

Council Member Name: \_\_\_\_\_

**Alcohol and Drug Policy Council**

**August 4, 2016**

**To: Members of the ADPC**

**Re: Vote on Sub-Committee Recommendations Presented August 4, 2016**

**Guidelines:**

- Please submit to Karen Urciuoli (DMHAS staff) with name and signature TODAY AT THE CONCLUSION OF THE MEETING
- Rank order recommendations beginning with 1 (highest priority) and ending with 15 (lowest priority)
- Please consider the Governor’s charge of the reconstituted ADPC  
<http://www.ct.gov/dmhas/lib/dmhas/publications/ADPC-ChargeLetter102915.pdf>
- Please consider impact on the opioid public health crisis and the residents of CT
- Please consider completeness of recommendation (e.g. fully developed, clear ownership and measures of success)
- Please consider feasibility of recommendation (e.g. availability of human and fiscal resources)

Recommendations	Rank Order-Final Vote (1=highest priority)	Notes
A. Identify core competencies for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff).		
B. Develop and implement a communication strategy that raises awareness of and provides education on the dangers of opioids and reduces stigma and other barriers for individuals and family members seeking help.		
C. Provide education and resources regarding dispensing, safe storage and disposal of prescription medications.		
D. Expand professional trainings available on adult and adolescent Screening, Brief Intervention and Referral to Treatment (SBIRT) to increase the frequency and number of individual screenings for opioid misuse, brief interventions, and referrals to treatment.		
E. Support the integration of the Prescription Drug Monitoring Program (PDMP) with Electronic Medical Records (EMRs) to improve access to patient data and reduce prescription drug misuse and overdose.		
F. Enhance early identification of substance use problems by <u>requiring children’s Enhanced Care Clinics (ECC)</u> , for youth age 12-17 inclusive, at intake to services to: <ul style="list-style-type: none"> <li>i. Conduct urine toxicology screening for common substances of abuse/misuse including opioids. Screening protocols should be trauma-informed and follow best practice standards of care for the populations served.</li> <li>ii. Implement Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) protocols according to national standards and/or as established by DCF, DMHAS and/or the UConn Health SBIRT Training Institute.</li> </ul>		
G. <u>Establish Rapid Access Centers</u> in each area of the state to engage and facilitate adult and adolescent entry into opioid addiction treatment and recovery support services. The centers would include a core staff comprised of professionals and peers:		

