State of Connecticut

Department of Mental Health and Addiction Services

Triennial State Substance Abuse Plan

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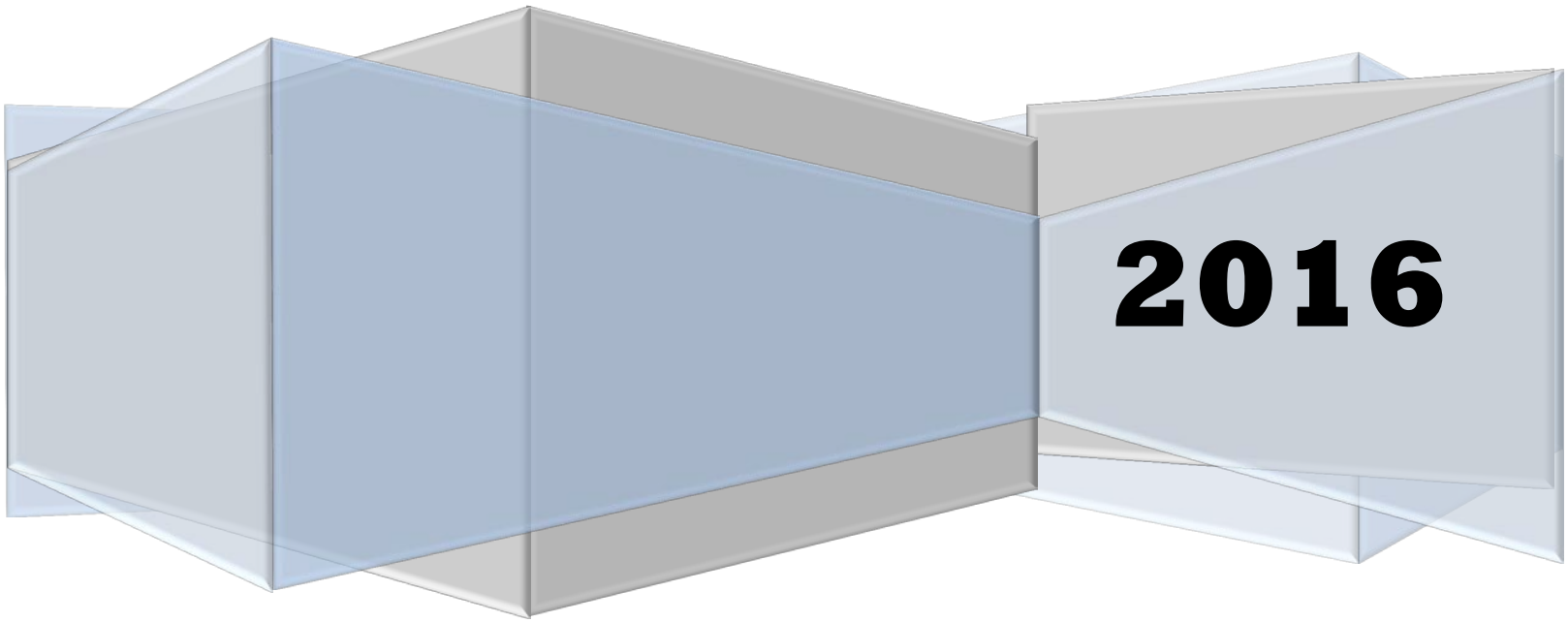

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Introduction

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 abuse 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 abuse 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 heavily influenced many of the activities that state agencies are focused on. Connecticut has been in the grips of an opioid epidemic that has resulted in increasing numbers of overdose deaths across the state. At the same time, the substance abuse treatment system has seen substantial growth in treatment admissions that are directly related to opioid use. Overdose deaths and an increase in treatment admissions have rapidly intensified over the past three years. This issue has now become perhaps the single most important health concern we as a state are facing. The Governor has recognized this and has proactively introduced legislation designed to reverse this epidemic. At the same time he has re-invigorated the Alcohol and Drug Policy Council (ADPC), charging the group with the development of a plan to address the opioid crisis.

As a substance abuse 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 include core strategies and actions that are necessary to maintain and enhance the overall system of care. However, this year's plan will also recognize the opioid epidemic by including a Triennial Report Opioid Annex. The core strategies will have significant overlap but all strategies and accomplishments that are specifically related to opioids will be separated from the "larger" report and will be included in the Opioid Annex.

As Commissioner, I would like to thank the Governor, legislature and all of the state agencies that are involved in this important work. Connecticut is seen as a national leader in the provision of behavioral health services thanks to the leadership at multiple levels within the state. The Commissioners and senior leadership at each of the agencies providing substance abuse 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 my hope that this report details the significant accomplishments that have already been achieved while highlighting areas that require our concerted 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. Based on these legislative changes the state's substance abuse plan must be completed by July 2016. The last Biennial Report completed in 2013 can be found at the following link: http://www.ct.gov/dmhas/lib/dmhas/eqmi/biennialreport.pdf

The state's substance abuse plan is expected to include comprehensive strategies for the prevention, treatment and reduction of alcohol and drug abuse 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 abuse 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 is closely aligned to the reconstituted Alcohol and Drug Policy Council (ADPC) and the charge that was given to them by Governor Malloy. 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, reconstitutes the Alcohol and Drug Policy Council with Commissioners Miriam Delphin-Rittmon (DMHAS) and Joette Katz of the Department of Children and Families (DCF) as the co-chairs. The Council will help direct the state's efforts to coordinate substance use prevention and treatment throughout Connecticut's system of care. This reconstituted council includes new members from the medical, recovery and treatment communities and is uniquely positioned to make expert recommendations to guide our prevention and treatment efforts. Governor Malloy directed the ADPC to focus on the emerging opiate epidemic in Connecticut. The ADPC began meeting again in fall 2015 and subcommittees are currently working to develop recommendations related to the charge given to them by the Governor.

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 abuse prevention and treatment throughout Connecticut.

While the Department's prevention services serve all Connecticut citizens, its 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 abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse 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 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 rehabilitation, intensive and intermediate residential services, medication assisted treatment including methadone maintenance, outpatient, partial hospitalization, and recovery supports. DMHAS' budget for substance abuse services is approximately $148,000,000 and blends state general funds with federal block grant funds. The DMHAS substance abuse treatment system includes approximately 51providers 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 problems 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 abuse services within state-operated facilities, namely Connecticut Valley Hospital. Detoxification and intensive residential services are provided in Middletown and in Hartford at the Blue Hills location. Other state-run facilities including Connecticut Mental Health Center and the Southwest Connecticut Mental Health System offer specialized addiction 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 abuse are changed, leading to healthier communities.

DMHAS served almost 60,000 unduplicated substance abuse clients in FY 15. There were almost the same numbers of admissions to funded or operated substance abuse 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 2015 Annual Statistical Report at the following link: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.pdf. This provides a much more comprehensive analysis of our substance abuse service system.

DMHAS administers and funds 122 prevention coalitions covering 169 towns, and 60 community-based prevention programs provide services statewide or at the regional or local level.

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 Mental Health Boards, and one designee each from the 15 substance abuse Regional Action Councils.

Connecticut also has a number of other state agencies that are involved to some extent in the delivery of substance abuse treatment and prevention services. The Departments of Children and Families (DCF), Social Services (DSS), Public Health (DPH), Correction (DOC) 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 abuse prevention and treatment services.

Evidence Based Practices in the DMHAS Substance Abuse Treatment System

DMHAS is actively working to expand the adoption of evidence-based practices within our substance abuse 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.

Connecticut utilizes a number of evidence-based practices within our substance abuse 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 chaired by the DMHAS Commissioner 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 opiate addiction. DMHAS has a statewide network of funded methadone maintenance providers that serve over 15,000 individuals annually. This number increases to 18,300 when one adds in 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 Torrington area has seen a significant growth in persons using opiates and the Hartford Dispensary responded by opening a clinic in that area several years ago.

DMHAS has also been actively working to increase the number of physicians who prescribe buprenorphine, another form of MAT that has proven to be effective at dealing with opiate addiction. Like methadone, which is tightly regulated, the federal government restricts who can prescribe buprenorphine and the number of individuals they 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 low 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 is proposing to relax the restrictions on the numbers that can be treated at any one time from 100 to 275 individuals. If approved, this may increase access to an evidence-based option to people addicted to opiates.

Behavioral therapies are used across the DMHAS system at many of our provider agencies. This includes 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.

Legislative Initiatives Impacting Substance Abuse Service Delivery

A number of legislative initiatives related to substance abuse have been introduced over the past three years. A primary emphasis of these activities has related to the growing opioid epidemic. These legislative activities date back to state fiscal year 2011 when legislation was first introduced to address the increase in overdose deaths. PA 12 -159 *An Act Concerning Treatment for a Drug Overdose*) became effective October 1, 2012. This bill was designed to make Naloxone/Narcan more widely available. This prescription medication reverses an opioid overdose. This initial piece of legislation allowed physicians to prescribe Naloxone to families that had members that were using opiates and at-risk for overdose. This early effort has continued to be developed as Connecticut has aggressively worked to make Narcan more widely available.

Other pieces of legislation related to increasing access to this life saving drug include the following:

Narcan legislation:

- http://www.cga.ct.gov/2011/sum/2011sum00210-R02HB-06554-sum.htm
- http://www.cga.ct.gov/2012/act/PA/2012PA-00159-R00HB-05063-pa.htm
- http://www.cga.ct.gov/2014/ACT/PA/2014PA-00061-R00HB-05487-PA.htm
- http://www.cga.ct.gov/2015/FC/2015HB-06856-R000913-FC.htm

The 2011 bill was part of Good Samaritan legislation providing protection for individuals who intervened in a medical emergency. The 2012 bill provided protections to physicians, permitting them to prescribe Naloxone to family members. The 2014 legislation provided additional protections to medical personnel who intervene with someone who is believed to be overdosing as a result of using opiates.

In 2015 Governor Malloy introduced comprehensive legislation to combat the opioid crisis (an Act Concerning Substance Abuse and Opioid Overdose Intervention). There were a number of pieces contained in this legislation but one of the hallmarks was that pharmacists could prescribe and dispense Narcan after completing an approved certification course. This meant that family members and other interested parties could simply go to a participating pharmacy and receive Narcan without having to consult a physician. Department of Consumer Protection (DCP) implemented an online training program in summer 2015 and almost 600 pharmacists are now certified and willing to prescribe Narcan. Major pharmacy chains in Connecticut utilize separate continuing education programs. Legislation passed in the most recent legislative session focused on ensuring that municipality's primary emergency medical services provider is equipped with Narcan and its personnel has received training, approved by the Commissioner of Public Health, in how to administer the medication.

Another component of the 2015 legislation focused on physician training related to prescription opiates in an attempt to reduce the overuse of these drugs. Another component focused on strengthening legislation related to the state's Prescription Drug Monitoring Program and the legislation limited initial prescriptions for opioids to 7 days. This same legislation underscored the gravity of the opiate crisis by re-constituting the ADPC with a clear charge that the group was to focus on the opiate epidemic.

Legislation regarding criminal offenders has been introduced that has relevance to the state's substance abuse efforts. Over the past several years the Governor has introduced legislation aimed at assisting offenders to re-integrate into society. The legislation has been framed as "Second Chance Initiatives" a package of innovations that assists offenders in the area of employment, housing, and the reduction of penalties for non-violent drug offenses.

Connecticut Alcohol and Drug Policy Council

The Connecticut **Alcohol and Drug Policy Council (ADPC)** is a legislatively mandated body comprised of representatives from all three branches of State government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug (ATOD) use and abuse in Connecticut. Governor Malloy reconstituted the ADPC through legislation that was enacted in 2015. The Council, co-chaired by 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. The Governor

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 he encouraged them to make recommendations on issues requiring legislative change, administrative actions and statewide cooperation.

The ADPC began meeting again in late October 2015 after a several year hiatus. The ADPC has created three subcommittees that are working in areas related to the general charge. The subcommittees have begun to meet and are expected to have recommendations available later in the summer of 2016. The subcommittees and their areas of focus are described in greater detail below:

ADPC Committee 1: Prevention, Screening & Early Intervention

Co-Chairs: Ingrid Gillespie, Judith Stonger, Dr. Mark Grossman

Mission:

Recommend policies, programs, and services to prevent the onset of illegal drug use; prescription drug misuse, abuse and proper disposal; alcohol misuse and abuse; and underage alcohol and tobacco use.

