.

DMHAS Funded Outpatient and Intensive Outpatient SUD programs for PPW

Agency	Program	Location
CASA, Inc.	Project Courage	Bridgeport
Wheeler Clinic	Lifeline	New Britain
MCCA	Women & Children’s Program	Danbury
Connection, Inc.	Connection Counseling Center	Norwich
APT Foundation	Access Center	New Haven
Wellmore Behavioral Health	Wellmore Counseling Center	Shelton & Waterbury

Evidence-Based Practices

Medication Assisted Treatment: Research indicates that because Neonatal Abstinence Syndrome (NAS) is treatable, medication assisted treatment (MAT) is typically recommended instead of withdrawal or abstinence. The use of MAT during pregnancy is a recommended best practice for the care of pregnant women with opioid use disorders. MAT is the use of medications in combination with counseling and behavioral therapies to provide a whole patient approach to the treatment of substance use disorders. MAT is clinically driven, focuses on individualized client care, and lowers the risk of pregnancy complications and of having a child with neurobehavioral problems.

Opioid Initiatives – CT adheres to Federal Opioid Treatment Provider (OTP) standards which require special services and policies and procedures for pregnant women that reflect the special needs of this population. Prenatal care and other gender-specific services are provided either by the OTP or by referral to appropriate healthcare providers. MAT/ Methadone clinics are monitored by the Department’s Community Services Division. A quarterly OTP Learning Collaborative focuses on quality improvement through review of evidence-based practices and engagement and client retention strategies. DMHAS Local Mental Health Authorities are involved in a Learning Collaborative to expand the availability of Buprenorphine as a component of Medication Assisted Treatment.

Two-Generation Interventions (2 Gen) – The Department has partnered with sister agencies in the adoption of a two-generation focus in the PPW programs by creating programming and

interventions that support a women's role as caregiver and as an integral component of the family unit. One such intervention is the partnering of DMHAS PPW providers with the Office of Early Childhood/Early Head Start. Early Head Start has been offered to all women and children in the PPW residential programs since 2015 to provide access to comprehensive services and support for all low-income children.

Through the Head Start Family Partnership, Head Start grantees partnered with residential programs in their communities to increase Early Head Start enrollment, to "child proof" residential programs, and to work better together to support families with housing needs. By engaging one another in each other's service networks, resources are shared, thus offering more coordinated services to families. Each program has developed a memorandum of agreement with a local Early Head Start provider, and several had the opportunity to participate in Infant Mental Health and Circle of Security Training to help women and children improve attachment, recover from trauma and understand the interaction of these topics within the parent-child relationship and family system.

Every Woman Connecticut (EWCT) – DMHAS is a partner and strong advocate of the EWC initiative. EWC leadership works with state agencies, community members, health care providers, professional organizations, and community-based partners. The initiative focuses on addressing improvements in care for women and men of childbearing age, recognizing that physical, emotional, and social health are vital to overall wellbeing. Every Woman Connecticut is designed to be a place-based initiative made up of teams including maternal and child health professionals from communities across the state. Participation in this initiative allows opportunities to further strengthen multi-agency local referral networks with PPW programs throughout the state. Current provider networks have been developed in the Greater Torrington area, Danbury, Eastern Shore region, Norwalk, Waterbury, New Haven, Southeastern CT, and Hartford. A primary intervention promoted by EWT is "One Key Question©. "

March of Dimes – One Key Question (OKQ©): OKQ© "Would you like to become pregnant this year?" – The backdrop for this intervention stems from concerns affecting the lives of women. Nearly 3 out of 10 pregnancies in Connecticut in 2013 were unplanned, only 56.6% of women who were not trying to get pregnant at the time, were using some form of birth control at the time they got pregnant, and 40.7% of postpartum women using birth control, were using less or least effective methods of birth control. Non-Hispanic Blacks, Hispanics, younger women (<20 and 20-24 years), and women who were on Medicaid or uninsured were disproportionately affected by poor health status before, during, and after a pregnancy, unintended pregnancies, and poor birth outcomes.