Council Member Signature \_\_\_\_\_

**Council Member Name:** \_\_\_\_\_

<p>1) <i>Professional call center staff</i> who</p> <ul style="list-style-type: none"> <li>a. identify a caller’s eligibility for services (e.g., insurance, entitlements, special population status, etc.);</li> <li>b. confirm the real-time availability of services;</li> <li>c. make initial “warm” connections to a local provider and a peer support staff member, and</li> <li>d. ask permission to conduct a follow-up call within one week, 5 business days, to callers to ensure a connection to care and/or supports occurred;</li> </ul> <p>2) <i>Peer support staff</i> who</p> <ul style="list-style-type: none"> <li>a. provide recovery coaching/support to callers (person-to-person) by building recovery capital and helping remove barriers to accessing care (sharing community resources to facilitate recovery, advocating for the individual and family, providing transportation, identifying child care, etc.,)</li> <li>b. helping callers navigate multiple service systems,</li> <li>c. Enrolling recoverees in enhanced Telephone Recovery Support) weekly follow-up phone calls to discuss the individual’s recovery process.</li> </ul>		
<p>H. Require the 13 DMHAS operated/funded Local Mental Health Authorities (LMHA) to provide Buprenorphine treatment on-site, including psychosocial and recovery support services. Psychosocial services require a comprehensive assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate. The assessment should include the individual's stage of readiness and receptivity to the recommendations.</p>		
<p>I. Reduce disparities in access to medical treatment by <u>expanding the availability and clinical use of MAT to a broader group of incarcerated offenders and offenders re-entering communities</u> using community-based standards of care. This recommendation expands DOC’s implementation of MAT in two facilities to the entire corrections system. In doing so, equitable opportunity to access MAT is offered to inmates regardless of facility.</p>		
<p>J. <u>Establish a workgroup to identify and address regulatory barriers that limit access to care.</u> Some examples include: LADC scope of practice; lack of integrated MH/SA program license; limits on which practitioner licenses can be used in outpatient hospital clinics; hiring regulations and practices regarding persons in recovery; and Medicaid eligibility interruptions given incarceration/ hospitalization.</p>		
<p>K. The ADPC adopt the “Recovery Language” document developed by the Recovery and Health Management Committee to ensure that all members of the Council and members of the sub-committee are familiar with some alternatives to traditional terminology and can promote the use of such terminology.</p>		
<p>L. The ADPC develop and adopt Fact Sheets for prescribers and supports the dissemination process of such Fact Sheets.</p>		
<p>M. The ADPC adopt one or more of the Public Service Announcements that have been developed by DMHAS and other currently available educational materials for distribution and assists with the identification of necessary resources to do so.</p>		
<p>N. Insure that school administrators and/or nurses and college public safety personnel have naloxone available to them and that the ADPC assists with obtaining funds, if necessary.</p>		
<p>O. The appropriate State agencies re-visit the possibility of utilizing the standing order model in CT</p>		

**Council Member Signature** \_\_\_\_\_

A.

## Subcommittee Recommendation to the Alcohol and Drug Policy Council

<b>Subcommittee Name:</b> Prevention, Screening and Early Intervention Subcommittee				
<b>Date of Initial Recommendation</b> (should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
<b>Detail Recommendation (1):</b> <u>Background:</u> Pain has been described as the fifth vital sign and oftentimes opioids are prescribed for its relief. Opioids may be necessary for the relief of pain, but improper use poses a threat to the patient and to society. Where core competencies for safe opioid prescribing exist in schools of medicine across the state, they are often inconsistent. A set of strong and streamlined core competencies will provide prevention strategies for prescription drug misuse while supporting pain relief. <u>Recommendation:</u> Identify core competencies for Continuing Medical Education around Safe Opioid Prescribing and Pain Management (for both prescribers and non-prescribing medical staff).  Is this a <input checked="" type="checkbox"/> short-term (less than 6 months) or <input type="checkbox"/> long-term (more than 6 months) implementation initiative?				
<b>Recommended Lead and Partnering Agencies:</b> CT State Medical Society				
<b>Implementation Plan</b>				
<b>Action Steps:</b> <b>Target Date:</b> <b>Actual Completion Date:</b> <b>Measure of Success:</b> <b>Notes/Updates:</b>				
Build on existing trainings and practice guidelines through the American Society of Addiction Medicine (ASAM) and CT State Medical Society's Addiction Medicine.	6 months from approval of recommendation		<ul style="list-style-type: none"> <li>• Development of common core competencies for safe opioid prescribing</li> </ul>	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

7\_6\_2016rev

B.

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

<b>Subcommittee Name:</b> Prevention, Screening and Early Intervention Subcommittee				
<b>Date of Initial Recommendation</b> (should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
<b>Detail Recommendation (2):</b> <u>Background:</u> Individuals lack education and awareness of the dangers of sharing medication, heroin addiction and the risks of overprescribing opioids. Additionally, the stigma associated with opioid misuse makes it difficult for the user and family members to seek help. <u>Recommendation:</u> Develop and implement a communication strategy that raises awareness of and provides education on the dangers of opioids and reduces stigma and other barriers for individuals and family members seeking help.				
Is this a ___ short-term (less than 6 months) or <input checked="" type="checkbox"/> long-term (more than 6 months) implementation initiative?				
<b>Recommended Lead and Partnering Agencies:</b> DMHAS, DPH, DCF, CPN, Wheeler Clinic/CT Clearinghouse, The Governor's Prevention Partnership, DAS/DOIT				
Implementation Plan				
Action Steps:	Target Date:	Actual Completion Date:	Measure of Success:	Notes/Updates:
Update the drugreect.org website to improve user interface and increase ease of access to information	6 months from approval of recommendation		<ul style="list-style-type: none"> <li>• # of website hits</li> <li>• Increase in calls to the toll free number</li> </ul>	
Support the increased use of evidence-based prevention programs	6 months from approval of recommendation		<ul style="list-style-type: none"> <li>• Increased number of individuals being trained</li> <li>• Reduction in use rates</li> </ul>	

Results of Council vote:

\_\_\_ Proceed with Recommendation    \_\_\_ Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

<b>Subcommittee Name:</b> Prevention, Screening and Early Intervention Subcommittee				
<b>Date of Initial Recommendation</b> (should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
<b>Detail Recommendation (3):</b> <u>Background:</u> The risk of accidental overdoses can be decreased by adopting the use of sealed patient packages for tablets and capsules; expanding mechanisms for proper disposal of unused medication and providing information on safe storage and disposal to be distributed to their clientele by pharmacists, funeral service providers, hospice providers, realtors and others. <u>Recommendation:</u> Provide education and resources regarding dispensing, safe storage and disposal of prescription medications.				
Is this a ___ short-term (less than 6 months) or <input checked="" type="checkbox"/> long-term (more than 6 months) implementation initiative?				
<b>Recommended Lead and Partnering Agencies:</b> DCP, DPH, DMHAS				
Implementation Plan				
Action Steps:	Target Date:	Actual Completion Date:	Measure of Success:	Notes/Updates:
<p>Explore: new ideas for disposing medication; safe storage disposal informational flyers being used across the state and country; and the benefits and burden of requiring blister packs for medication.</p> <p>Develop and implement distribution strategy for safe storage informational materials.</p>	TBD		<ul style="list-style-type: none"> <li>• Development of educational materials</li> <li>• Number of pharmacists, funeral service providers, hospice providers, realtors and others distributing educational materials</li> <li>• # of educational materials distributed</li> </ul>	

Results of Council vote:

\_\_\_ Proceed with Recommendation    \_\_\_ Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):



E.

## Subcommittee Recommendation to the Alcohol and Drug Policy Council

<b>Subcommittee Name:</b> Prevention, Screening and Early Intervention Subcommittee				
<b>Date of Initial Recommendation</b> (should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
<b>Detail Recommendation (5):</b>				
<u>Background:</u> PDMP data is used to help physicians clearly distinguish those patients who legitimately need opioids from those who may be seeking to misuse and abuse them. It is therefore a necessary tool in fighting the opioid epidemic. If physicians/health care providers can access this (PDMP data) through a patient's electronic medical record (EMR) at the point of care, it improves their decision-making, reduces the need for multiple sign-ins and improves workflow challenges.				
<u>Recommendation:</u> Support the integration of the Prescription Drug Monitoring Program (PDMP) with Electronic Medical Records (EMRs) to improve access to patient data and reduce prescription drug misuse and overdose.				
Is this a ___ short-term (less than 6 months) or <input checked="" type="checkbox"/> long-term (more than 6 months) implementation initiative?				
<b>Recommended Lead and Partnering Agencies:</b> DCP				
Implementation Plan				
Action Steps:	Target Date:	Actual Completion Date:	Measure of Success:	Notes/Updates:
Survey healthcare providers to assess the barriers to the CT Prescription Monitoring and Reporting System (CPMRS)	TBD		<ul style="list-style-type: none"> <li>• Increase in the # of system users</li> <li>• Generation &amp; distribution of data reports from the system</li> </ul>	
Review other state electronic health information sharing models – like EDIE in Washington state	TBD			
Conduct a pilot and work with CHA to expand it.	TBD		<ul style="list-style-type: none"> <li>• Documentation of integration issues</li> <li>• Expansion of pilot to other healthcare providers</li> </ul>	