Promote effective substance abuse prevention practices that enable communities and other organizations to apply prevention knowledge effectively.

Work-to Date

Three meetings of the Prevention, Screening and Early Intervention Subcommittee were held since its establishment in February 2016. Membership on the subcommittee includes elected officials, state agencies, medical and behavioral health providers, and representatives from the

Regional Action Councils (RACs). The membership will be expanded to include representatives from the recovery, pharmaceutical, faith-based as well as other communities.

The work of the subcommittee will focus in a number of areas:

- Increasing statewide public awareness of the dangers of non-prescription opioid use and addiction via public service announcements, billboard messages, and the state's website – ensuring that resources are available for parents, youth, users, family members, medical and other professionals.
- Increasing prescribers' awareness of the risks and dangers of sharing medication and over prescribing, and increasing their engagement in the Prescription Drug Monitoring Program. The subcommittee will recommend training and assist in disseminating information.
- Promoting awareness and use of naloxone, and screenings for opioids and heroin in SBIRT initiatives.
- Developing an inventory of evidence-based and effective strategies for prevention, screening and early intervention and promoting increased use of them.

ADPC Committee 2: Treatment & Recovery Supports

Co-Chairs: Dan Rezende, Dr. Charles Atkins, Phil Valentine

Mission:

Recommend policies, programs and services to improve access, reduce barriers, and promote high quality, effective treatment and recovery services.

Recommend strategies to close the gap between available treatment and recovery supports capacity and demand.

Promote the adaptation and adoption of evidence-based and best practices by community-based treatment and recovery programs and services.

Recommend policy to improve and strengthen substance abuse treatment and recovery organizations and systems.

ADPC Committee 3: Recovery & Health Management

Co-Chairs: Shawn Lang; Deb Henault

Mission:

Recommend policy that incorporates a spectrum of strategies to promote harm reduction including safer use, managed use and abstinence, and overdose prevention.

Promote recovery-oriented care and recovery support systems that help people with mental and/or substance use disorders manage their health and behavioral health conditions successfully.

Recommend other policies that support recovery including but not limited to housing, employment, medical care, and community re-entry.

Previous state plans submitted by DMHAS were expected to describe actions that the ADPC was taking to address substance use issues in Connecticut. This report will focus heavily on activities that are being taken by DMHAS and other state agencies to address the opiate crisis. While the ADPC has not yet created a formal plan, a number of activities are underway and these activities and progress that is being made will be detailed in this report. Recent legislation that was passed is requiring the ADPC to develop by January 1, 2017 a comprehensive inter-agency plan that details how the state will reduce overdose deaths

Emerging Trends in Substance Abuse

The State Substance Abuse Plan that will be presented is responsive to emerging trends that affect substance abuse service delivery in the State. Over the past three years various trends have impacted the substance abuse prevention and treatment system in Connecticut. Certain trends relate to increases in the use of opioids, other trends relate to political or administrative changes that are impacting the substance abuse service delivery system in Connecticut. For example Connecticut and the rest of the nation have seen a huge spike in opioid use and overdose deaths related to this increase. During the same period, the Affordable Care Act was fully implemented which created changes in terms of who was insured and how substance abuse services were funded. The trends related to the opioid crisis will be presented in Opioid Annex at the end of this report.

Impact of Affordable Care Act

The Affordable Care Act (ACA) was introduced during this report period. The introduction of ACA has created changes in how substance abuse services are delivered, funded, and has increased the number of individuals that are eligible to receive these services. The ACA in Connecticut through the Medicaid Expansion 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. In FY 13, the number of uninsured was believed to be approximately 13.2% of the state's population and this was reduced to approximately 4% in late 2015. While the Medicaid substance abuse benefit available to these individuals has not changed over that period, more individuals are eligible to receive substance abuse services.

The ACA has impacted how substance abuse services are funded in Connecticut. Approximately 150 million in mental health and substance abuse funds that previously supported Low Income Adults (LIA) in Connecticut were shifted out of DMHAS' budget into DSS' budget beginning in FY 14. Similarly, the clients that have found insurance through the state's health care exchange have resulted in higher numbers of individuals being served for substance abuse services. DMHAS' own data system shows a 10% increase in clients served in non-funded substance abuse treatment programs over the past 4 years. This is believed to be attributable to the increase in clients who are eligible for Medicaid or purchase insurance through the state's health care exchange.

Plan Development

The 2016 State Substance Abuse Plan is organized under key strategy areas. 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 relate to the opioid crisis as much attention has been focused on trying to reverse this epidemic. However, many action steps 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 Abuse 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 abuse 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 and the availability of substance abuse 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***

- Achieve quantifiable decreases in substance use and abuse, 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.

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.	**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.
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.	**Action Step:** Support prevention efforts within the state by building the capacity of individuals and communities to deliver alcohol, tobacco and other drug abuse prevention services directed at schools, colleges, workplaces, media and communities through the Governor's Prevention Partnership.
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 Initiative.	**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.
Action Step: Provide leadership on substance abuse prevention through engagement of senior college administrators and implementation of evidence based policies, practices and strategies through the CT Healthy Campus Initiative.	**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.
Action Step: Conduct activities focusing on the prevention of community problem substance misuse or abuse utilizing the five-step Strategic Prevention Framework (SPF) through CT SPF Coalitions, and the Partnerships for Success Initiative.	**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.
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.	**Action Step**: Disseminate information via print and electronic media on substance abuse, mental health and other related issues through the Connecticut Center for Prevention, Wellness and Recovery.

Action Step: Assist prevention providers/local communities in assessing prevention needs and coordinating resources to address these needs through Regional Action Councils.	**Action Step:** Deliver training and technical assistance to substance abuse and mental health practitioners through the Training and Technical Assistance Service Center.
Action Step: Develop and implement municipal-based alcohol and other drug prevention initiatives through Local Prevention Councils.	

Accomplishments:

Community Prevention Activities

The DMHAS Prevention and Health Promotion (PHP) Division utilizes the SAMHSA Strategic Prevention Framework (SPF) comprised of five steps: needs assessment, capacity building, planning, implementation, and monitoring and evaluation. Since 2013, the PHP has reorganized and re-procured its SAMHSA SAPT Block Grant-funded initiatives to align with the SPF. The new initiatives are as follows: the CT SPF Coalitions (2015-2020-12 communities); the Training and Technical Assistance Service Center, and the Center for Prevention Evaluation and Statistics. In addition, the PHP has been awarded and is directing multiple SAMHSA-funded discretionary grants impacting communities statewide: the Safe Schools Healthy Students Initiative (2013-2018-3 communities); Now is the Time – Healthy Transitions, CT Seamless Transitions & Recovery Opportunities for Network Growth Initiative (2014-2019-3 communities); Specialized CIT for Young Adults Initiative (2013-2016-8 communities); Partnerships for Success Initiatives (2009-2014- 19 communities; 2015-2020-8 communities); Garrett Lee Smith State Youth Suicide Prevention Initiatives (2011-14-34communities, 5 regions; 2015-2020-5 regions and 1 community).

Tobacco Cessation

The State Tobacco Prevention and Enforcement Program (TPEP) enforces the federal Synar Act, and annually submits the Synar Report to SAMHSA that details tobacco compliance activities and success at reducing underage use and enforcing tobacco retail. For years CT's violation rate has been below the required rate of 20%, and was 9% in 2015. Through the TPEP, with a grant from the CT Tobacco and Health Trust Fund (2014-2015), the Urban Tobacco Inspection Program provided funded four urban areas to: 1) conduct tobacco compliance inspections to enforce state law at the point of sale; and 2) provide retailers with education and awareness material including information about the new online training program. Lastly, the TPEP established the Tobacco Sales: Do the Right Thing interactive online training in 2014 designed to build the skills and knowledge of tobacco retail owners, managers, and front line retail personnel

to prevent retailer sales of tobacco products to youth under the age of 18. The learning components feature real-life scenarios, state and federal tobacco laws and the associated legal requirements. This training is now mandated via 2015 legislation for first time violators.

Prescription Drugs

With support from multiple DMHAS-contracted prevention providers, the state now has over 70 drop boxes where unused medication can be disposed of and has hosted the annual DEA Drug Take Back Day in multiple communities. DMHAS, in collaboration with the Regional Action Councils, has conducted approximately 15 public forums on opioids statewide, and 10 more are scheduled to occur this year. The forums include local substance abuse experts, persons in recovery, and leaders from state agencies who provide information about the scope of the problem. Information and awareness materials, instructions for accessing Narcan, and treatment resources are available at the forums. Additional contracted prevention providers, like the Connecticut Clearinghouse and the Governor's Prevention Partnership have collected and posted a range of resources to help inform the public and providers about this issue.

Suicide Prevention

Since 2006, the DMHAS PHP Division has received three SAMHSA-funded Garrett Lee Smith (GLS) Youth Suicide Prevention grants. Over the past 10 years the PHP has been working to integrate substance abuse and suicide prevention and mental health promotion, and build the capacity and readiness of communities, campuses, and prevention and treatments providers to address these issues, and has become a national model to other states. Results of the 2011-2014 grants proved statistically significant increases in the capacity and readiness of communities to implement suicide prevention and response efforts. The PHP staff, along with the CT Department of Children and Families (DCF), co-leads the CT Suicide Advisory Board, and has collaborated with multiple stakeholders, many of them DMHAS-funded prevention providers, to advance this objective.

Accomplishments and contributions since 2013 include: cooperative braiding of GLS and mental health, substance abuse, public health, and maternal and child health block grant dollars via DMHAS, DCF and Department of Public Health sub-recipient non-profits; consultation to and partnership with multiple systems and settings to enhance suicide prevention efforts and reduce risk to community members; statewide dissemination and adoption of evidence-based practices and free training and education in multiple settings; participation in the Zero Suicide for Health and Behavioral Health Care Systems Academy, Baltimore, MD June 24-25, 2015 and initiation of the CT Zero Suicide Learning Community October 2015; support to and engagement of survivors of suicide death and attempt and their foundation efforts in collaboration with the Office of the Child Advocate, Office of the Chief Medical Examiner and the CT Chapters of the American Foundation for Suicide Prevention; and development and release of the CT Suicide Prevention Plan 2020.

Strategy 2: *Strategies Related to Treatment*

- Expand access to broad spectrum of substance abuse services.
- Increase the use of evidence-based treatments (EBP's)

Action Step: Create statewide network of walk-in assessment centers to rapidly assist clients to find appropriate treatment.	**Action Step:** Maintain comprehensive substance abuse treatment system
Action Step: Provide specialized services to DCF involved parents with substance abuse problems (Project SAFE and RSVP)	**Action Step:** Increase access to specialized substance abuse services for persons involved with CSSD, DOC, DCF through ATR IV
Action Step: Increase capacity in substance abuse outpatient programs to prescribe buprenorphine.	**Action Step:** Apply for federal funding being made available to expand substance abuse services.
Action Step: Maintain screening for substance abuse and early intervention after grant expiration. (SBIRT)	**Action Step**: Improve linkages from detoxification programs to follow-up care
Action Step: Implement a statewide toll free call line to connect callers to treatment options.	**Action Step:** Increase adoption and expansion of EBP's through learning collaboratives

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 ambulatory care, residential detoxification, long-term care, long-term rehabilitation, intensive and intermediate residential services, methadone or chemical maintenance, outpatient, partial hospitalization, and aftercare. DMHAS' budget for substance abuse services is approximately $148,000,000 and blends state general funds with federal block grant funds. The DMHAS substance abuse treatment system includes approximately 51providers with over 300 programs. The state as a whole spends almost 335 million for a range of substance abuse 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**.

Walk-In Evaluation Centers

Over 50 programs have agreed 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

DMHAS implemented what is called the **Opioid Agonist Treatment Protocols** (OATP) over 10 years ago. These are procedures designed to rapidly link individuals who are being detoxed from heroin to methadone maintenance programs. These procedures were originally designed for frequent users as a way to reduce repetitive admissions to detoxification programs while quickly connecting clients to the most desirable treatment option, methadone maintenance. Eligibility criteria for participation in these protocols have been relaxed and more people are now eligible to use this service. This remains an area for enhancement as many people who enter detoxification programs with opiates being reported as their primary drug are not being connected to medication-assisted treatment.

Brief Screening and Intervention SBIRT

In 2011 DMHAS was awarded a federal grant for Screening and Brief Intervention and Referral to Treatment (SBIRT). This was a five-year grant that will end in August 2016. The purpose of the grant is to dramatically increase identification and treatment of adults age 18 or older that are at-risk for substance use disorders or have been diagnosed with one. The program was implemented in 12 federally qualified health centers (FQHC's) across the state at 29 locations. Over the 5-year period 64,000 individuals have been screened. 14,000 individuals screened positive for alcohol and another 6,000 screened positive for substance use. Three additional FQHC's have implemented SBIRT but were not funded to provide data. Outcomes have been closely tracked for those individuals who were referred to treatment. A random sampling showed significant reductions in binge drinking, illegal drug use, and marijuana use. Efforts are being directed at sustaining the project after the funds end.

Expanding Access to Recovery - ATR IV

The award notice for ATR 4 was received April 30, 2015 for a 3 year contracting period. During the first year of CT ATR IV, the call center received 2740 calls and scheduled 2612 intakes across 35 access centers. Of the scheduled intakes, 1900 face to face intakes were completed for a 73% completion rate. 84.7% of ATR 4 participants were between the ages of 25-54 and 64.7% were male. As for the racial split, 43.5% reported as white, 33.9% as African American and 16.4% as "none of the above. Client portals at Department of Correction facilities and Community Support Services Division accounted for 46.5% and 21.5% respectively of those who accessed ATR 4 services. The highest utilized services were Recovery Assessment, Transportation and Care Coordination followed by Basic needs (Gift Cards for clothing/household items), Medical Care/Wellness, Recovery Management, Faith Recovery Oriented Services and Supported Recovery Housing Services. As part of the award and a federal mandate, all grantees are required to collect and report performance data under the Government Performance and Result Act (GPRA) collected at the intake and at the follow-up (6 month) assessment. Grantees are required to obtain a minimum of 80% Follow-up GPRA rate. The FGPRA rate for the first year reflected a rate of 89.8% as compared to the average of all grantees with an average of 72.1%.

Federal Grant Opportunities

Besides the federal grants described above, DMHAS is applying for 5 federal grants focused on prevention and treatment. In total, the grants are worth several million dollars and would provide supplement funding for overdose prevention and would provide additional treatment for individuals struggling with opioid addiction.

Project SAFE and Recovery Specialist Voluntary Program (RSVP)

Project SAFE is a legislatively mandated collaboration between DCF and DMHAS that has 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.

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

Strategy 3: Strategies Related to Recovery

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

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

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.

Recovery University

Advocacy Unlimited, a Hartford-based consumer run organization, has developed an 80 hour certification program for Peer Specialists. The program trained almost 100 individuals last year at locations across the state. The training is designed to develop a pool of certified Recovery Specialists who can be used in programs that are seeking to expand their use of peer staff.

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. 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.

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.

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.

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 results.

Strategy 4: Strategies Related to Criminal Justice

- 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

Action Step: Investigate the effectiveness of Law Enforcement Assisted Diversion (LEAD) programs, a pre-booking program that diverts to services as an alternative to arrest. Seattle has one example of such a program	**Action Step:** Transition offenders with drug convictions to community substance abuse programs
Action Step: Eliminate mandatory sentencing laws for those convicted of non-violent narcotics possession.	**Action Step:** Increase housing opportunities for ex-offenders
Action Step: Implement diversionary services for individuals arrested for crimes related to substance use.	**Action Step:** Increase employment training and job opportunities for ex-offenders.
Action Step: Provide substance abuse services to persons who are incarcerated.	

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

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. More than 650 clients have participated in the two programs.

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 abuse 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. However, this initiative is likely to be scaled back due to fiscal constraints.

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 abuse 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.

In SFY16 DMHAS received additional funding to expand JDSA to two additional courts and also received a MacArthur Safety and Justice Challenge to a third court.

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 avoids costly duplication of efforts

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

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Multi-Dimensional Family Therapy (MDFT)

MDFT is a comprehensive, family-centered treatment program for adolescent and young adult ages 11-18 with drug abuse 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.

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.

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

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

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

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 abuse 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 abuse 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 2016. 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 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 Annual Statistical Report can be found at the link listed below:

http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.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. 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 13, 14, and 15 is as follows:

FY 13: 59%

FY 14: 61%

FY 15: 62%

Other State Agency Substance Abuse Initiatives and Accomplishments

➢ *Department of Children and Families*

During the last three years DCF has expanded its commitment to serving youth and families in their communities using evidence-based substance use treatment approaches that integrate treatment for mental health, trauma and victimization, and family therapy. All 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 heroin and prescription drugs. Community-based services include outpatient and intensive in-home services for youth, as well as services for caregivers who are involved with child protective services who have substance use problems. DCF also funds residential treatment services for adolescents with substance use problems with or without co-occurring mental health problems.

DCF has prioritized community-based and family-focused care.

In the past decade, as a proportion of total spending, there has been:

86% reduction in spending for residential treatment

149.5% growth in spending for community based services

All substance use treatment programs receiving DCF funds are required to use an evidence-based assessment called the Global Appraisal of Individual Needs (GAIN). Data from the GAIN is used to inform individualized treatment plans, local program evaluation, and statewide program planning by the Department. In SFY09, the Department implemented the Programs and Services Data Collection and Reporting System (PSDCRS), since renamed the Provider Information Exchange (PIE), to improve monitoring of the services DCF funds. PIE standardizes the information reported to DCF by providers while retaining the ability to assess program-specific goals. Data from the GAIN and PIE systems enhance DCF's ability to identify the population served, conduct needs assessment, compare client information across programs, implement systematic monitoring of outcomes and meet its statutory obligation to report on programs to the legislature.

<u>Adolescent Substance Use Services</u>

Over the past decade, DCF has shifted considerable funding for adolescent substance use treatment from residential treatment programs to community and family-focused services, particularly toward intensive in-home services. Intensive in-home services include Multi-

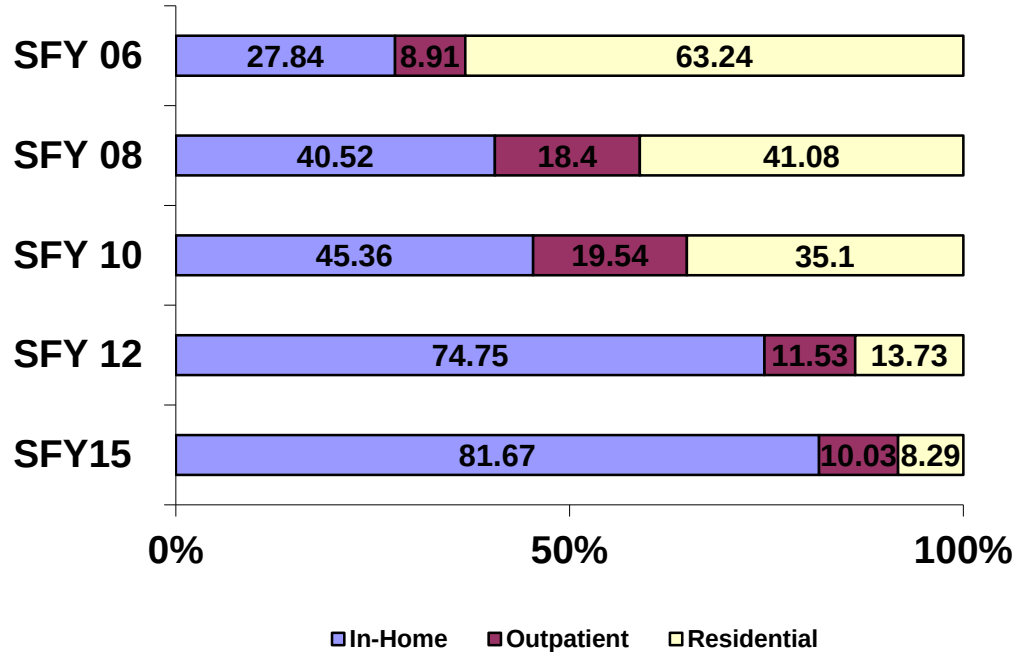
Systemic Therapy (MST) and Multidimensional Family Therapy (MDFT), as well as targeted adaptations to these models to meet the specific needs of special populations. DCF funds

Adolescent Community Reinforcement Approach with Assertive Continuing Care (ACRA-ACC) programs to provide evidence-based outpatient treatment services to adolescents. A description follows of each service and their adaptations for special populations of youth.

In response to concerns related to youth and family access to local community-based care and to provide alternatives to care in congregate settings, DCF repurposed some funding for residential treatment programs. This shift in allocations expanded access to care in less restrictive environments, particularly among evidence-based intensive in-home services in local communities. DCF's network of providers throughout the state currently includes:

- 29 MDFT teams across 13 providers statewide
- 6 MST teams across 3 providers covering nearly the entire state
- 6 ACRA/ACC teams across 4 providers statewide
- 1 Seven Challenges residential treatment program
- 1 MDFT residential program (under development)

Figure 1. Adolescent Substance Use Treatment: Outpatient (ACRA), Intensive In-home (MDFT, MST) and Residential Services. Percent of Total Funding by State Fiscal Year (SFY).



Outpatient Substance Use Services

Adolescent Community Reinforcement Approach with Assertive Continuing Care (A-CRA-ACC)

A-CRA 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 seeks to replace 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. When the recovery goals are achieved, adolescents may be referred to ACC which provides recovery support and case management in the youth's home or community for an additional three months.

Intensive In-Home Substance Use Services

Multidimensional Family Therapy (MDFT)

MDFT is a family-based intensive in-home treatment for adolescents, typically 11-18 years of age, with significant behavioral health needs and 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 typically occur three times a week for four to six months. During this time MDFT provides individual, caregiver and family therapy, and case management services to each family in their home. Some MDFT treatment teams will provide services to at-risk children as young as 9 years old.

MDFT Re-entry and Family Treatment (MDFT RAFT)

An enhanced MDFT approach for youth involved with parole who have problems related to substance use and who are re-entering their communities after a year or more in a controlled environment. Initially MDFT 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. Referrals now must be made at least 60 days prior to anticipated or scheduled release from the facility. Services begin 60 days prior to release 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 families in their homes. Upon release MDFT-RAFT services are provided to youth and families together in their homes. MDFT-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. The typical length of service and service intensity of MDFT RAFT is similar to standard MDFT.

Multi-systemic Therapy (MST)

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 returned or are returning home from out-of-home care or who are at imminent risk of placement due to 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 Family Integrated Transitions (MST-FIT) is a re-entry service for youthful offenders 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 families in their homes. Upon release MST-FIT services are provided to youth and their families in their homes. It is a promising practice that 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 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 Problem Sexual Behavior (MST-PSB) is an intensive in-home family service with clinical interventions for children and adolescents age 10-17.5 years who are returning home from an out of home placement that has provided sex offender specific treatment, or for adolescents with problem sexual behaviors living in the community who are at high risk for incarceration or residential treatment if intensive community based services are not provided. MST-PSB aims to reduce out of home placements and improve child and youth outcomes related to problem behaviors, family relationships, illegal activity, and educational and/or vocational

engagement. The length of service and service intensity of MST-PSB is five to seven months with up to three home visits weekly.

DCF Residential Substance Use Treatment Programs

Multi-Dimensional Family Therapy Residential program at CT Junior Republic (*Coming online at the end of May 2016)* is an 8-bed, short-term (4 months), family-centered Multidimensional Family Therapy (MDFT) residential program that will serve males, ages 15-18, who are committed delinquent to the Department of Children and Families and who are experiencing substance use problems. This program will integrate the MDFT model into all aspects of residential and clinical programming and will provide an expansive array of educational, vocational, clinical, and residential programming.

Seven Challenges at Rushford Academy is a 6-bed residential treatment program that utilizes the Seven Challenges evidence based practice model to treat males age 13-17 years inclusive. The average length of stay is six (6) months. Rushford Academy provides individual, group and recreational therapy, as well as year-round educational programming.

Caregiver Substance Use Services

Project SAFE

Project SAFE is a legislatively mandated collaboration between DCF and DMHAS that has 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 06-FY 15)

	# Referred for Treatment	# of Referrals Receiving Treatment	Percent of Referrals Receiving Treatment
FY 06	2,437	1,244	51.05%
FY 07	2,559	1,342	52.44%
FY 08	2,554	1,447	56.66%
FY 09	2,480	1,417	57.14%
FY 10	2,217	1,558	70.28%
FY 11	2,347	1,577	67.19%
FY 12	2,605	1,399	53.70%
FY 13	2,214	1,204	54.38%
FY 14	2,284	1,185	51.88%
FY 15	2,231	1,141	51.14%

Recovery Supports for Caregiver Substance Use

Recovery support and intensive case management services have been added to Project SAFE 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.

Treatment for Caregiver Substance Use and Child Maltreatment

DCF has extended its implementation of evidence-based practices to include intensive in-home services for caregivers with problems related to substance use that also have involvement with child protective services. 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 abuse treatment model for parents of children under 2 years of age who are involved with DCF child protective services. The model integrates two treatment modalities to focus on attachment, parenting, substance abuse recovery, and psychotherapy: Coordinated Intervention for Women and Infants (CIWI), an attachment-based parent-child therapeutic approach that was developed at the Yale Child Study Center and Reinforcement-Based Treatment (RBT), a contingency management substance abuse treatment model that was developed at John Hopkins University. The aims of FBR are to promote safe, secure, drug-free family environments where 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.

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 abuse and child maltreatment. This program integrates an innovative evidence-based treatment for adult substance abuse (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. The aims of MST-BSF are to promote safe, secure, drug-free family environments where children can live with their parents or be quickly reunified.

Table 1: SFY15 DCF Substance Use Expenditures by Service Type.

Service Type	FY2015 Expenditure
Adolescent Outpatient treatment (Individual, Family and Group)	1,668,587.00
Adolescent Home-based treatment services	13,581,515.00
Adolescent Residential treatment	1,378,760.00
Adolescent Evidence-based Practice Quality Assurance	754,406.00
Adolescent Services Total	**$ 17,383,268.00**
Recovery Support Programs (RSVP and RCM)	1,637,942.00
MST-Building Stronger Families	1,658,949.00
Family Based Recovery	2,894,460.00
MST-BSF Consultation & Quality Assurance	341,840.00
Caregiver Services Total	**$ 6,533,191.00**
TOTAL Substance Use Expenditures	**$23,916,459.00**

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		RCM only
	Norwich	X	X	X	X		X				X
	Willimantic	X	X	X	X		X				X
4	Hartford	X	X	X	X		X	X	X	X	X
	Manchester	X	X	X	X		X		X		X
5	Waterbury	X	X	X	X	X	X	X	X	X	
	Danbury	X	X	X	X				X		
	Torrington	X	X	X	X				X		
6	New Britain	X	X	X	X		X	X	X	X	X
	Meriden	X	X	X	X	X		X		X	X

DCF Substance Use Initiatives & Accomplishments

Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)

DCF in partnership with DMHAS, UConn Health, Boston University Medical Center and CT Clearinghouse has initiated an A-SBIRT program within the Emergency Mobile Psychiatric Service (EMPS) and other community settings. Using federal funding from SAMHSA's Center for Substance Abuse Treatment, the A-SBIRT partners have developed a train-the-trainer model to increase the ability of youth-serving organizations statewide to train their staff to identify substance use problems among adolescents using the CRAFFT tool and implement an age-appropriate brief intervention protocol. In addition to the training on the CRAFFT screening tool and brief intervention approach, the A-SBIRT training model includes a number of stand-alone modules on adolescent development and substance use, motivational interviewing, and training skills development that can be configured to best meet the needs of diverse training audiences. The primary aim of the A-SBIRT initiative is to embed screening for substance use problems into the EMPS service. DCF Enhanced Care Clinics (ECC's) already use a screening tool for substance use. The A-SBIRT partners plan to enhance the utility of the screening tool by adding the brief intervention approach to this service. In addition to EMPS and ECC's, A-SBIRT has included DMHAS Regional Action Councils, youth service bureaus, and youth prevention organizations in the program.

The Connecticut Substance Exposed Infant (CT SEI) Initiative

The CT SEI program was developed through an In-Depth Technical Assistance (IDTA) award from the National Center for Substance Abuse and Child Welfare (NCSACW) to build a statewide infrastructure to address substance exposed infants, particularly infants exposed to opioids in utero. Until recently, CT was one of the few states in the country that did not have a dedicated position to address problems related to substance exposed infants. The state has not adopted legislation that directly addresses this issue nor is there any funding specifically designated for prevention, screening, early intervention or treatment efforts for these infants and their families. These policy gaps mean that decisions to conduct screening to detect infant exposure and to make reports to child protective services when an infant is substance exposed is left up to interpretation that could result in bias, disparities and inequalities in access to care and needed support services. DCF is leading the **CT SEI Initiative,** with ABH as the coordinating entity, through an inter-agency and community collaboration using the IDTA to guide and direct the development of that state's infrastructure to do the following:

- **Establish a Fetal Alcohol (FASD)/Neonatal Abstinence (NAS) statewide coordinator**. DCF and DMHAS jointly funded this position in 2015 at Advanced Behavioral Health.
- **Complete a shared values inventory** with project partners to identify mutual priorities related to the six IDTA goals (screening and assessment, engagement and retention in treatment, data and information sharing, joint accountability and shared outcomes, services for pregnant women and substance exposed infants, and safety, permanency and well-being of children and families),

- **Assess the state's capacities and needs** related to SEI that will serve as the architecture for establishing policy and developing infrastructure for prevention and intervention services including workforce development, and identification and implementation of best-practice models.
- **Develop a statewide plan** to address SEI in a coordinated fashion to offer a continuum of services to vulnerable families, including prevention, early intervention and intensive intervention.
- **Conduct financial mapping** to identify and maximize fiscal resources to support ongoing SEI efforts.

CT's SEI IDTA project will mark the state's first attempt at a coordinated cross-agency effort to address substance exposure among infants.

Family Stability Project (FSP)

The Family Stability Project (FSP) is an expansion of the Family Based Recovery (FBR), a promising practice model. FSP will bring the FBR program to an additional 500 DCF-involved families over 4 years. The Department received Technical Assistance from Harvard's Kennedy School of Government to develop a Pay for Success funding mechanism to support this expansion. FBR serves caregivers with substance use disorders and their children (age 0-3) in a community and home based setting.

Improving Access Continuing Care and Treatment (IMPACCT) Project

DCF was awarded a two-year planning grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) to develop 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. The project period is 9/30/15 – 9/29/17. DCF is partnering with the Judicial Branch Court Support Services (CSSD), the CT Behavioral Health Partnership (CT BHP), Department of Mental Health and Addiction Services (DMHAS) and State Department of Education (SDE), youth and families, and local and national technical experts to develop the state's plan for youth. The plan will be informed by a comprehensive financial map of substance use and co-occurring mental health expenditures, and it will include strategies to enhance workforce development, to increase access to evidence-based treatment, and social marketing strategies to increase awareness of and access to available services.

Medication Assisted Treatment Education Sessions

Recognizing that many caregivers involved with the Department are receiving medication assisted treatment (MAT), the DCF in partnership with DMHAS and the Judicial Branch launched a statewide training initiative in September 2015 aimed at improving knowledge of MAT treatments across the child welfare system, the provider network, and the Judicial branch. To date, 261 individuals have been trained in the *ABC's of MAT* at 12 DCF Area Offices throughout the state.

Naloxone®/Narcan Training

The heroin and prescription drug abuse epidemic in the northeast also prompted DCF to provide Narcan awareness training for its staff. Two voluntary training sessions were held in March 2016 to gauge staff interest in Narcan education. Both sessions reached capacity and nearly 60 staff received training in prescription drug abuse, harm reduction approaches, problem recognition, Connecticut's legislation regarding Narcan, and Narcan administration. The high level of interest in these grant-sponsored trainings as prompted DCF's Academy for Workforce Development to add these sessions to its regular course offerings. DCF also has drafted a Narcan policy for staff and facilities that currently is under internal review. The Department also is partnering with its congregate and therapeutic foster care providers to develop a policy specific to the use of Naloxone in these settings.

Randomized Controlled Trial of recidivism in MST-TAY services

Drs. Maryann Davis (University of Massachusetts Medical School), Ashli Sheidow (Oregon Social Learning Center), and Mike McCart (Oregon Social Learning Center), in collaboration with the Connecticut Department of Children and Families, were awarded 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). MST-EA, referred to in Connecticut as a Transition Age Youth (TAY) program, will be evaluated for recidivism reduction and mental illness outcomes, as well as other functional outcomes. The 4-year trial will take place in Connecticut, with the NIMH grant providing all research costs and nearly $50,000/year of the MST-EA program's costs. This will represent the first randomized controlled trial ever conducted in the U.S. or internationally that focuses on reducing recidivism in emerging adults.

Substance Abuse Family Evaluation, Recovery & Screening (SAFERS) Project

Since 2013 DCF has been piloting a screening protocol in three DCF offices using a federal grant from the Children's Bureau to enhance identification of trauma and behavioral health needs for families at risk of losing their children due to problems related to substance use. The SAFERS project aims to improve identification of needs among caregivers, infants and young children through enhanced screening, establish cross-agency service planning and rapidly engage families in community-based services. The goals are to increase rates of treatment compliance and recovery as well as decrease the rate of child removals and improve children's overall well-being. SAFERS builds upon the partnership between DCF, the Department of Mental Health and Addiction Services (DMHAS), the Judicial Branch, Advanced Behavioral Health, Inc., (ABH), and the University of Connecticut Health Center (UCHC) established to implement the RCM program. The target population for SAFERS is DCF-involved caregivers with problems related to substance use and that have a child 6 months to 6- years old.

Workforce Development Collaborative

Through the Project SAFE and RSVP programs DCF is partnering with DMHAS, the Judicial Branch, the Connecticut Women's Consortium and Advanced Behavioral Health to offer a series of trainings related to substance use, treatment, recovery, and trauma to staff at partnering agencies. Trainings are jointly funded by the partnering state entities and sessions are offered free to staff. The aim of the workforce development collaborative is to increase education of staff to improve services to children and their families, and to help staff assist families in obtaining care and support that limits their involvement with child protective services and the courts.

➢ *Judicial Branch Court Support Services Division*

Multi-Systemic Therapy (MST)

MST is an 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 abuse, violence, severe emotional disturbance—at home, in school and arrest free.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)

This program addresses the comprehensive needs for youth with psychiatric and co-occurring disorders; helping families manage behaviors and keeping youth safe at home and in community; used when traditional outpatients services are not sufficient to avoid psychiatric hospitalization or facilitate re-entry thereafter.

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 abuse 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 abuse 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 abuse, 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.

New Choices (MOA w/DCF)*

Brief substance (90 days) abuse Treatment program for boys younger than 18 years old. ACRA / ACC is the treatment model. DCF holds contract, but CSSD refers most participants.

*This program has been removed from CSSD's service continuum effective 7/1/2016

Court Based Assessment (CBA)

Psychological and substance abuse 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.

Drug Intervention Program (DIP)

Program conducts clinical evaluations, prepares treatment plans, and delivers a full continuum of SA treatment, case management, residential (long and short term) and support services.

DMHAS Collaborative (via MOA)

Substance abuse 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 abuse and mental health evaluations, individual and group substance abuse, co-occurring, mental health, anger management and relapse prevention ; intensive outpatient treatment substance abuse 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 collaborated with the Connecticut State Medical Society through a $10,000 grant from the Federation of State Medical Boards (FSMB) to offer a live continuing education opportunity for Connecticut physicians and other prescribers entitled "Extended Release & Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)". Four (4) three-hour REMS educational sessions were held for 260 licensed prescribers during the fall of 2014. Others who were not able to take the course in person were encouraged to take the free training on line through the FSMB. The Department has also promoted other local opioid prescribing trainings to licensed prescribers sending out notifications through the e-license system.