Through prevention and reproductive health education via the March of Dimes the EWC Learning Collaborative prioritizes prevention by educating women about the importance of reducing and ceasing the use of opioids, alcohol, tobacco and other illicit drugs before and during pregnancy and in the postpartum period for breastfeeding mothers as a way to optimize the health and well-being of their children and by ensuring that women who are receiving opioid treatment for a medical condition or using illicit opiates understand the risks of prenatal exposure and have access to highly effective birth control methods. Attention is paid to client-centered pregnancy intention screening, increasing family planning referrals, supporting staff in talking about preventive reproductive health and improving maternal and child health outcomes.

Public-Private Collaborations

As part of the recovery oriented system of care for women and children, the DMHAS maintains strong collaborations with DCF, the Superior Court for Juvenile Matters, the Office of Early Childhood, the Office of the Child Advocate, CT Hospital Association (CHA) and professionals in obstetrics, pediatrics, substance use treatment, and mental health systems. Cross-system linkages are necessary to ensure services are coordinated across the spectrum of prevention, intervention, and treatment. A coordinated, multi-system approach best serves the needs of pregnant women with substance use disorders and their infants/children. Collaborative planning and implementation of services that reflect best practices for treating opioid use disorders during pregnancy are yielding promising results in CT communities.

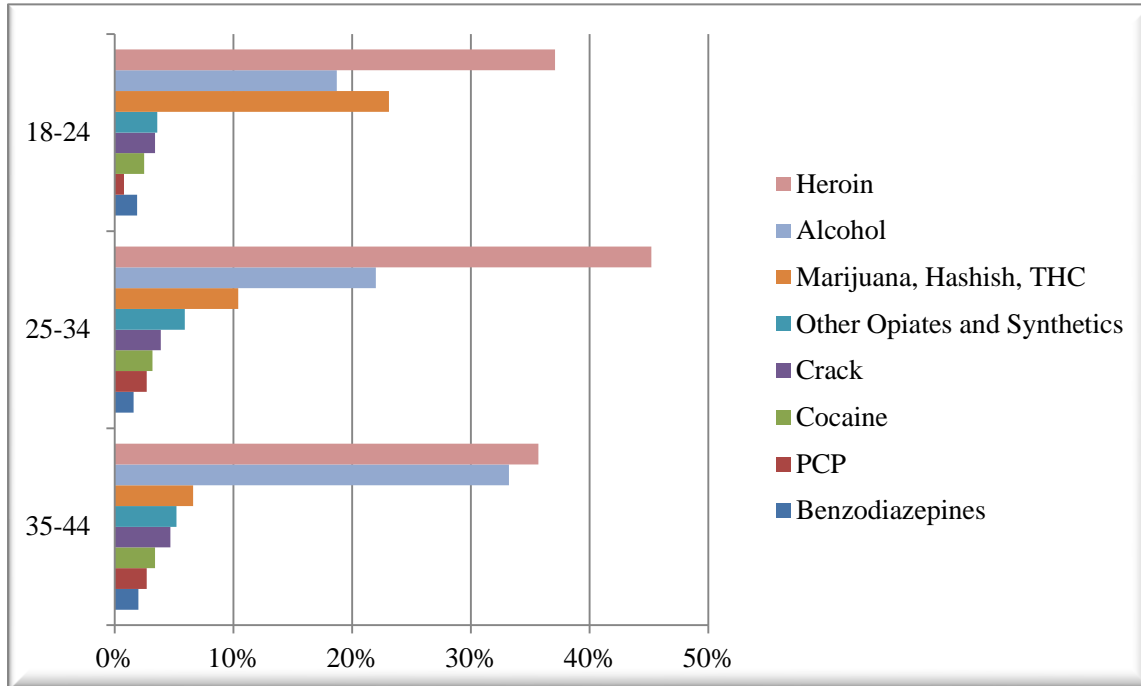
Women's Services Practice Improvement Collaborative (WSPIC) – Since 2004, DMHAS has collaborated with many stakeholders in sustaining the Women's Services Practice Improvement Collaborative. Through participation in ongoing training, technical assistance, and learning communities, women's behavioral health programs have implemented evidence-based practices to improve outcomes. WSPIC is held every other month and is co-facilitated by DMHAS and the Connecticut Women's Consortium. WSPIC's goal is to improve the quality of behavioral health services for women so that they are trauma-informed, gender-specific, holistic, and promote self-determination.

CT Keeping Infants Drug-free (CT KID) is an initiative funded by DMHAS and DCF and led by a core team from the public and private health care systems. The mission of CT KID is to improve the capacity of professionals to diagnose, treat and prevent prenatal substance exposure, including NAS and Fetal Alcohol Spectrum Disorder (FASD) and through education, policy, and increase coordination of services that engage and support families impacted by substance use. The backdrop for the prevalence of substance-exposed infants begins with the contextual

framework of the number of children born in Connecticut, drug use among children and adults, and DCF involvement with families affected by substance use.

Chart 1 depicts FY2018 treatment admission data from DMHAS for women of child bearing years. The data show that the primary substances of choice reported at treatment admission were heroin and alcohol. However, the 18-25 year old age group preferred marijuana to alcohol.

Chart 1: Primary Substance of Choice at Treatment Admission, Women in CT, FY 2018



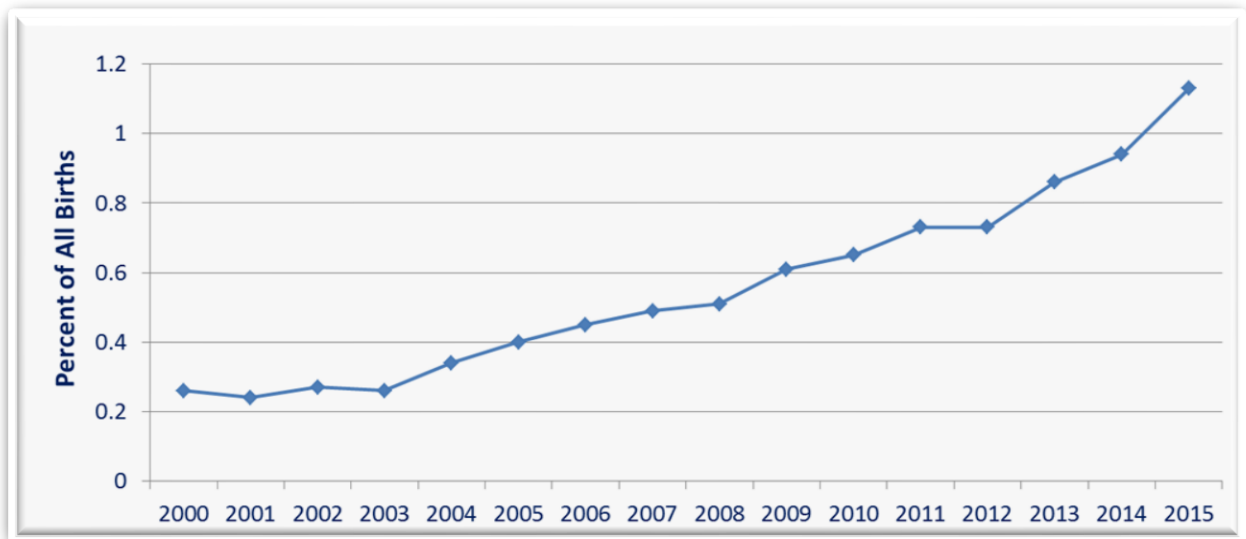
Cost of NAS – Information and data is available from the state Department of Public Health, Office of Health Care Access (OHCA) in association with the ChimeData program administered by the Connecticut Hospital Association (CHA). ChimeData is used to help hospitals meet regulatory reporting requirements and to support CHA's advocacy efforts. ChimeData is the most comprehensive hospital database in the state, containing over 31 million patient encounters dating back to 1980. It includes administrative discharge (UB-04 claims-based) data from inpatient admissions, hospital-based outpatient surgery, and emergency department non-admissions. According to Connecticut ChimeData Hospital discharges related to NAS rose 164% in the 10 year period between 2003 and 2012. Total patient days for these infants also increased by 150% from 2,589 to 6,474 during this time period.

The costs associated with NAS are significant and rising. Statewide hospital discharge data for FFY12 show that the median charges at discharge for a NAS infant was \$49,103 compared to \$5,163 for a non-NAS infant.¹ The majority of medical costs are covered by the state’s Medicaid Program (82%), a percentage that closely aligns with the national average of 80%. While Sixteen percent of NAS infants have their care paid for by private insurance, the remaining 2% of NAS infants’ medical costs were covered out-of-pocket. And, in 2012, Medicaid was the expected primary payer for 79.9 percent of neonatal stays related to substance use compared with 46.2 percent of all other neonatal stays.