Results of Council vote:

\_\_\_ Proceed with Recommendation    \_\_\_ Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

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FI

Subcommittee Recommendation to the Alcohol and Drug Policy Council

<b>Subcommittee Name:</b> Treatment and Recovery Support				
<b>Date of Initial Recommendation</b> (should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
<b>Detail Recommendation:</b> ___ short-term (less than 6 months) ___x___ long-term (more than 6 months)				
Enhance early identification of substance use problems by <u>requiring children’s Enhanced Care Clinics (ECC), for youth age 12-17 inclusive, at intake to services to:</u>				
i. Conduct urine toxicology screening for common substances of abuse/misuse including opioids. Screening protocols should be trauma-informed and follow best practice standards of care for the populations served.				
ii. Implement Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT) protocols according to national standards and/or as established by DCF, DMHAS and/or the UConn Health SBIRT Training Institute.				
This recommendation leverages the state’s existing SBIRT training infrastructure developed by DMHAS for adolescents and adults using state funding and federal funding from SAMHSA/CSAT. SBIRT Federal funding ends 8/30/16. Fiscal resources would include funding to support technical assistance and training activities to conduct SBIRT, maintenance of SBIRT Institute website for ECC trainings, data collection, and materials in both print and digital formats to support ongoing implementation.				
Recommended Lead and Partnering Agencies: Departments of Mental Health and Addiction Services (DMHAS), and Children and Families (DCF)				
<b>Implementation Plan</b>				
<b>Action Steps:</b>				
	<b>Target Date:</b>	<b>Actual Completion Date:</b>	<b>Measure of Success:</b>	<b>Notes/Updates:</b>
Amend existing contract with the UConn Health SBIRT Training Institute to provide technical assistance, training, and coaching to children’s ECC providers to conduct A-SBIRT. <u>Option:</u> Amend existing contract also to capture A-SBIRT screening data, and to provide de-identified aggregate screening data reports to lead agencies.	9/1/16		Contract Amended	SBIRT Training Institute already has a contract with DMHAS. To the extent that this recommendation changes the existing scope of service, an amendment may be necessary.

Results of Council vote:

\_\_\_ Proceed with Recommendation \_\_\_ Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

F2

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

Initiate training and technical assistance sessions for children's ECC provider staff to conduct A-SBIRT.	10/1/16		<ol style="list-style-type: none"> <li>1. # of Training/ TA Sessions Conducted.</li> <li>2. # ECC Providers Trained.</li> <li>3. # Clients Screened</li> <li>4. # Clients who receive BI</li> <li>5. # Clients Referred to Treatment</li> </ol>	This includes training to conduct A-SBIRT, and technical assistance and/or consultation sessions with children's ECC providers. Some clinics already may have been trained in A-SBIRT protocols through other DMHAS initiatives. Train-the-trainer sessions also may be held as part of this work.
Review and amend ECC contracts to include the urine toxicology screening requirement.	9/1/16		Contract Amended	This recommendation could apply to adult serving ECCs as well.
Provide consultation/technical assistance related to reimbursement options for urine toxicology screening services.	9/1/16		# Consultation/TA sessions held	As needed.
ECC adolescent clients whom screened positive to be evaluated ASAP by the DCF regional SATP program providers and receive immediate access to ACRA/ACC services and behavioral health services as needed.	9/1/16		# of adolescents admitted to SATP and ACRA/ACC services from child ECCs.	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

7\_6\_2016rev

G.

Subcommittee Recommendation to the Alcohol and Drug Policy Council

Subcommittee Name: Treatment & Recovery Support				
Date of Initial Recommendation(should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
Detail Recommendation: <u>Establish Rapid Access Centers</u> in each area of the state to engage and facilitate adult and adolescent entry into opioid addiction treatment and recovery support services. The centers would include a core staff comprised of professionals and peers:				
1) <i>professional call center staff</i> who				
a. identify a caller's eligibility for services (e.g., insurance, entitlements, special population status, etc.);				
b. confirm the real-time availability of services;				
c. make initial "warm" connections to a local provider and a peer support staff member, and				
d. ask permission to conduct a follow-up call within one week, 5 business days, to callers to ensure a connection to care and/or supports occurred;				
2) <i>peer support staff</i> who				
a. provide recovery coaching/support to callers (person-to-person) by building recovery capital and helping remove barriers to accessing care (sharing community resources to facilitate recovery, advocating for the individual and family, providing transportation, identifying child care, etc.,)				
b. helping callers navigate multiple service systems,				
c. Enrolling recoverees in enhanced Telephone Recovery Support) weekly follow-up phone calls to discuss the individual's recovery process.				
Is this a <u>  X  </u> short-term (less than 6 months) or <u>      </u> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: DMHAS, DCF				
<b>Implementation Plan</b>				
Actual				
Action Steps:	Target Date:	Completion Date:	Measure of Success:	Notes/Updates:
Explore existing infrastructure to support the development and implementation of this service (e.g., DMHAS crisis services; DCF EMPS; case management dollars; peer services; existing dollars through current 1-800 number).	10/31/16		Identification of existing resources to support this implementation.	
Implement rapid access services.	2/1/17		Connect to care rates at 7 days, 30 days, 60 days, 90 days, and one year	

Results of Council vote:

       Proceed with Recommendation           Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

Subcommittee Name: Treatment and Recovery Support				
Date of Initial Recommendation(should coincide with ADPC meeting date): <b>AUGUST 4, 2016</b>				
Detail Recommendation: Require the 13 DMHAS operated/funded Local Mental Health Authorities (LMHA) to provide Buprenorphine treatment on-site, including psychosocial and recovery support services. Psychosocial services require a comprehensive assessment to determine an individual's recovery plan, including which medication(s), level of care and recovery supports would be most appropriate. The assessment should include the individual's stage of readiness and receptivity to the recommendations.				
Is this a <u>  X  </u> short-term (less than 6 months) or <u>      </u> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: DMHAS				
<b>Implementation Plan</b>				
Actual				
Action Steps:	Target Date:	Completion Date:	Measure of Success:	Notes/Updates:
Develop and communicate new policy and requirement.	9/1/16		Written directive is circulated to all LMHA CEOs.	
Participating physicians receive required one day training for the DATA Waiver.	10/15/16		# of physicians that receive the DATA waiver from the LMHAS.	
Program assistance and mentorship to help develop high-quality programs that meet all compliance guidelines (e.g., DEA, Joint Commission, CMS, DPH, DMHAS) is given to LMHA physicians.	11/1/16		# of TA and mentoring sessions provided to LMHA physicians.	This would need to be an ongoing effort.
Provision of Buprenorphine on-site with associated psychosocial/recovery services begin.	12/1/16		- End of year 1 (12/1/17), at least 50% of physicians at each LMHA are prescribing Buprenorphine and each carry caseload of 20 or more clients; - End of year 2 (12/1/18), at least 50% of prescribers each carry caseload of at least 70 or more clients.	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):





K.1

Subcommittee Recommendation to the Alcohol and Drug Policy Council

Subcommittee Name: <b>Recovery and Health Management</b>				
Date of Initial Recommendation: <b>AUGUST 4, 2016</b>				
Detail Recommendation: Some of the language related to addiction and recovery may not reflect the "illness" of addiction or "hope for recovery" from the illness and may contribute to stigma. <b>This committee recommends that the ADPC adopt the "Recovery Language" document developed this committee to ensure that all members of the Council and members of the sub-committee are familiar with some alternatives to traditional terminology and can promote the use of such terminology.</b>				
Is this a <input checked="" type="checkbox"/> <b>short-term</b> (less than 6 months) or <input type="checkbox"/> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: <b>ADPC (including sub-committees)</b>				
<b>Implementation Plan</b>				
Action Steps: Target Date: Actual Completion Date: Measure of Success: Notes/Updates:				
Present "Recovery Language" document to ADPC	8/4/16	8/4/16	Approval by ADPC	
Post to website (if approved)	8/12/16	8/12/16	Posting date	DMHAS will post
ADPC members and sub-committee members will utilize suggested language as appropriate	ongoing			