- Physicians, advanced practice registered nurses (APRNs), dentists, and physician assistants (PAs) licensed by the Department of Public Health are now required to take continuing education in prescribing controlled substances and pain management effective October 1, 2015 pursuant to Public Act 15-198.

- The Department added an attestation requirement to the online physician license renewal process to acknowledge aware of this requirement that includes a link to the Department of Consumer Protection's PDMP website in case the physician has not yet registered. Public Act 15-198 also required practitioners to check the Department of Consumer Protection's Prescription Drug Monitoring Program (PDMP) prior to prescribing more than a 72 hour supply of controlled substances, and to review the PDMP at least every 90 days for patients on long term treatment with controlled substances.

Office of Emergency Medical Services (OEMS)

- The Department is a member of DESPP's Naloxone Advisory Committee, and as such shares data on first responder use of naloxone across state agencies. Civilians, state police, municipal police and all levels of EMS providers have the ability, after training, to administer naloxone in

the event of an opioid overdose. Almost every community in CT has one or more equipped providers.

HIV Prevention Program

- **Community Naloxone Distribution Activities**- This program is integrated into current syringe exchange programs that are under contract with the DPH HIV Prevention Program. The funding source is **state** (AIDS) funding and at this time provides funds ($189,000) to purchase naloxone and syringes.
- **Overdose Prevention Activities**- In 2015, the DPH HIV Prevention program developed OPEN Access CT trainings, organized an Overdose Prevention Summit, developed a social marketing campaign (billboard), and developed Overdose prevention Kits (without naloxone). The funding for these activities was through a **one-time carry-forward request** under our **federal** HIV Prevention Cooperative grant with the CDC in the amount of $190,000.

Tobacco Program

- **Prevention Activities**-DPH is implementing evidence-based programs that incorporate interventions into local communities through policy, systems, and environmental changes. These programs will be 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 that is in place until 2019.DPH offers tobacco use cessation programs at various 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 the gaps.

- **Training Institute**-DPH provides training for community partners based on needs and updated research, and sends resource materials to assist with various community initiatives. During the fall of 2015 DPH offered two policy workshops about working with communities that included point of sale initiatives.

Funding provided for these activities includes:

CDC funding for tobacco control program	$824,868
Tobacco and Health Trust Funds	$1,171,722

Office of Injury and Violence Prevention

DPH organized a workshop in the fall of 2014 to streamline and build on an action plan developed at the Prescription Drug Abuse Policy Academy in Bethesda Maryland sponsored by SAMHSA. The workshop focused on primary prevention by addressing these two objectives (1) implementation of action steps to increase prescribers' engagement in preventing prescription drug abuse; (2) launching a multi-level public awareness and prevention campaign across communities in Connecticut.

To date, one of the workgroups created after the workshop has completed and launched two major deliverables.

- A Public Service Announcement to address the misuse and abuse of prescription medication and opioid-based drugs in youths
- A comprehensive state website www.drugfreect.org that is a compendium of opioid information from overdose prevention, addiction treatment and re-integration back into the community.

The two activities listed have no budget.

➢ *Department of Consumer Protection (DCP)*

The Department is tasked with promoting access to safe and effective pharmaceutical care services in Connecticut and protects 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 Abuse Initiatives and Accomplishments:

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

Prescription Drug Monitoring Program

The PDMP 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 controlled substances 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 accuracy of the data as previous requirements specified that

data must be entered within a one week period. Connecticut now shares data with 20 states, with New York being a state recently added.

DCP has provided educational campaigns targeting prescribers and pharmacists on drug-seeking behavior and how to use the PDMP. They have also provided educational campaigns to law enforcement personnel on prescription fraud and the use of the PDMP. The agency is also in the process of finalizing a Proper Prescribing Course for practitioners

Community Drug Take Back Programs

Another important initiative of DCP has been the establishment of a prescription drop box program. There are now over 70 in operation and the state police, as part of this effort, recently launched the program in 13 new locations. DCP has also sponsored Community Drug Take back days. DCP also offers educational campaigns for the general public about prescription drug abuse and safe storage and disposal of over-the-counter and prescription medications.

Medical Marijuana Program

DCP has established and implemented Connecticut's Medical Marijuana Program. The Program utilizes a pharmaceutical model for the manufacturing and dispensing

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 pharmacists are certified and can now prescribe Naloxone in the state.

➢ *Connecticut Office of Policy and Management*

Residential Substance Abuse 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 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 abuse treatment services.

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

Description of Strategies: The majority of grant funds will continue to support (1) FT Correctional Substance Abuse 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 abuse 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 abuse 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*

The Department of Correction has a dedicated Addiction Services unit that provides a graduated system of substance abuse treatment programs. According to the agency's Objective Classification System greater than 80% of the inmates who come into the system have a significant need for substance abuse treatment. A range of treatment options are available to meet offenders individual needs, from brief treatment focusing on re-entry and reintegration issues for offenders returning to the community; intensive outpatient (IOP), with cognitive behavioral therapy curriculum; residential substance abuse treatment in a modified therapeutic community setting. The Addiction Services Unit provides an aftercare program designed to provide a continuum of care and maintenance of recovery. The Addiction Services unit also provides specialized services for youth, women, DUI offenders, clients on methadone maintenance and parolees at risk for violation of parole.

Major Initiatives and Accomplishments:

DUI Offenders

Legislation in 2011 (CGS 18 – 100h) provides the Department of Correction the discretion to allow eligible offenders convicted of Driving Under the Influence to serve a portion of their sentence under supervision of a parole officer in the community under home confinement. The first focuses on DUI offenders serving the mandatory portion of their sentence. These offenders are assessed by addiction services staff to determine the required level of treatment prior to release, provided that treatment and released to serve the remainder of their sentence on home confinement. They are supervised by a specially trained Parole unit. This program has assessed, treated, and successfully supervised more than 1600 offenders, since it began in 2012.

In-prison Addiction Treatment

The DOC Addiction Services Unit provides in-prison treatment services to approximately 5,000 offenders annually. These services include brief treatment, intensive outpatient, therapeutic community

treatment, youth specific intensive outpatient treatment, DUI specific treatment, Time Out of Parole for at risk parolees. An addition 650 was supported in methadone maintenance groups.

Community Aftercare

As a sub-grant recipient of the Residential Substance Abuse Treatment (RSAT) grant from OPM, DOC has increased its ability to provide continuity of care from in-prison to community care for prisoners following participating in residential substance abuse treatment. These services include behavioral health treatment as well as recovery supports such as employment and housing assistance, transportation and more.

Naloxone Project

In the summer of 2015 DOC sponsored training for DPH staff to train parole officers and halfway house staff in the use of Naloxone for opiate overdose reversal. DPH donated kits to be carried by all parole officers as well as maintained in all of the halfway houses where DOC clients reside.

Medication Assisted Therapy

A pilot program began at New Haven Community Correctional Center in October of 2013, offers 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 of 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. More than 650 clients have participated in the two programs.

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.

➢ *Department of Education*

The Connecticut State Department of Education (CSDE) offers several programs that provide substance abuse education, substance use prevention and referrals for counseling or treatment. Many of these programs are aimed at positive youth development including social-emotional and physical development and the prevention of behavioral health problems of which substance use is often an area of focus.

After School Grant Program

The After School Grant Program was established by the Connecticut General Assembly for the purpose of creating high-quality after school programs outside of regular school hours. After school programs are defined as programs that: take place when school is not in session; provide educational enrichment and recreational activities for students in Grades K-12; and include parent involvement and wellness components. After school programs provide students with academic enrichment opportunities, as well as additional activities designed to complement academic programs. These programs, located in elementary or secondary schools or community-based facilities, can provide a range of high-quality services to support student learning and development. Services include tutoring and mentoring; homework help; academic enrichment (such as hands-on science or technology programs); and may also include youth development activities; drug, violence and pregnancy prevention programming; counseling; project-based learning; art, music, and technology education programs; service learning; and character education and recreation programs that are designed to reinforce and complement the regular academic program of participating students, as well as provide parent involvement opportunities for families.

Youth Service Bureaus

The CSDE provides supports to Youth Service Bureaus (YSB) financially and through technical assistance. Each year the Connecticut General Assembly commits approximately $3-million to support the activities provided by YSBs. YSBs offer a broader scope of services than most other youth-serving agencies. Direct services offered by YSBs include: behavioral health counseling; individual and family therapy; employment and training counseling; recreational and enrichment activities; outreach programs for children, youth and families; and preventive and positive youth development programs. YSBs are also responsible for assessing the needs of youth; identifying gaps in services and coordinating services for youth to fill gaps; and avoiding duplication of services. Many YSBs also play a special role in working with the juvenile justice system to meet the needs of children and youth found to be delinquent, by providing and/or making referrals to various health services including behavioral health and substance use counseling.

Safe Schools/Healthy Students

The CSDE is participating in a federal Safe Schools/Healthy Students (SS/HS) Grant Program in collaboration with DMHAS. It is an $8.6-million award over four years. Bridgeport, New Britain and Middletown are partner districts that are allocated $2-million each. Element 4 of the SS/HS grant: Preventing Behavioral Health Problems including Substance Use, includes developing substance use prevention partnerships with community, advocacy and health care delivery organizations; implementing student surveys and improving substance use data collection activities; providing training to teachers, administrators and behavioral health staff; and enhancing referral systems. The SS/HS State Management Team is also involved with developing and/or implementing support to 12 Coalitions that were identified to receive funds to utilize the Strategic Prevention Framework (SPF) and have begun to

receive training. District specific funding is allocated based on their activities within Element 4. These specific dollars are varied based on district focus and need. On the SS/HS State Management Team level, DMHAS, DCF and DPH are all providing certain levels of support or funding to this effort with the SS/HS districts.

➢ *Department of Veterans Affairs*

Intensive Outpatient Program

DMHAS in collaboration with the DVA has developed an eight week Intensive Outpatient Program with an additional four week outpatient component offered to veterans with substance use disorders. Admissions are voluntary. The twelve week **Intensive Outpatient Program** consists of scheduled group sessions including the following: Relapse Prevention 1 and 2, Peer-led Meditation, 12 Step, "Search for Meaning", Therapy Base Group, Community Meeting, Anger Management 1 and 2, Exercise & Relaxation, "Man to Men", Leisure Education and two optional groups: Recovery And Spirituality and Exploring Trauma. In addition, each participant is assigned and individual counselor.

➢ *Department of Social Services*

The Department of Social Services (DSS), the state Medicaid agency, provides Medicaid fee for service reimbursement for Connecticut's substance abuse treatment related levels of care in a variety of settings including Methadone Maintenance, Routine Outpatient, Intensive Outpatient, Partial Hospitalization, Ambulatory Detoxification, and Medical Detoxification services.

State Spending for Substance Abuse Services in Connecticut

Connecticut spends over $334,000,000 on substance abuse services within the state. Over 293 million is spent on treatment and over 37 million on prevention. Each state agency submitted their expenditures for substance abuse spending for fiscal year 2015. The data is shown is the table below.

Agency (FY 15 data)	Prevention	Deterrence	Treatment	Total
DMHAS	$15,718,326	$0	$132,403,326	$148,121,652
DSS			$84,316,657	$84,316,657
JUDICIAL-CSSD JUV.	*$6,827,825	$0	$5,703,422	$12,531,247
JUDICIAL-CSSD ADULT	$11,725,682		**$19,003,439	$30,759,121
DCF	$6,533,191	$0	$17,281,268	$23,814,459
DOC	$0	$0	$16,168,892	$16,168,892
DOT	$2,351,968	$3,778,866	$0	$6,130,834
DPH	$2,375,590	$0	$0	$2,375,590
DCP	$1,471,260			$1,471,260
DVA	$0	$0	0	0
OPM	$349,879	$0	$0	$349,879
SDE	$8,600,000	$0	$0	$8,600,000
TOTAL	$55,953,721	$3,778,866	$274,877,004	$334, 639, 591

***CSSD's juvenile prevention funding includes some treatment service dollars**

****CSSD"s adult services treatment dollars includes some prevention dollars**

Department of Mental Health and Addiction Services Triennial Report 2016 Opioid Annex

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DMHAS Triennial Report Subsection Responding to the Opioid Epidemic

Introduction

Connecticut, like most states in the country has seen a significant increase in opioid use over the past five years. This increase in heroin and other opioid use has been described by the Centers for Disease Control (CDC) as an epidemic. This increase in use is reflected in escalating numbers of overdose deaths attributable to opioid use; it is also reflected in increases in admissions to Connecticut's treatment system specifically related to opioid use. Many of these overdose deaths involve the use of multiple substances. Overdose deaths involving Fentanyl comprise a particularly troubling trend. Fentanyl is a far more potent opioid that is being mixed with or substituted for heroin, leaving unwitting users at much higher risk for fatal overdoses.