Substance-Exposed Infants – DMHAS has a long history of advocating for services for substance exposed infants, including those affected by FASD and more recently as a result of the opioid health crisis, those with NAS.

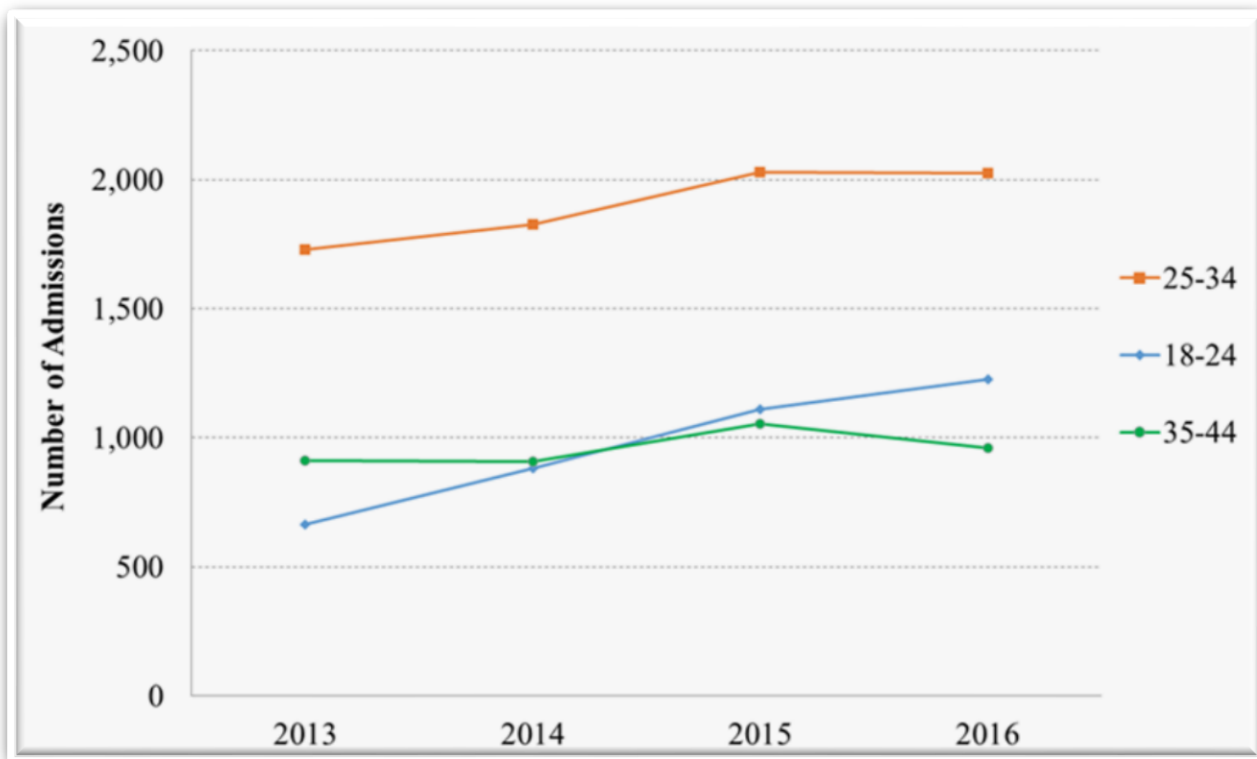
According to the Connecticut Office of Health Care Access, the number of hospital discharges with a diagnosis of NAS rose dramatically from 2000 to 2015 (Chart 2, along with the total number of patient days required for treatment.

Chart 2



Coupled with these data, the number of women admitted to treatment for heroin use from 2013 to 2016 also increased (Chart 3), with the greatest increase among women age 18 to 24.

¹ CT DPH OFFICE OF HEALTH CARE ACUTE CARE DISCHARGE DATABASE AND HOSPITAL REPORTING SYSTEM REPORT, p.185.



CT K.I.D. State Strategic Plan 2016-2022 – The overarching rationale for a state plan stems from the recognition that Connecticut has developed multiple strategies to coordinate between state agencies and organizations and local entities and healthcare providers around the issue of substance exposed infants. Over the past few years, systems are increasingly communicating about programs and services they offer for this population. As a result, pregnant and postpartum women with substance use disorders and their children have increased pathways for engaging with substance use disorder services.

Strategic planning seeks to increase knowledge and expertise among professionals, systems stakeholders, and the community at large about substance use during pregnancy and the effects on infants and children. Efforts are underway to educate relevant groups about the teratogenic effects of drugs and alcohol during pregnancy by partnering with professional organizations, multiple state agencies and public/private universities to design and provide professional development to target groups/populations, and to educate all in-home service programs about SEI and FASD so as to provide primary prevention through information/education to pregnant and postpartum women, fathers and families.

During CT K.I.D. workgroup meetings, the specifics of these needs and collaborations have included ongoing efforts to engage and train professional disciplines about the effects of substance use during pregnancy, and to continue to increase public awareness around substance use and associated risk factors for child maltreatment during pre-pregnancy, pregnancy and postpartum for youth, and women of child bearing ages. The Data Workgroup is methodically identifying sources for data on substance exposed infants to use in public awareness efforts. Through focused training initiatives, the medical community has begun to address stigma and disparate treatment associated with pregnant women who disclose substance use to medical professionals and others while child welfare entities are developing training curricula and consulting with the adult mental health and substance use system.

SEI Statewide Coordinator – DMHAS and DCF established and jointly funded a NAS/FASD Statewide Coordinator position in 2015. The SEI coordinator is tasked with determining ongoing mutual priorities with project partners related to screening and assessment, engagement and retention in treatment, and data and information sharing.

Women’s REACH (Recovery, Engagement, Access, Coaching & Healing) Program – In 2019, DMHAS implemented a new outreach and engagement model to support the unique needs of women and families in the community. Five regionally based hubs have been established to support the work of 15 Women’s Recovery Navigators. Each Navigator is a woman in recovery charged with engaging individuals, particularly women who are pregnant and parenting, in a combination of recovery coaching and case management activities. Navigators also assume a key role in helping pregnant women develop their Plan of Safe Care in line with Child Abuse Prevention and Treatment Act legislation. Through development of community relationships within the healthcare network, recovery community and social service system, linkages are established to ensure women are aware of the support resources available to them to help support and sustain a safe and healthy path for women and their families.

Women’s Behavioral Health Services Program – Women’s Recovery Specialists provide holistic services to maximize the likelihood of a woman’s success as she reintegrates into the community after discharge from Women’s Specialized Residential Programs. The ability to transfer the recovery capital built during residential treatment – including sober living skills, a sense of community and parenting skills – to a non-structured environment is imperative. Recovery Specialists facilitate successful client treatment outcomes by participating in discharge planning, improving linkages among treatment providers, identifying community based supports, and working collaboratively with DCF workers for up to 6 months post-discharge from DMHAS’s Women and Children’s Substance Use residential programs.

Collaboration with Medication Assisted Treatment Providers – DMHAS is collaborating with MAT providers to disseminate information about NAS, build capacity for the referral of pregnant clients receiving MAT to prenatal care, and support and coordinate MAT dosing with women's residential programs and hospitals. The Department is also connecting MAT providers to DCF's Substance Use Managed Service System (SUMSS) meetings, WSPIC bi-monthly meetings and the CT Women and Opioids Workgroup.

Neonatal Abstinence Syndrome Comprehensive Education and Needs Training (NASCENT) – CT Hospital Association (CHA) CHA's goals for NASCENT are to initiate standardized approaches for the recognition and treatment of NAS across hospitals and to improve early recognition of substance use disorders in pregnant women. CHA is utilizing the *Educating Practice In the Community* (EPIC) approach to promote best practices in opioid prescribing. Education focuses on issues of stigma related to women and pregnant women with substance use disorders, and infants with NAS. Training modules promote educational initiatives to promote a better understanding of NAS and messaging such as Newborn babies are NOT born “addicted” and referring to newborns with NAS as “addicted” is inaccurate, incorrect, and highly stigmatizing. Via training webinar modules and in-person training the medical community is guided toward a deeper understanding of the multiple paths to recovery for women with substance use disorders and that recovery for women and infants is possible rather than viewing women as perpetrators which further perpetuates the criminalization of addiction. Messaging throughout the training supports the premise that recovery is possible and attainable with the appropriate treatment course and NAS is treatable and has not been associated with long-term adverse consequences.

State Health Improvement Plan (SHIP) – SHIP addresses the category of mental health and substance use disorders by seeking to improve overall health through the lifespan through access to quality behavioral health services that include screening, early intervention, prevention and treatment as well as reducing non-medical use of pain relievers across the lifespan. In the area of Maternal, Infant and Child Health work is being directed toward optimizing the health and well-being of women, infants and families with a focus on disparate populations.

CT Women and Opioids Workgroup – CT-WOW was created following the Department's participation in a Region I Women and Opioids Invitational Symposium, sponsored by the Federal Office of Women's Health during October 2016. Representatives from DMHAS, UCONN; two provider agencies (Recovery Network of Programs & Connection Inc.) representing Medication Assisted Treatment and PPW Substance Use Disorder Residential treatment respectively; two women with lived experience (one from CT Community for

Addiction Recovery (CCAR), one from Advocacy Unlimited), and the Executive Director from the CT Women’s Consortium (Experts in training and education related to trauma and gender initiatives) attended a three day working conference and identified cross-cutting target areas for continued interventions which included: Creation of partnerships and a strategic plan to address the Child Abuse Protection and Treatment Act (CAPTA) which requires the notification by healthcare settings of substance exposed infants to DCF; Incorporation of reproductive health education for women with substance use disorders; and further investigation of evidence-based practices for pain management for women with substance use disorders. The workgroup meets bi-monthly and has added additional members including DCF, the Hartford Dispensary and a UCONN faculty member.

System wide Training and Education

- November 2016 Symposium – *Opioid Epidemic: Assessment, Intervention, and Call to Action: A Public Health Approach*
- September 2016 – *Understanding Substance Exposed Infants, Children and their Families*
- Opioid Overdose Prevention/Naloxone (Narcan) Initiative – ongoing training conducted in PPW programs
- June 2017 – CT Judges Institute, UCONN School of Law. Audience: 35 Juvenile/Family Court Judges. *The Biology of Addiction*. Potential for Continuing Legal Education credits for Juvenile/Family Court Judges and Attorneys
- May 2017 – One Key Question introductory training for DMHAS Substance use/Behavioral Health providers
- June 2017 – One Key Question implementation workshop for DMHAS Substance use/Behavioral Health providers
- August 2017 – “*Sexuality, Reproduction, optimal birth spacing and family planning options*” training for DMHAS Substance use/Behavioral Health providers
- September 2017 – *Recovering Together-A Collaborative Framework from an Infant Mental Health Perspective* with CWC for Women’s Services providers, DCF, OEC and home visiting staff- (cross collaborative training event) presenters
- November 2017 – Women, Babies and Opioids, Quinnipiac University

Conclusion

Interagency efforts have been significantly strengthened over the past few years as evidenced by DMHAS's involvement with various state partners such as DCF, DSS, DPH, and OEC and more recently with the healthcare system including the CT Hospital Association, ACOG, and CT Children's Medical Center, entities at the forefront of addressing multiple health and well-being outcomes for women, children and families.

Through multi-agency collaborations the Department has developed training, education, and best-practices related to screening and assessment in the prenatal period, testing at birth, notification to child protective services in cases where infants are identified as substance affected and the provision of services to parent and SEI's after a referral to DCF has been made or other agencies have become involved.

Connections with Maternal, Infant and Child Health have been critical as SEI issues must be handled in an intensely collaborative manner so as to address the full range of needs of all substance-exposed infants. Interagency networking with agencies and organizations such as home visiting programs for high-risk infants, developmental screening programs, child welfare agencies, preschool providers, hospitals and others have provided opportunities for all partners to best consider appropriate intervention with women with substance use disorders and their families.

The Department anticipates that ongoing coordination with entities charged with addressing various facets of substance use disorder services for women and their infants will provide the best path for women and family-based recovery and improved child welfare outcomes. This system of care also creates opportunities to optimize the health of women before, between, and beyond potential pregnancies and provides a critical opportunity to receive recommended clinical preventive services, screening and management of chronic conditions that may affect birth outcomes and family stability.

i Mohlman, Mary K., et al. "Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont." *Journal of Substance Abuse Treatment*, vol. 67, 2016, pp. 9-14.