Results of Council vote:

Proceed with Recommendation  Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

K2

## The Language of Recovery

*For more than two centuries, addicted and recovering people in America have been the object of language created by others. People experiencing severe and persistent alcohol and other drug problems have inherited a language not of their own making that has been ill suited to accurately portray their experience to others or to serve as a catalyst for personal change.*

(\* "The Rhetoric of Recovery Advocacy: An Essay on the Power of Language", William L. White)

The goal is to help individuals to get in and stay in recovery, however, the stigma and discrimination experienced by people who are addicted to alcohol and other drugs and/or who are recovering are profound. We are all exposed to the negative comments and beliefs expressed by people who don't understand. As recovery allies, it is important we use language that represents the hope and reality that people DO RECOVER from addiction. We must work together to establish a culture of recovery, to enable more people find their way to a recovery foothold and lifestyle. Language matters and sets the expectation for what can be accomplished.

### ***Language we use now***

#### **Addiction is a chronic relapsing illness**

Addiction is clearly a chronic illness. It does not go away once you have it. However, no comprehensive research has been conducted that demonstrates a high level of relapse. For *some* people, relapse is part of this illness. It is not helpful to establish the expectation that relapse will *always* occur during the recovery process. It is more helpful to teach that people can recover.

#### **Substance Abuse**

The term abuse is moralistic and refers to actions that are intentional and harmful to others. People with addiction are not abusers. They use substances because they have an illness.

#### **Relapse Prevention**

We set an expectation when we teach that recovery is about preventing relapse. Recovery is about becoming alive. How do we

### ***Language that promotes recovery***

#### **Addiction is a chronic illness**

#### **Recovery is possible**

#### **Recovery from addiction is a reality**

#### **More than 23 million Americans are in recovery from addiction**

#### **Substance addiction**

#### **Alcohol & drug related problems**

#### **Substance use disorder**

#### **Recovery Enhancement**

#### **Developing Recovery Capital**

convey this hope?

**Recovering Addict or Alcoholic**

The labels – ‘addict’ & ‘alcoholic’ - have a negative stereotype in our culture. They identify the person in recovery with their illness, deepening societal stigma.

**Self-help**

This says people with addiction problems are supposed to help themselves get better. This sets a false expectation: most people need the support of others to sustain the difficult work of recovery. Their strength is their ability to accept help.

**Consumer**

This defines a person in a power relationship that labels him/her as someone who receives treatment services, not as a human being who has chosen to enter a pathway of recovery.

**Medication Assisted Treatment Patient  
Methadone Client**

Some people believe that use of Medication Assisted Treatment defines a person as ‘not being in recovery’. However, some people use medication to assist them in their recovery process. The use of Methadone, Suboxone, Vivitrol and other medications may lead to stigma and labeling from others creating greater barriers to recovery.