Governor Malloy, recognizing this problem, has introduced a number of pieces of legislation focused on this epidemic. During the 2015 legislative session, the governor introduced and signed "An Act Concerning Substance Abuse and Opioid Overdose Prevention" into law. One element of this legislation, reconstituted the Alcohol and Drug Policy Council (ADPC) with Commissioners Miriam Delphin-Rittmon of the Department of Mental Health and Addiction Services (DMHAS) and Joette Katz of the Department of Children and Families (DCF) as the co-chairs. The Council will help direct the state's efforts to coordinate substance use prevention and treatment throughout Connecticut's system of care. In fall 2015, Governor Malloy requested that the ADPC focus on the emerging opioid epidemic in Connecticut.

This year's Triennial Substance Abuse Plan includes a special annex related to the opioid crisis in Connecticut. Numerous state agencies and community organizations have already taken many steps to address this crisis. This subsection is intended to describe what has occurred and identify key elements and strategies that will guide Connecticut's continuing response to the opioid crisis. The annex details strategies and action steps in the areas of overdose reversal, prevention, treatment, criminal justice, and law enforcement. The plan's strategies and action steps involves multiple players alongside state agencies, including treatment and prevention providers, the recovery community, community organizations, and other stakeholders. Recently the Governor has requested that experts from Yale University assist the state to create an overarching strategy to reduce opioid addiction and overdoses. Yale has begun that work and will be collaborating with the Alcohol and Drug Policy Council over the coming months to develop a comprehensive plan that will better coordinate the state's efforts.

Connecticut's Opioid Epidemic

Connecticut's epidemic primarily involves heroin use but the use of other opioids has made an impact on our state as well. Other opioids include prescription opioids such as hydrocodone, oxycodone, codeine, and morphine. Methadone prescribed for pain may be abused as well. More recently, Connecticut has been impacted by an increased use of Fentanyl. Fentanyl is being mixed with or substituted for heroin placing users at greater risk due to the much greater potency of this drug. The clearest impact of the epidemic in Connecticut can be seen in the escalating overdose deaths related to opioids, especially over the past three years. Evidence of the epidemic has also been felt in the substance abuse treatment system where admissions related to opioids have increased substantially over the past five years.

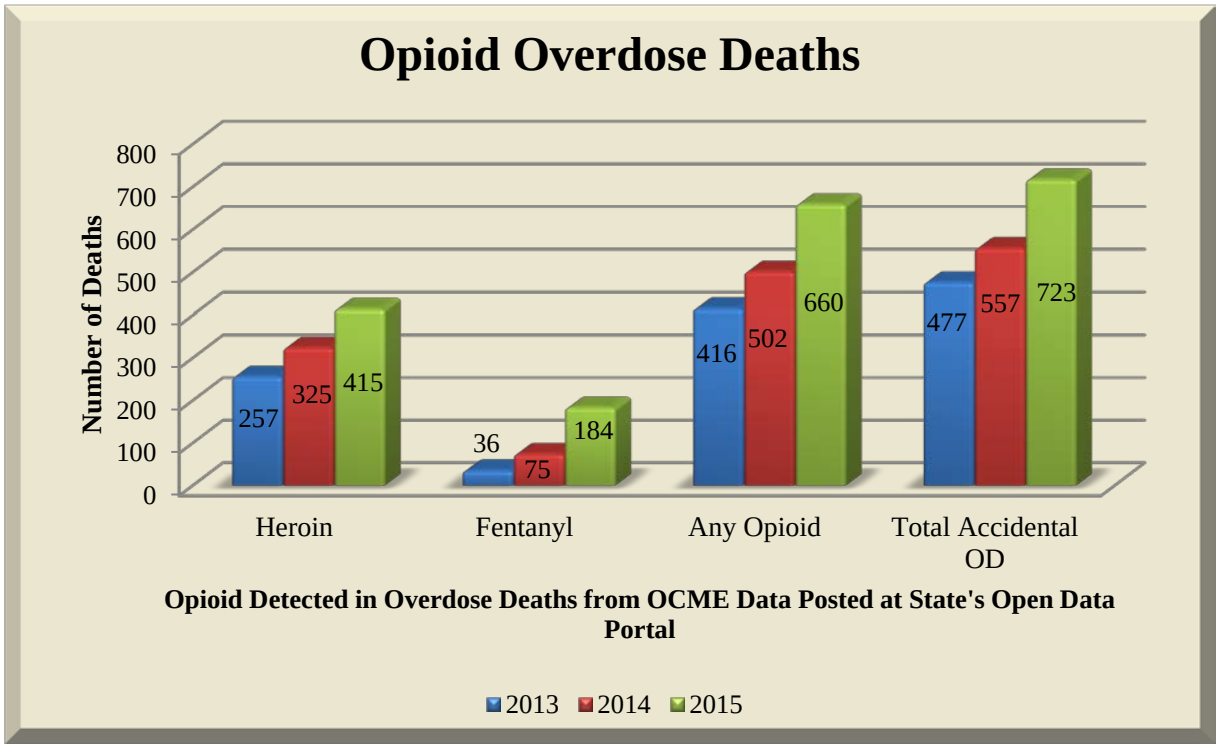

Figure 1: Opioid Overdose Deaths, FY13-15

Overdose deaths have been steadily rising in the state. Data produced by the Office of the Chief Medical Examiner (OCME) available through the State's Open Data portal (https://data.ct.gov/Health-and-Human-Services/Accidental heroin. Heroin alone was detected in over 400 deaths last year. Perhaps even more alarming is the fact that opioids were detected in almost 90% of the overdose deaths reported last year. The OCME data also illustrates the growing impact of fentanyl in overdose deaths. In Calendar Year 2013, fentanyl was detected in 36 overdose deaths. This increased in CY 2014 to 75 and grew even further in CY 2015 where it was detected in 184 of the total overdoses.

DMHAS research staff recently began to examine how many deaths are related to combinations of benzodiazepines and opioids. A very preliminary analysis shows that benzodiazepines were involved in 474 (26.8%) deaths over this three-year period. Opioids and benzodiazepines were both present in 415 of the overdose deaths (23.4% of total deaths and 87% of benzodiazepine related deaths), highlighting the dangers of co-prescribing these medications.

The increase in heroin use has also been evident in Connecticut's treatment system over the past five years. Heroin and other opioid related admissions were in a slow decline from 2006 through 2010. However, admissions increased slightly in 2011 and have been steadily increasing since that time. Opioid-related admissions increased by 54% - from 17,553 in FY 11 to 27,103 in FY 15.

-Drug-Related-Deaths-2012-2015/ecj5-r2i9 , shows that 1,771 individuals died of a drug overdose over the past 3 calendar years. Many of these overdose deaths involved poly-substance use. In FY 15, 723 overdose deaths were reported with almost 60% related to

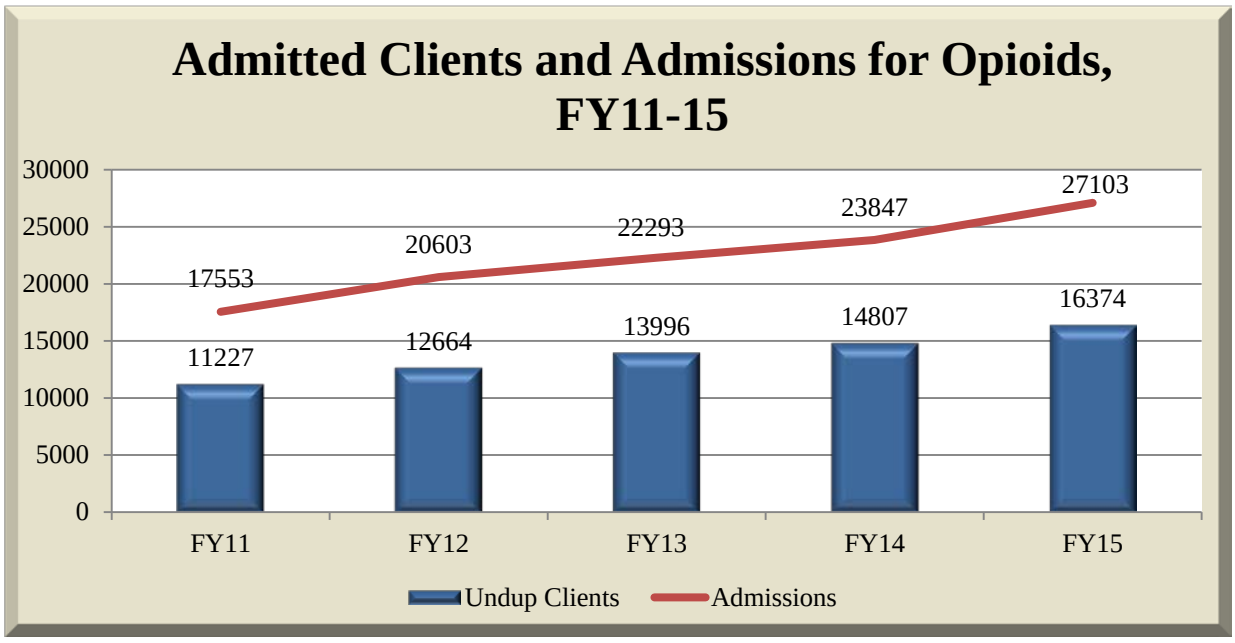

Figure 2: Admitted Clients and Admissions for Opioids, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

The impact is not just seen in admissions to DMHAS treatment programs. Unduplicated clients involved in these admissions have also increased significantly. When individuals are admitted to DMHAS substance abuse services they report their "primary drug" of choice. DMHAS served 11,227 unduplicated clients with heroin or other opioids as their primary drug in FY 11 and served 16,374 in

FY 15, an increase of 46%. For years, alcohol was the most frequently reported primary drug at admission. Heroin has now replaced alcohol as the primary drug reported at admission within the SA treatment system. In FY 15, heroin, along with prescription opioids, accounted for almost 40% of all SA treatment admissions.

