

**CONNECTICUT ALCOHOL & DRUG
POLICY COUNCIL**

2008 Report
to
Governor M. Jodi Rell
and the
Connecticut General Assembly

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TABLE OF CONTENTS

	<u>Page</u>
Introduction	1
Policy Brief #1: Removing Barriers	3
Policy Brief #2: Workforce Development	7
Policy Brief #3: Information Coordination	10
Policy Brief #4: Reducing Underage Drinking	16
Policy Brief #5: Special Populations	21
a. Older Adults	21
b. Medication Assisted Treatment	24
c. Adolescent Substance Abuse Treatment	26
d. Family Based Treatment	28
Appendix I – ADPC Membership	30
Appendix II – ADPC Meeting Dates	32

Introduction

This report reflects the work of, and submits key public policy recommendations from, the Connecticut **Alcohol and Drug Policy Council (ADPC)** for calendar year 2007. The 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. The Council, co-chaired by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (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. This is consistent with the responsibility held by DMHAS as the federally-designated Single State Authority (SSA) for substance abuse, and administrator of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS). The Council submits this report annually to the Governor and the Connecticut General Assembly in accordance with Connecticut General Statutes Sec 17a-667.

In 2007, the ADPC focused on both infrastructure and target population areas. Following its initial calendar year 2007 meeting, which included agency heads (e.g., commissioners, chiefs, directors, etc.), cross agency infrastructure issues were identified and seen as priority needs to improve the delivery of services across the system. Included were clearly defining and initiating the **Removal of Barriers** to assisting individuals in recovery to regain their lives. A similar cross-agency issue involved **Information Coordination** that would allow data sharing by key State agencies and other service providers to enhance the quality of care. Finally, **Workforce Development**, an issue for many public and private non-profit service providers, received focused attention.

The ADPC also saw it necessary to continue to address target population-specific prevention and treatment issues identified last year, and that remain in the forefront of concern at national, regional and statewide levels. At the national level, **Reducing Underage Drinking** has received increased attention during the past year including a coordinated, nationwide effort through town hall meetings, on college campuses and through screening, brief intervention and referral to treatment (SBIRT) in primary healthcare sites.

Of grave concern, the issue of opioid use among teens (primarily whites from suburban areas) who begin misusing and abusing prescription opioids (e.g., hydrocodone, oxycodone), then quickly switch to less costly and more widely available heroin, continued to be a primary area of focus. Overdoses, emergency department visits, and opioid-related poisoning deaths have risen dramatically – some related to the misuse of methadone (rarely diverted from highly regulated methadone treatment programs but primarily obtained, illegally, from others who receive methadone prescribed by private physicians in pill form for pain management). In response, the ADPC paid focused attention to both **Adolescent Substance Abuse Treatment** and **Medication Assisted Treatment (MAT)** during 2007. One particular topic that was explored, particularly to support the need for effective services for adolescents, was Family Based Treatment.

Finally, ADPC members from the private sector raised the issue of age-specific services to older adults – a growing population with an increasing need for medication management and abuse

prevention and treatment. It was recognized that the leading cause of death for 45-60 year-olds has become “accidental poisoning” – a euphemism for drug and alcohol abuse-related mortality.

This report and the specific recommendations contained herein are respectfully submitted with a sense of both hope and urgency that these issues will receive full attention in order that the health of Connecticut’s substance-using citizens will be preserved, future years of tax-consumptive and self-destructive behaviors affecting families and their children will not be wasted, and that hundreds of lives will be saved.

Policy Brief #1: Removing Barriers

Based upon specific issues raised by agency heads, the charge of the “Removing Barriers” subgroup was to identify parole- and pardons-related barriers specifically to housing, and workforce development for ex-offenders.

The numbers of offenders being released from a period of incarceration every year has significant implications for community safety and public spending.

A comprehensive continuum of services is a key component in the successful re-integration of ex-offenders and individuals in recovery. The majority of offenders being released cannot successfully transition back into society without recovery and employment services, treatment and affordable housing. Without these support systems in place many offenders fail and most are rearrested within three years of release.

Housing is a significant challenge and barrier for ex-offenders and parolees who require independent living. Individuals with felony convictions are often denied by landlords the ability to use State or Federal vouchers or housing certificates based on their convictions.

For individuals with additional medical problems and mental health concerns, these issues multiply. Correctional managed healthcare planners collaborate with Department of Correction (DOC) re-entry staff to arrange for community healthcare upon release, however, these efforts are dependent upon available housing. There is insufficient, affordable housing for re-entering offenders; and homelessness is subsequently prevalent.

Procurement of personal identification and driver’s licenses was another barrier the offender encounters upon release.

Upon discharge from DOC to parole, transitional supervision or a treatment program, many offenders do not have basic photo identification (ID) readily available. Not having a credible, government-issued ID slows down the process of procuring employment, obtaining or renewing a driver’s license and access to support services such as State Administered General Assistance (SAGA) benefits. Critical to the latter is the ability to smoothly transition to a continuum of behavioral health (particularly substance abuse) services in the community. Offenders may also have other licensure issues, e.g., driver’s license suspension and employment licensure for trade workers.

Another barrier for many male offenders surrounds child support issues. Upon release from incarceration many offenders have significant debt owed to the State for dollars that have been paid to support children/family.

The child support orders can be modified upon admission to DOC. In many cases, these issues fall through the cracks and an offender may be discharged many years later, owing sums of money that have been as high as \$40,000. In many cases, this is a debt that will not get paid.

This has a significant impact on the expectations for this newly released offender to remain in the community, while working a minimum wage job and meeting all the responsibilities that come with life, many resulting from their own past behavior.

The following recommendations were drafted after three meetings that included representatives from the following public and private agencies: Board of Pardons & Paroles (BPP), Connecticut

Renaissance, Judicial Branch Court Support Services Division (CSSD), Catholic Charities, New Day Program, Legal Aid, Community Renewal Team (CRT), Correctional Managed Healthcare, The Connection and the Connecticut Community for Addiction Recovery (CCAR).

Problem:

Identify parole- and pardons-related barriers to employment, housing, and workforce development for ex-offenders and individuals in recovery.

Barriers discussed:

Housing, Personal Identification and Licensure, Child Support, Existing Barriers for Individuals with Drug and Other Convictions, and Provisional Pardons.

Housing

Housing is a significant challenge and barrier for ex-offenders and parolees who are seeking independent living through Section 8 housing. Individuals with felony convictions are often denied the ability to use vouchers and housing certificates by landlords based on their convictions. For individuals with serious medical and mental health issues, these challenges multiply. CMHC discharge planners collaborate with DOC re-entry staff to arrange community health care for these individuals; however these efforts are dependent on available housing.

Recommendations:

1. Face to face meetings with a network of current and potential landlords to negotiate and advocate housing for ex-offenders.
2. Reach out to, and form an alliance with, Partnership for Strong Communities to benefit from the in-roads they have made in the area of housing.
3. Expand funding for supportive housing for the offender population.
4. Mayors from the five major urban areas, together with heads of key State agencies, need to reach out to current and potential landlords to explore possible expansion of housing opportunities and standardization of transitioning ex-offenders off supervision and enabling them to maintain housing.
5. Explore the possibility of tax incentives for participants in providing housing to the target population.

Resources:

1. DMHAS, Department of Social Services (DSS), DOC, DRS, CSSD, CCAR, Partnership for Strong Communities and Legal Services.
2. Provide funding for supportive housing.
3. Pass legislature to extend time line for use of housing certificates from 120 days for use to fiscal year-end expiration dates.

Personal Identification and Licensure Issues

Upon discharge from DOC to parole or a program, many individuals do not have basic ID available. Not having an ID slows down the process of procuring employment, getting a driver's license and access to supportive services such as SAGA. Individuals may also have other licensure issues; drivers license suspension, employment licensure (trade workers, medical, etc.)

Recommendations:

1. Correctional counselors identify offenders with identification, licensure and other legal issues prior to offender release.
2. Traveling magistrates and Motor vehicle staff visit DOC facilities to address identification and other legal issues at correctional facilities for offenders before discharge.

Resources:

Judicial and Department of Motor Vehicles (DMV).

Child Support Issues

Many male inmates/parolees have to deal with significant debt owed to the State for dollars that have been paid to support children/family. The orders should be modified upon entrance to a DOC facility but, in many cases it falls through the cracks and the inmate ends up discharging many years later, owing sums of money that have been as high as \$40,000.00. In many cases, this is a debt that will not get paid. This has a significant impact on the expectations for this inmate to remain in the community, while working a minimum wage job and to meet all of the additional financial responsibilities that come with life.

Recommendations:

1. DSS, Legal Services, the Office of the Chief Public Defender and Judicial Branch form a committee to explore and streamline practices to deal with open motor vehicle cases and the modification of child support orders.

Resources:

DSS, Legal Services, the Office of the Chief Public Defender and Judicial Branch.

Existing barriers for individuals with histories of drug and other convictions

Recommendations:

1. While no specific laws have been identified as barriers, former offenders in recovery or otherwise can, as a first step, apply for a provisional pardon hoping that if a legal, or more commonly an employer initiated, barrier exists -- to eradicate that barrier.
2. Conduct outreach and possibly institute State incentives for hiring former offenders -- in recovery or otherwise.

Resources:

BOPP, Chambers of Commerce.

Review possibility of provisional pardons

Recommendations:

1. A committee should be formed to identify the best way to implement the use of the provisional pardon -- a valuable tool in removing these barriers and in educating the employment/business community on its implementation.
2. Establish and implement advocacy for utilization of the provisional pardon in an effort to develop positive relationships for applicants that currently have little, limited or anti-social associations.
3. Develop an outreach effort through community-based organizations such as Chambers of Commerce, Rotary Clubs, similar existing advocacy groups and the Department of Labor (DOL).
4. Explore the value of Federal bonding programming and its realistic effectiveness for employability of ex-offenders.
5. Establish a fee waiver for indigent applicants at agencies such as Public Safety and Judicial.

Resources:

Community based organizations, Chambers of Commerce, Rotary Clubs, other existing advocacy groups and DOL.

Subcommittee Membership

Chairman Robert Farr, Board of Pardons & Parole
Rasa Pakalnis, Parole & Community Services Manager, Board of Pardons & Paroles
Fred Watton, Parole Officer, Board of Pardons & Paroles
Tony Corso, CT Renaissance, Inc.
Cindy Theran, CSSD
Chris Pawlik, Catholic Charities
Lou Paturzo, New Day Program
Sarah Parker-McKernan, Legal Aid
Chris McCluskey, CRT
Fran Emerzian, CMHC
Cindy Couture, UCHC-CMM
Linda Urbano, The Connection
Cheryle Pacapelli, CCAR

Policy Brief #2: Workforce Development

Recommendations:

Recommendation #1

Leverage existing mental health and substance abuse workforce development initiatives established through the Mental Health Transformation - State Incentive Grant (MHT-SIG), and the national “Action Plan for Behavioral Health Workforce Development” to encompass the broader behavioral health field, including addiction services across the lifespan.

The proposed recommendation will build upon several promising strategies meant to address a multitude of needs relating to Connecticut’s behavioral health workforce. Once an inventory and review of the various initiatives is complete, strategies should be developed to broaden representation to include all pertinent State agencies and sectors of the behavioral health field in the planning and implementation of workforce strategies. The Connecticut Workforce Collaborative, which is being established to coordinate planning and implementation of workforce development, should be designed as a Behavioral Health Collaborative that encompasses workforce issues related to mental illness, addictions, and co-occurring disorders among both adolescents and adults.

As the existing experienced behavioral health workforce is reduced due to a number of factors including: retirement, low compensation, minimal supervision, high burnout rates, and lack of career advancement, it has become a crucial component of any workforce development strategy to focus on recruitment. It is essential that a statewide public relations marketing campaign highlighting careers in the behavioral health field be included in the development of these workforce strategies.

Recommended Actions

1. Expand the concept of a Workforce Collaborative to include the field of addiction services.
2. Fund a dedicated staff position to manage and coordinate addiction services workforce initiatives such as: 1) **leveraging** existing resources; 2) **linking** Connecticut’s addiction services and higher education systems to develop a culturally diverse and appropriately trained provider network; 3) **assessing** addiction services workforce development needs including the review of all existing data sources; 4) **instituting** a biannual strategic planning process; 5) **implementing** interventions such as trainings, coaching, and mentoring to strengthen the workforce; 6) **promoting** cultural diversity and the employment of persons in recovery in the addiction services workforce; 7) **disseminating** and **coordinating** best practices across the addictions services system; 8) **advising** Connecticut executive, legislative, and judicial branches on workforce issues and policy; and 9) **applying** for other potential sources of funding.

3. As the existing experienced behavioral health workforce is reduced due to a number of factors including: retirement, low compensation, minimal supervision, high burnout rates, and lack of career advancement, it has become a crucial component of any workforce development strategy to focus on recruitment. It is essential that a statewide public relations marketing campaign highlighting careers in the behavioral health field be included in the development of these workforce strategies.

Recommendation #2

Explore current initiatives within Connecticut and nationally that address the clinical supervision needs of the behavioral health workforce, including addiction services.

The present reality in the behavioral health field is that clinical supervisors maintain reduced caseloads which increase on a regular basis due to staff vacancies. This often results in the provision of limited clinical supervision for the staff that need it the most. The negative effect of this scenario becomes compounded as it has been indicated that staff note a lack of clinical supervision as a reason for their departure from a particular organization. A focus should also be placed on the provision of funding to increase the potential for clinical supervisors to participate in trainings which will ultimately enhance their own skill sets. Clinical supervisors are often unable to attend such trainings due to the issues relating to staff vacancies mentioned previously.

Collaboration between State agency purchasers of service and private non-profit providers of services is essential to develop and implement new strategies that support the provision of supervision involving the provision of care. One such initiative to explore in concept is the Connecticut Recovery Purchasing Project's outpatient services supervision pilot in Bridgeport. Provided this pilot develops outcomes to evaluate, this model could provide a template for expanding collaborative state agency funding beyond outpatient services.

Recommendation #3

Examine current staff retention and career advancement barriers and challenges in the behavioral health field, including addiction services, and develop or build upon existing strategies to effectively address them.

Lack of real or perceived career advancement and professional growth opportunities is a key factor for staff turnover. Salary is generally only one of many factors that staff cite for leaving a position. Other factors that impact turnover include: the availability of clinical supervision, non-financial rewards and recognition, clarity regarding functional job duties and the nature of the work environment, including a supportive team approach to delivering care. Explicit strategies that address these key factors should be developed and implemented to reduce staff turnover and improve the quality of workforce roles in the behavioral health system.

One such example to explore is in the area of student loan forgiveness. To potentially increase both recruitment and retention in the behavioral health field, individuals would receive a graduated incentive by means of loan compensation in exchange for employment commitment. For example, a new employee commits to a minimum three year period of employment. The

educational loan agent will receive a direct payment at the end of each year that increases over the three year period (e.g. first year = \$10,000, second year = \$12,500, and third year = \$15,000). This potential strategy could also be structured to include a second phase involving incentives for graduate level education once employed.

Additional strategies to explore and consider: (a) other financial incentives such as tuition assistance and training stipends; (b) new, more accessible, and/or more relevant training programs that promote career entry, mobility, advancement, and leadership development including supervision; (c) collaborations between higher education and the public behavioral health system on curriculum reform, recruitment, and job placement; (d) development of “realistic job previews” (e.g. job shadowing, video clips of staff performing their duties, etc.) that foster retention of employees hired; (e) provider organizational trainings in the area of retention and recruitment; and (f) a Web portal for employers to post available positions and for job seekers to post resumes.

Subcommittee Membership

Stephen Grant, Judicial Branch-CSSD
Alfred Bidorini, DMHAS
Michael Peloso, Judicial Branch-CSSD
Dan Bannish, DOC
Deborah Henault, DOC
Rick Persky, DMHAS
Jeff Walter, Rushford Center
Barbara Bugella, DMHAS
Michael Hoge, Yale
Leanne Dillian, CPAS
Melissa Sienna, DCF

Policy Brief #3: Information Coordination

Background:

Lack of information coordination across state agencies regarding addiction and support services has a profound influence on both the effectiveness and efficiency of these services. It can hamper efforts at assuring continued care from prison to community, hinder a sustained recovery once in the community, and ultimately costs the state in poor outcomes such as re-involvement with the criminal justice system. The sharing of data across state-funded systems is essential for evaluation and performance measurement, cost containment, and policy and program development. Yet, while persons often overlap various services and programs administered or funded by State agencies, there are few examples of successful and comprehensive data sharing projects.

Most often the concern that inhibits sharing of information is confidentiality requirements. This includes State statutes, Federal laws and agency regulations. Many of these limitations on disclosure are in the interest of the person receiving services as in the case of substance abuse treatment. While posing a certain level of difficulty, such requirements have not been an absolute barrier. There are several examples of successful data sharing within Connecticut such as the gun registry program that overcame privacy restricts while meeting the objective of gun safety. Other attempts at data sharing have been more limited requiring statutory changes or strict adherence to privacy requirements such as informed consent and release of information.

Over the past decade, advances in information technology have removed, for the most part, the mechanical impediments to sharing data. Integration of large data systems does pose challenges but more so due to the complexities of business functions than hardware and software needs. While all would agree that a real-time, integrated system would be the ideal, such systems very often have expensive price tags, take years to implement, and drain limited staff resources.

Beyond the confidentiality and technical challenges lies the resources required post implementation to adequately maintain a fully integrated system. Staffing in the form of technicians, data and content analysts, and program coordinators are essential to system maintenance, to evaluate and recommend program and policy initiatives, and to coordinate service delivery on the ground. In the end, information coordination in the form of data sharing is a tool and, as with any tool, must be guided with expert hands.

Most recently, there have been several major ongoing efforts to bridge data hosted within disparate State systems. One example is the Connecticut Health Information Network or CHIN which received funding in the 2007 state legislative session and is working with several state agencies to share health data. Another, the Offender Based Tracking System (OBTS) provides a single repository of offender data that integrates data from 15 different systems (with common data or format) in eight different criminal justice agencies. Other initiatives include the Mental Health Transformation – State Incentive Grant and the Medicaid Infrastructure Grant both which have a data integration component.

Also, there are a number of existing collaborative efforts such as the Jail Diversion Program, Connecticut Offender Re-entry Program and others that are sharing criminal justice and behavioral information on a client level. These serve as good models from which to expand efforts and enhance the timely sharing of information.

The following recommendations were drafted after two meetings which included representatives of the Departments of: Correction, Children and Families, Information Technology, and Mental Health and Addiction Services, along the Judicial Branch's Court Support Services Division. Also represented on the Information Coordination Committee was a private nonprofit community based agency serving criminal offenders. While the following recommendations address well founded concerns over data sharing and coordination, they do reflect the limited time (two, three-hour meetings) devoted to discussing issues and suggesting realistic solutions.

Recommendation #1:

Implement a data-sharing agreement among Department of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), Judicial Branch's Court Support Services (CSSD), Department of Correction (DOC), Board of Pardons and Paroles (BOPP), Division of Criminal Justice (CSA-DCJ) and the Department of Motor Vehicles (DMV) to enhance treatment planning and public safety

This recommendation addresses a longstanding interest in streamlining data sharing across the criminal justice sector (Judicial Branch, DOC, BOPP, DCJ, DMV - for Per Se DWI violators) and the children's (DCF) and adult (DMHAS) behavioral health system. While there are initiatives in place that allow information sharing, these are mostly paper-based, cumbersome, and often not timely. Also, the recommendation begins to address some of the barriers identified through the Criminal Justice Policy Advisory Commission's (CJPAC) Behavioral Health Subcommittee including:

- Difficulty in sharing of information among DMHAS, DOC, CSSD due to legal issues;
- Limit ability to evaluate the impact of mental health and substance abuse programs in reducing recidivism given the agencies' current infrastructure, technical expertise and access to data analysis resources;
- Insufficient understanding of defendants with serious psychiatric disorders and co-occurring serious psychiatric disorders and substance use disorders by judicial and law enforcement personnel;
- Limitations in maintaining continuity of care for sentenced inmates reentering community;
- Less than full capacity to ensure ready access to services and sustained care and recovery support services (e.g. housing, transportation, basic needs) upon reentry; and
- Lack of standardized Behavioral Health/Medical Release of Information Form.

The basis for the following recommendation fully recognizes what currently exists in pre-release/re-entry planning and jail diversion programs as it applies to data sharing. This recommendation is meant to extend these initiatives, expanding the scope and intensity.

1a.) To coordinate the sharing of behavioral health data between DMHAS and criminal justice agencies for those offenders released to the community through probation, parole, transitional supervision, halfway house, or pre-trial programs.

The **first phase** of this recommendation achieves the desired objective of sharing clinical-level information with various criminal justice agencies without major retooling of existing systems. As envisioned, independent information systems would reside as they do now in each agency and pertinent data elements would be shared electronically.

This phase would include only those **offenders released under community supervision** including:

- DOC Community Release → transitional supervision, halfway house
- Judicial Branch (CSSD) → bail or pre-trial and probation supervision (both sentence to probation and split sentenced)

Release of information requests specific to DMHAS behavioral (mental health and/or substance abuse) health services would be obtained at time of discharge planning for (disposition to) community release. Releases of behavioral health information would be obtained and in compliance with federal and state laws/statutes. The release would specify the criminal justice agency(ies) and service providers under contract to the criminal justice agency(ies). Notification of a signed release would be sent to DMHAS with verification by a DMHAS staff person.

While the best possible solution would be to develop an integrated data system, this first phase would focus on more timely access to client information. Currently, on a very small scale, behavioral health treatment history is obtained by state criminal justice agencies by paper (faxed copies) which is not timely or efficient. In order to expedite and streamline that process, requested information, once validated for release, would be extracted from the DMHAS behavioral health database and electronically transferred (via secure transport, e.g., Tumbleweed) to the appropriate criminal justice staff.

Benefits of such information sharing include:

- Improved treatment planning - pre-release from DOC;
- Enhanced coordination of care in the community;
- Increased public safety ;
- Reduced duplication of effort; and
- Cost effective, e.g., reduction in recidivism rates.

Costs associated with the first phase would be additional staff for managing behavioral health data requests including validation of releases (including client matching), authorizing release of records to requesting agency, and project coordination.

It is also recommended that release forms be automated including an electronic signature process. Use of e-signature based forms:

- Provide for secured tamper-proof storage.
- Adhere to Health Insurance Portability Accountability Act (HIPAA) and other privacy regulations governing use of electronic documents and signatures.
- Integrates seamlessly into existing information systems environment.
- Eliminates paper completely from the process.
- Improves Customer Service - Customers can walk away or be emailed electronically signed original eMedical Form.

Several different e-signature software applications exist and depending on the functional requirements, cost will vary accordingly.

1b.) Coordinate the sharing of behavioral health data between DMHAS, DCF, the University of Connecticut Health Centers, and DOC for incarcerated (pre-trial and sentenced) offenders.

The exchange of behavioral health information for incarcerated persons admitted to the Department of Correction requires more dialogue between state agencies (DMHAS, DCF, DOC and the University Of CT Health Center – Correctional Managed Health Care) as to the extent of the shared information (all admitted to the DOC, or selected persons) and purpose. Primary to this discussion is the release of information and consent form or some other process, if allowable, such as a qualified service agreement (QSA). As such, a study group should be formed to explore the specifics of data sharing between state agencies with the aim of suggesting final recommendations to the Alcohol and Drug Policy Council regarding incarcerated persons.

Recommendation #2:

Develop an integrated data system across State agencies that provides critical information for the purpose of day-to-day operational needs and longer range planning, policy making and program development.

The Information Coordination Committee, while considering Recommendation 1a a good first step, strongly suggests that a more integrated approach be developed over time. This would require a systems development process which clearly defines all business and information technology requirements. It is recognized that there are currently a number of data sharing and/or integration projects being considered or underway (CHIN, OBTS, MSIG, etc.). Any efforts at integrating criminal justice and behavioral data systems should, to the extent possible, complement these initiatives. Critical to the success of this recommendation is a “business sponsor” that can bring all the pertinent parties to the table.

Depending upon the system design (i.e., central repository or unified information system), State agencies may or may not be required to retool their existing systems. Using Connecticut's gun permit (C.G.S. 17a-500) program (central repository) as a model, each agency could retain its independent information system, sharing person identifiers (name, Social Security number, date of birth, gender) and other agreed-to data items. Through probabilistic (i.e., matching on key person identifying data elements) data linking, person specific information would be available to collaborating State agencies. Depending upon the need to know, either disaggregated (identifiable) client level information would be available or -- for planning, policy and program development -- limited de-identified or aggregated data. Inconsistencies in data definitions would still exist in this model, since it does not require State agencies to confirm to any standard definitions, as would be the case under a unified information system.

Cost considerations include:

- Project management including system design (business requirements), system implementation;
- Development of the uniform application including linking of records;
- Ongoing system maintenance; and
- Other staff resources including system maintenance.

Under the first phase it is recommended that a feasibility study be conducted. Such a study would analyze the current situation describing how the current system works and identify known problems. The following steps are part of this stage¹:

- Develop a Business Activity Model. Business events and business rules would also be investigated as an input to the specification of the new automated system.
- Investigate and define requirements. The objective of this step is to identify the problems associated with the current environment that are to be resolved by the new system. It also aims to identify the additional services to be provided by the new system and users of the new system.
- Investigate current processing. It investigates the information flow associated with the services currently provided, and describes them. At this point, a data flow model, representing the current services with all their deficiencies, is developed. No attempt is made to incorporate required improvements.
- Investigate current data. This step is to identify and describe the structure of the system data.
- Derive logical view of current services. The objective of this step is to develop a logical view of the current system that can be used to understand problems with the current system.

¹ W. Stevens, G. Myers, L. Constantine, "Structured Design", IBM Systems Journal, 13 (2), 115-139, 1974.

Once the feasibility study has been completed, and based upon findings from that study, stages of system development can move forward including: 1) logical system specification, 2) requirements specification, 3) logical process and design, and 4) physical design. The cost of a feasibility study would be determined by the desired scope of the data integration.

Obviously the timeline for this recommendation extends into the future and is contingent upon adequate support in funding and other resources. Development of either a central repository or unified system should be “scalable” so that it can meet future needs.

Recommendation #3:

Better coordinate and communicate service delivery, planning and policy initiatives across State agencies and the Judicial Branch.

This recommendation addresses concerns regarding duplicative efforts across committees, commissions and other statutorily defined or ad hoc planning, implementation or policy bodies. In order to maximize State resources, an inventory of existing bodies (include less formal committees) and their purpose should be housed in a central database. This would allow for easier review of existing initiatives/efforts which State agencies and the public could access. Additionally, the Information Coordination Committee suggests that an inventory be conducted of existing and proposed data systems and that information also be housed in a central location.

It is recommended that a state website be developed as a clearinghouse (one stop information shopping) for State activities including committees, task forces, councils and other study or advisory bodies of interest to State agencies and the general public. The clearinghouse would contain a complete list of all such governmental bodies with a key word search capability. Information housed (or linked to source agencies) would include pertinent information of the body such as: members, charge or function, meeting schedule, documents produced, etc. Functionally, there may be separate access capability for State employees (e.g., could view draft documents) and the general public. This concept is also suggested for reporting of aggregate data. Having a virtual clearinghouse will greatly reduce the cumbersome navigating of individual State agency websites, enhancing communication across State agencies and provide a vehicle for data sharing (aggregate, de-identified reports).

Subcommittee Membership

Loel Meckel, DMHAS, Forensic Division

Mark Thomas, DMHAS IT Director

Steve Casey, DOIT

Melissa Sienna, UConn Health Center, representing DCF (Peter Panzarella)

Bob Cosgrove, DOC, Director IT

Celia Siefert, Judicial Branch, CSSD, IT

Teresa Saiya, Community Solutions Inc., SA Provider (serving CJ population)

Deb Henault, DOC

Mike Peloso, JB-CSSD

Al Bidorini, DMHAS

Policy Brief #4: Reducing Underage Drinking

Problem Statement

Underage use of alcohol continues to be a seemingly intractable problem in Connecticut and across the nation. Underage drinking has been a challenging issue both on and off college campuses while remaining an unfortunate, informal rite of passage deeply entrenched in the American culture. More than one-half of American adults (higher in Connecticut) use alcohol with most doing so responsibly. Yet, due in part to their own successful maturation despite their experiencing widespread underage drinking, they have avoided addressing the problem of underage drinking unequivocally and head-on. As a result, attitudes of acceptance and ambivalence prevail, tacitly enabling the continued use of alcohol by young people (under age 21) who engage in high rates of initiation, excessive use and abuse of alcohol -- with all the associated high-risk behaviors and negative consequences. Only when a local tragedy occurs -- such as the death of a 'promising' young student -- do communities pause to pay attention to this issue, let alone act to facilitate change. Unfortunately, such opportunities to create social change have often been short-lived, and this insidious problem returns to its common place -- in the background of the societal action agenda.

As noted in the January 2007 ADPC Report, