MEETING MINUTES

Alcohol and Drug Policy Council: Treatment and Recovery Support Subcommittee

Meeting Date: September 29, 2016

Present: Charles Atkins, Craig Allen, Sherrie Sharp, Melissa, Sienna, Julienne Giard, Marsha Murray, Kathleen Maurer, John Hamilton, Dan Rezende, Marcia Dufore, Colette Anderson, Aili Arisco, Gabriela Krainer, Dave Borzellino

On the Phone: Allison Kernan, Karen Zaorski

TOPIC	DISCUSSION	ACTION
Review of Commissioners' responses to our 5 recommendations	D. 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. **Rank**: 4 **Co-Chair's' Response**: (a) The Treatment Sub-committee will: Collapse Recommendations D (accepted as submitted) and F (requesting more detail on scope and scale as well as resources needed) working within existing resources F. 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: i. 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. ii. 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. **Rank**: 9 **Co-Chair's' Response**: (b) The Treatment Sub-committee will: Collapse Recommendations D and F Utilize and incorporate content experts at DSS, DMHAS and DCF related to SBIRT and ECCs Detail scope and scale of recommendation, revisit need for additional resources ECC urine screen Drug screen and adolescent engagement [informed by empirical literature] Standard of care about screening before seeing provider Research: 1st visit engagement & visit screen ASBIRT: risk management Suggestion: Identification when there is a concern	

	Suggestion: screening at some point not necessarily during the first visit/ keeping in mind the harm reduction approach, removing the punitive tone To do: ECC data about the process/ SU detection and how many have processes in place to identify SU Adolescent population: Integration care of behavioral health with physical, may require training Revising DSS transmittal policy G. Establish Rapid Access Centers in each area of the state to engage and facilitate adult and adolescent entry into opioid addiction treatment and recovery support services. The centers would include a core staff comprised of professionals and peers: 1)professional call center staff who a. identify a caller's eligibility for services (e.g., insurance, entitlements, special population status, etc.); b. confirm the real-time availability of services; c. make initial "warm" connections to a local provider and a peer support staff member, and d. ask permission to conduct a follow-up call within one week, 5 business days, to callers to ensure a connection to care and/or supports occurred; 2)peer support staff who a. provide recovery coaching/support to callers (persono-person) by building recovery capital and helping remove barriers to accessing care (sharing community resources to facilitate recovery, advocating for the individual and family, providing transportation, identifying child care, etc.,) b. helping callers navigate multiple service systems, c. Enrolling recoverees in enhanced Telephone Recovery Support) weekly follow-up phone calls to discuss the individual's recovery process. **Rank**: 3 **Co-Chair's' Response**: (c) The Treatment Sub-committee, should they pursue reconsideration, will: -Operationalize a project plan with feasible first steps or component parts incorporating adult and youth systems (differences and similarities) -Detail fiscal impact as this recommendation is not cost-neutral as written -If funded, one DMHAS grant submission speaks to expansion of the 1-800 line (which was implemented with no additional dollars). Explore relevance to this recommendation; incorporate action step H. 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. **Rank**: 1 **Co-Chair's' Response**: (a) The Treatment Sub-committee will: Work with DMHAS as a lead on implementation plan	

	Consider private and state LMHA's To Do: Which LMHA's are currently provide buprenorphine treatment including psychosocial & recovery support services? Create structure for implementation across all LMHA's What are the challenges to get this treatment up and running Induction .vs. maintenance Monitoring around the process/ clinics base Information support around prescribing lifespan providers & the challenges associated with MAT for adolescents providers as well Consider impatient process/treatment as we increase the outpatient access A event with the Women's Consortium, for (1) Prescribers & (2) Those putting this program together Including breakout sessions within event, topic examples: (1) Adolescents MAT & (2) Outpatient MAT Suggestion: Mark F. DCF has invited him in the past/ doing MAT for both lifespan and adolescent MAT The CRAFT motivational techniques to families/ maybe including this as an component of the event Suggestion: Mary W. is looking for partners/collaborators for this kind of work to increase exposure in her area. Must include strong peer support/ CHR, CMHA, Wheeler & Mc Call Map for MAT across the state/consider using TurningPointCT.org Map The referral aspect is important and should be included in the event, specifically where to send patients for supports Measures of success/ what will our measures be to assess effectiveness? Practitioner based or client based metrics? (suggestion: we should do both) Suggestion: sponsorship for food (for event), representation of community programs & different types of treatments available/informational tables I. 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 reentering 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. **Rank**: 5 **Co-Chair's' Response**: (a) The Treatment Sub-committee will: Work with DOC as the lead and within available funding. This effort may be limited to a pilot (grant funded) DOC in facilities & halfway houses there is difficulty with prescribed Suboxone to this population. Challenges encouraging the associated therapy with Suboxone Consider the difference between: Methadone, Vivitrol and Buprenorphine; Vivtrol drops off over time, suggestion: looking at other barriers for treatment retention Skills over Pills including psychosocial elements in treatment Vivtrol may offer a method to excuse therapeutic supports J. 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. **Rank**: 7 **Co-Chair's' Response:** (b) The Treatment Sub-committee will: -Involve DPH in definition of limitations of existing regulation -Explore activities/workgroups in existence to limit duplication of efforts -Provide examples that are specific to ADPC and governor's charge -Involve DSS in discussion of Medicaid rules related to incarcerated individuals; clarify any mis-information regarding benefits	