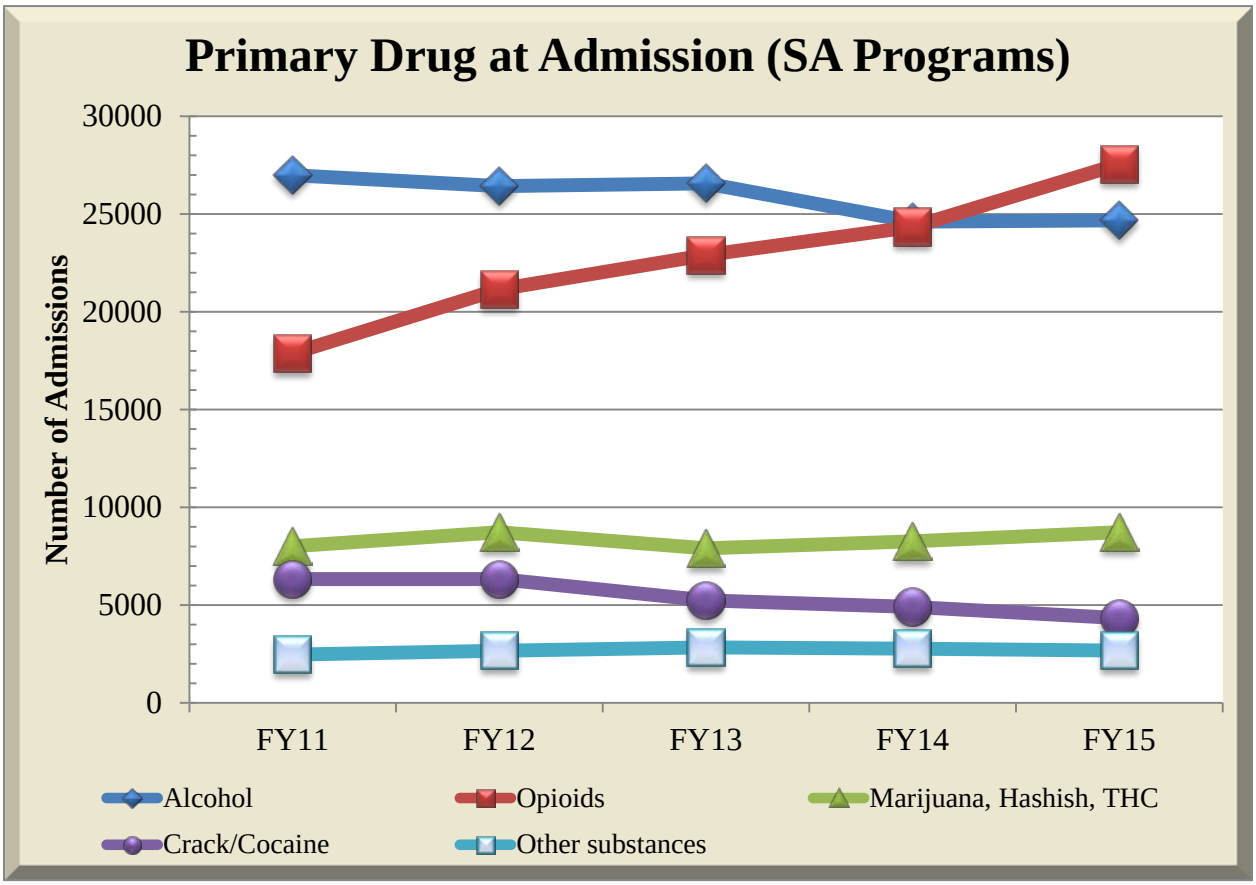

Figure 3: Primary Drug at Admission, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

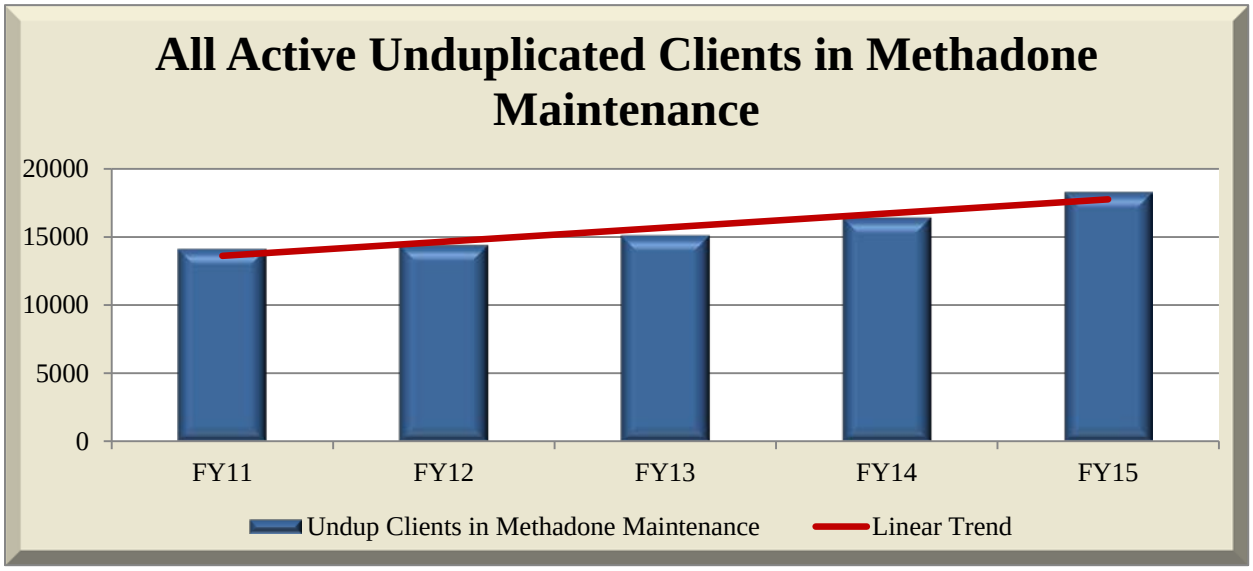

Figure 4: Unduplicated Clients in Methadone Maintenance, FY11-15
(*Data from DMHAS EDW; includes all funding sources)

The impact of the opioid epidemic has been evident in certain treatment levels of care. In FY 11 DMHAS served 14,148 in methadone maintenance programs and that number grew to 18,315 in FY 15, a 29% increase. Based on data submitted through March 31, 2016, approximately 20,000 individuals will be served in methadone maintenance programs by the end of FY 16. Below, the graph illustrates the yearly increases in admissions and unduplicated clients served in methadone maintenance programs.

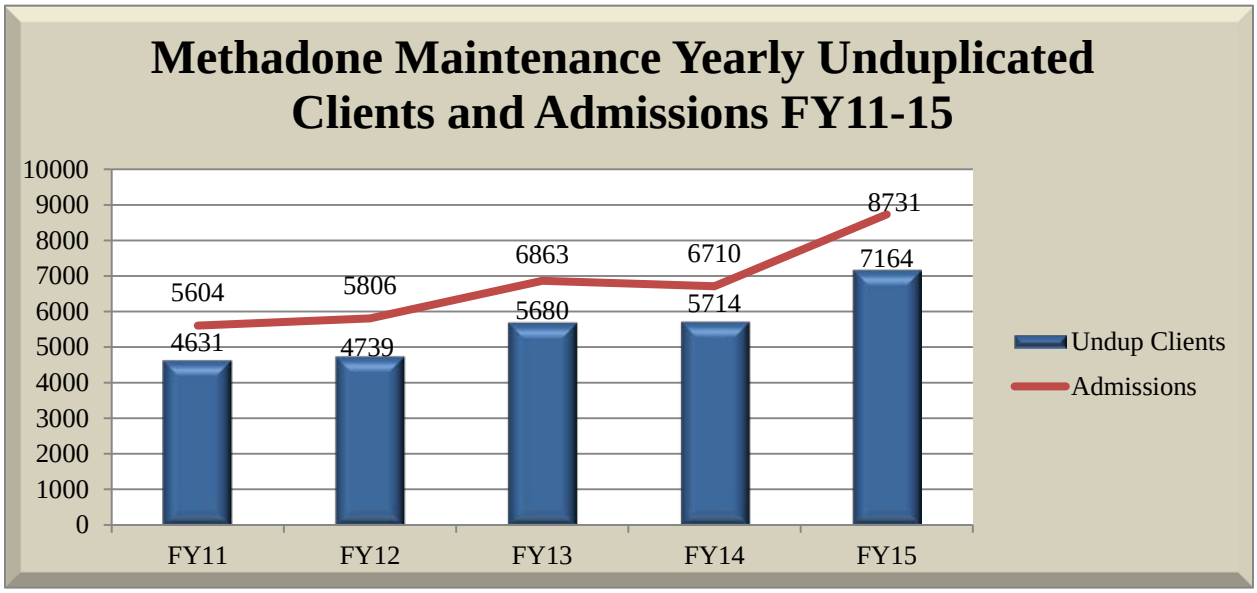

Figure 5: Yearly Admissions and Clients in Methadone Maintenance, FY11-15
(*Data from DMHAS EDW; includes all funding sources)

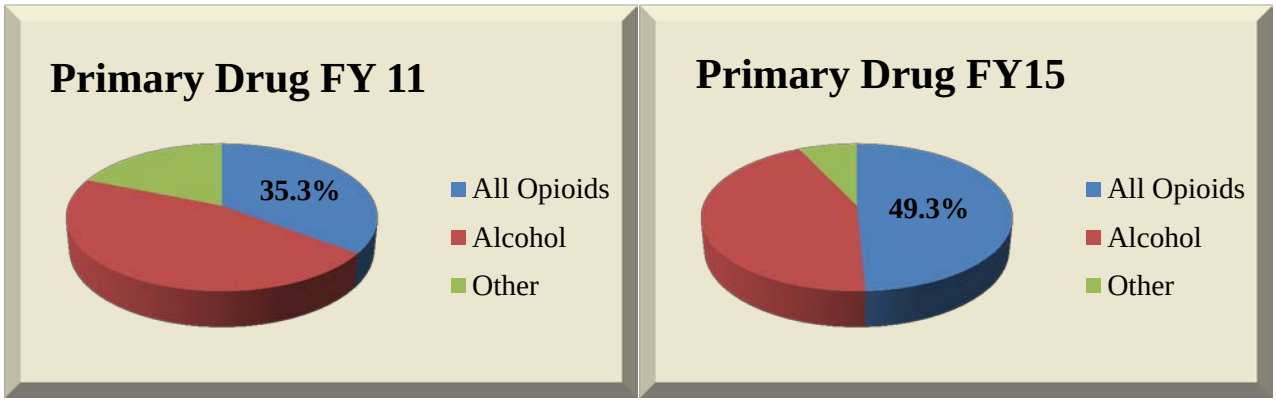

Figure 6: Primary Drug at Admission in Detoxification Programs, FY11-15

(*Data from DMHAS EDW; includes all funding sources)

Detoxification programs had over 15,300 admissions in FY 15. Almost **50%** of all detoxification program admissions are now related to heroin or other opioids. For comparison, the number was **35%** in FY 11. Many of these individuals are not being connected to evidence-based medication assisted treatment services such as methadone maintenance or buprenorphine treatment. Instead, many of these opioid users have multiple admissions to detoxification programs.

The demographics associated with opioid users are also changing. Males have consistently accounted for about 70% of all opioid-related admissions. However, over the past five years there has been an increase in white, non-Hispanic males that are being admitted into our treatment system. 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. A DMHAS report which shows the towns of origin for all admissions related to opioids over the past five years, shows how opioid use has increased. Smaller cities like Bristol, Torrington, and New Britain have seen a substantial increase in admissions and in the number of unduplicated clients being treated for opioids during that period.

Another changing demographic relates to the age of individuals using opioids. There has also been a substantial increase in one age group. Admissions for individuals between the ages of 25-34 have almost doubled over the past five years from about 3,500 in FY 11 to almost 7,000 in FY 15. This shift deviates from some national data which appears to show that more young people (18-25) are being admitted for opioid treatment. No age group has been spared from the epidemic as admissions have been reported for individuals over 65 and as young as 18.

The opioid epidemic shows no signs of abating. Overdose deaths continue to increase and opioid-related admissions into our treatment system in FY 16 look as if they will exceed FY 15's count. Similarly, nine-month data for FY 16 shows that more people will be served in methadone maintenance programs than at any other time in the past 20 years. Stopping the course of an epidemic requires multi-pronged strategies that target various components of this crisis. These efforts must include the reduction of overdose deaths through widespread availability of Narcan, aggressive enforcement of drug laws, especially as they relate to trafficking, diversion of non-violent offenders into treatment, prevention and

education activities designed to keep individuals from being introduced to opioid use, and rapid access to a broad range of treatment alternatives once somebody has begun to use opioids. The plan will incorporate necessary legislative and policy changes that are supportive of the overall state efforts as well.

The Triennial Report's Opioid Annex details six over-arching strategies that are believed to be essential in combatting an epidemic such as the one we face. As will be demonstrated in this report, many of these strategies are already in place and can be built upon in order to effectively stop this epidemic. A range of actions or objectives will be presented under each of these strategies. The report will also detail accomplishments related to each strategy and areas for further enhancement.

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 and buprenorphine.

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 INFORCEMENT

- 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.

Adapted from the Addiction Policy Forum-Key Elements of a Comprehensive Response to the Heroin Epidemic

Strategy 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**

Action Step: Expand the statewide network of pharmacists that are trained and willing to prescribe and dispense naloxone.	**Action Step:** 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.
Action Step: Require that any state-operated or funded provider serving persons with opioid use disorders has a "rescue plan" for those individuals.	**Action Step**: Obtain and distribute Narcan kits to all state-run or contracted providers that are serving persons with opioid use disorders.
Action Step: Provide in-person training to law enforcement, first responders, treatment providers, community organizations and families regarding proper use of Narcan.	**Action Step:** Ensure that all first responders maintain a supply of Narcan as part of normal operating procedures.
Action Step: Make online training regarding Narcan available to the general public.	**Action Step:** Educate opioid users, family members, and the general public about Narcan.
Action Step: Distribute Narcan through syringe exchange programs.	**Action Step**: Ensure that all insurance carriers reimburse pharmacists for prescribing Narcan.
Action Step: Eliminate insurer's pre-authorization requirements for Narcan.	**Action Step:** Explore the feasibility of a database to collect information regarding overdose reversals.
Action Step: Apply for federal funding being made available to expand overdose prevention training.	**Action Step**: Expand or modify legislation in order to ensure Emergency Medical Technicians and other first responders carry Narcan
Action Step: Ensure Narcan is available in schools and universities in CT.	

Accomplishments: Narcan is becoming increasingly more available throughout Connecticut due to a succession of actions dating back to 2011. At that time, a Good Samaritan law was enacted providing protection to those who assisted an individual that was overdosing. Subsequent legislation allowed doctors to prescribe Narcan to family members. It was felt that the legislation did not go far enough and new legislation was approved in 2015 that permitted pharmacists to prescribe and dispense Narcan after completing an online training course.

This training was launched in summer 2015 by the state's Department of Consumer Protection and a statewide network of almost 600 pharmacists are now certified and willing to prescribe

Narcan. This information is now posted on various websites in order to be more broadly available to the public. Most recently, new legislation was passed by the CT House that requires municipalities to ensure that all first responders receive training in how to use Narcan and have it available at all times. While all of these activities have broadened access to Narcan greater emphasis must be placed on growing the pharmacy network while making Narcan more widely available to the general public.

Narcan Training has been delivered throughout the state by DMHAS and the Department of Public Health (DPH). These trainings "teach" participants how to administer Narcan and where it can be accessed. Almost 1,700 persons have been trained in Narcan administration through over 90 trainings offered by DMHAS. These trainings have been provided to substance abuse treatment providers, law enforcement, family members, and other stakeholders. Additionally, DPH has offered training to Connecticut's State Police and Narcan kits are now being carried by all State Police officers. These Narcan kits were made available through a cooperative agreement with the Medical Director of the Department of Correction. As a result of these training efforts most of DMHAS' substance abuse providers now have Narcan kits available to them.

DCF has incorporated Narcan training into its Training Academy. DCF also has drafted a Narcan policy for staff and facilities that currently is under internal review. The Department also is partnering with its congregate and therapeutic foster care providers to develop a policy specific to the use of Naloxone in these settings.

The DPH has been actively working to get Narcan kits out across the state. To date, DPH has distributed approximately 6,700 kits; DMHAS received 200 of these kits and has focused distribution of these kits on our residential programs and other treatment providers within our system. Efforts are ongoing to secure additional kits from the manufacturer in order to expand distribution efforts.

Anecdotally, Narcan is believed to have had a significant impact in Connecticut but its effectiveness has been difficult to quantify. Currently, the state police and the Connecticut Syringe Exchange are tracking the number of overdose reversals that have occurred. The state police have recorded 82 reversals since November 2014 and the CT Syringe Exchange has recorded 53 reversals since February 2015. While capturing this data is difficult, this is another area that could be enhanced. A centralized database that captured information about reversals could be supportive of Connecticut's efforts.

Strategy 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**

Action Step: 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.	**Action Step**: Apply for federal funds being made available to prevent opioid use and overdose deaths associated with heroin and other prescription opioids.
Action Step: Inform the public about risks of opioid use and prescription drug abuse through videos, social media, websites, PSA's, and posters and billboards	**Action Step**: Continue efforts through the state's prevention and treatment network to de-stigmatize addiction which is often a barrier to help-seeking.
Action Step: Develop and disseminate educational materials regarding opioids for students, parents, and school personnel.	**Action Step**: Expand community disposal sites for unused and expired prescription medications.
Action Step: Work with CT Medical Schools to ensure basic addiction training is included in core curriculums.	

Accomplishments: Connecticut has already initiated a number of prevention activities that are focused on prescription drugs or opioids. Some of this work began several years ago when the state hosted a conference focused on preventing prescription drug abuse. That conference resulted in actions that have focused on increased public awareness about the dangers of prescription drugs. Related to that is the safe disposal of prescription drugs as many adolescents access prescription opioids through their parent's medicine cabinet. The state now has over 60 drop boxes where unused medication can be disposed of. The State Police just added 10 additional disposal sites. The list of the these drop boxes and their location can be found at: http://www.ct.gov/dcp/cwp/view.asp?q=501922 .

A goal of any prevention effort related to heroin is to increase public awareness about the dangers of opioid use while educating Connecticut's citizens about the resources that are available to combat this problem. DMHAS has now conducted approximately 15 public forums across the state focusing on the opioid crisis across the state. Another 10 are scheduled to occur over the next several months. The forums include policymakers, local substance abuse experts, persons in recovery, and leaders from state agencies who provide information about the scope of the problem, ways to access Narcan, and treatment resources that are available for opioid users. Posters and other informational materials are made available as well.

State agencies have begun collaborating with partners to ensure that information about heroin and other opioids is broadly accessible to the public. The Governor's Office has introduced a website that focuses on the opioid problem, providing a range of resources to interested parties. Other state agencies have followed suit, providing information regarding agency specific resources. At the same time, contracted providers including the Connecticut Clearinghouse, Regional Action Council's, and the Governor's Prevention Partnership have collected and posted a range of resources to help inform the public and providers about this issue.

Strategy 3: *Strategies Related to Treatment*

- **Expand access to medication-assisted treatments (MAT) including methadone maintenance, buprenorphine, and naltrexone.**
- **Rapidly link opioid users to treatment**

Action Step: Create a statewide network of walk-in assessment centers to rapidly assist opioid users to find appropriate treatment.	**Action Step**: Establish and implement protocols to attempt to rapidly engage into treatment those individuals that were rescued from an overdose
Action Step: Implement a statewide toll free call line to connect callers to treatment options.	**Action Step:** Maintain and expand as necessary the statewide network of methadone maintenance programs.
Action Step: Increase capacity for outpatient programs to prescribe buprenorphine and naltrexone.	**Action Step**: Develop and implement a statewide buprenorphine expansion program.
Action Step: Apply for federal funding being made available to expand access to MAT.	**Action Step**: Improve linkages from detoxification programs to MAT

***Accomplishments*:** In order to address the opioid crisis effectively, Connecticut must have a comprehensive system of medication assisted treatment programs (MAT), an evidence-based treatment for opioid addiction. It is also important to offer a range of alternatives to individuals hoping to recover from opioid addiction. Connecticut has successfully built a statewide network of methadone maintenance programs, one type of MAT that served over 18,300 unique clients in fiscal year 2015. There are currently 25 methadone maintenance programs in operation in all areas of the state. These programs have demonstrated their capacity to meet additional demand for services. These programs have experienced substantial growth over the past 5 years. In FY 2011, approximately 14,148 people were served in these programs. The number served grew to over 18,300 in FY 15, a 29% increase in the numbers served in these programs. Current data should be evaluated in order to assess whether these programs can be accessed in rural areas in the state.

Alternatives to methadone maintenance like buprenorphine are not yet widely available in Connecticut or largely serve clients with private insurance or those that pay for these alternatives. This is not an option readily available to "public" clients in Connecticut. Buprenorphine is another form of medication that is similarly effective in treating opioid addiction. This treatment option is "physician driven" and is dependent on doctors that are "waivered" and willing to prescribe the medication. Many doctors have been uninterested in prescribing buprenorphine or may opt to serve higher income clients who can pay out-of-pocket. The federal government has placed restrictions on the numbers of persons a doctor may treat, limiting the availability of this drug. Connecticut's response to the opioid crisis could be

enhanced by developing a comprehensive statewide plan to expand the use of buprenorphine in clinics, especially for public sector clients.

Rapid access to treatment is another essential component of a comprehensive strategy designed to address the opioid epidemic. Connecticut implemented a toll free number for referral to services related to opioid addiction. The toll free line **1-800-563-4086** is staffed 24/7 and links callers to a network of walk-in centers where a person can receive a same day evaluation of their needs. Over 50 programs have agreed 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

DMHAS implemented what is called the *Opioid Agonist Treatment Protocols* over 10 years ago. These are procedures designed to rapidly link individuals who are being detoxed from heroin to methadone maintenance programs. These procedures were originally designed for "high utilizers" of services as a way to reduce repetitive admissions to detoxification programs and to quickly connect clients to the most desirable treatment option, methadone maintenance. Eligibility criteria for participation in these protocols have been relaxed and more people are now eligible to use this service. This remains an area for enhancement as many people who enter detoxification programs with opioids being reported as their primary drug are not being connected to follow-up care. Stigma is often a barrier to accepting treatment and a comprehensive plan must include activities to reduce stigma.

Strategy 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**

Action Step: Investigate the effectiveness of Law Enforcement Assisted Diversion (LEAD) programs, a pre-booking program that diverts to services as an alternative to arrest.	**Action Step:** Evaluate opportunities to replicate the New Haven methadone pilot in other jails and prisons or re-entry programs.
Action Step: Transition offenders with drug convictions to community substance abuse programs.	**Action Step:** Eliminate mandatory sentencing laws for those convicted of non-violent narcotics possession.
Action Step: Increase employment training and job opportunities for ex-offenders.	**Action Step:** Implement diversionary services for individuals arrested for crimes related to opioid use.

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. A pilot program began 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 February of 2015. 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. More than 350 clients have participated in the two programs. This needs to be further evaluated to determine if this "pilot" can be expanded into other jails or prisons.

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 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 abuse treatment program. Transitional Case Management is a re-entry program that provides pre-release engagement and discharge planning and post-release OP sub abuse treatment and support services for men.

In SFY16 DMHAS received additional funding to expand JDSA to two additional courts and also received a MacArthur Safety and Justice Challenge to a third court.

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.**

Acton Step: Provide DMHAS access line number to state and local police departments.	**Action Step:** Develop pilot to divert individuals addicted to opioids into treatment.
Action Step: Ensure law enforcement personnel have access to Narcan and are trained to administer the drug.	

Accomplishments: Law enforcement plays a critical role in interdiction and stopping criminal behavior related to opioid distribution. However, this section focuses on the interaction between law enforcement and behavioral health such as diversion or linkage to treatment. Preliminary steps have been taken to increase connections to law enforcement.

Both DMHAS and DPH have been involved in trainings focused on law enforcement personnel. DPH conducted training of State Police that resulted in all troopers carrying Narcan. The state police have recorded 82 reversals since November 2014. A number of other police departments have received training in the administration of Narcan and are now carrying the medication.

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 benzodiazapines).	**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: 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:** Limit opioid prescriptions for acute conditions to no more than 7 days.

Accomplishments: The State's Department of Consumer Protection has already take 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 controlled substances 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 accuracy of the data as previous requirements specified that data must be entered within a one week period.

Both DCP and DPH have offered training programs to prescribers regarding safe prescribing practices. DPH has trained over 260 individuals and has developed a capacity to offer the training online.

New bills recently passed by the Connecticut Legislature imposed limits on the length of opioid prescription for acute conditions. This will result in prescriptions for shorter amounts of time. These more stringent restrictions apply to adults or children who receive prescription opioids for pain.

Conclusion

This Annex is designed to be an initial step to formalize key strategies and to highlight the major efforts that have been ongoing as Connecticut attempts to address the opioid epidemic. Recently the Governor has requested that experts from Yale University assist the state to create an overarching strategy to reduce opioid addiction and overdoses. Yale has begun that work and will be collaborating with the Alcohol and Drug Policy Council over the coming months to develop a comprehensive plan that will better coordinate the state's efforts.