**Person in recovery**

**Living proof**

**Survivor**

**Recovery support**

**Mutual Aid**

**Person in recovery**

**Person in Medication Assisted Recovery  
Person in Recovery**

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

<b>Subcommittee Name: Recovery and Health Management</b>				
Date of Initial Recommendation: <b>AUGUST 4, 2016</b>				
Detail Recommendation: In order to maximize naloxone prescriber involvement and buy-in, they need to have sufficient and accurate information about prescribing naloxone including related laws. <b>This committee recommends that the ADPC develop and adopt Fact Sheets for prescribers and supports the dissemination process of such Fact Sheets.</b>				
Is this a <input checked="" type="checkbox"/> short-term (less than 6 months) or <input type="checkbox"/> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: LEAD: Recovery and Health Management Sub-committee. Partners for distribution: ADPC, DPH, DCF, DMHAS, JDCSSD, DOC, FQHC, DCP, CT Association of Directors of Health, CT State Medical Society, CT Pharmacist Association				
Implementation Plan				
Action Steps:	Target Date:	Actual Completion Date:	Measure of Success:	Notes/Updates:
This sub-committee to develop Fact Sheets for prescribers to include information on liability	10/1/16		Approval by ADPC	
Coordinate with partner agencies (listed above) to disseminate the Fact Sheets	12/1/16		Number of partner agencies that disseminate the Fact Sheets	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

M.

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

<b>Subcommittee Name: Recovery and Health Management</b>				
Date of Initial Recommendation: <b>AUGUST 4, 2016</b>				
Detail Recommendation: In order to maximize naloxone utilization, the general public needs to have sufficient and accurate information about the effectiveness of naloxone, access to it and related laws. <b>This committee recommends that the ADPC adopt one or more of the Public Service Announcements that have been developed by DMHAS and other currently available educational materials for distribution and assists with the identification of necessary resources to do so.</b>				
Is this a <input checked="" type="checkbox"/> short-term (less than 6 months) or <input type="checkbox"/> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: LEAD: Recovery and Health Management Sub-committee. Partners for distribution: ADPC, DPH, DCF, DMHAS, JDCSSD, DOC, FQHC, DCP, CT Association of Directors of Health, CT State Medical Society, CT Pharmacist Association				
<b>Implementation Plan</b>				
Action Steps: Target Date: Actual Completion Date: Measure of Success: Notes/Updates:				
This sub-committee to present identified materials and costs related to mass production/utilization at next full ADPC meeting.	10/1/16		Approval by ADPC and acquisition of necessary funds	
Coordinate with partner agencies (listed above) to disseminate the Fact Sheets	12/1/16		Number of partner agencies that disseminate the Fact Sheets	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

N.

**Subcommittee Recommendation to the Alcohol and Drug Policy Council**

Subcommittee Name: <b>Recovery and Health Management</b>				
Date of Initial Recommendation: <b>AUGUST 4, 2016</b>				
Detail Recommendation: Young adults are using opioids recreationally and may become dependent on them. Opioid dependency may result in overdose. Naloxone must be available in locations where young people congregate, in particular middle schools, high schools and college settings. <b>This sub-committee recommends that effort be put forth to insure that school administrators and/or nurses and college public safety personnel have naloxone available to them and that the ADPC assists with obtaining funds, if necessary.</b>				
Is this a <input checked="" type="checkbox"/> short-term (less than 6 months) or <input type="checkbox"/> long-term (more than 6 months) implementation initiative?				
Recommended Lead and Partnering Agencies: Recovery and Health Management Sub-committee; Department of Education; Board of Regents for Higher Education; The Clinton Foundation; pharmaceutical companies				
<b>Implementation Plan</b>				
Action Steps: Target Date: Actual Completion Date: Measure of Success: Notes/Updates:				
This sub-committee to identify contacts at key State agencies and/or associations that would support accessing naloxone for educational institutions.	10/1/16		Identification of key contacts and approval of concept.	
This sub-committee to identify potential naloxone suppliers and associated costs.	10/1/16		Identification of at least 2 potential suppliers and associated costs, if any.	
This sub-committee will assist with the logistics of naloxone distribution to educational institutions, if naloxone is successfully obtained.	12/31/16		There is an increase in the # of educational institutions that have naloxone on-site.	

Results of Council vote:

Proceed with Recommendation     Do not Proceed with Recommendation

Co-Chair Response: \_\_\_\_\_

Other Notes (as applicable):

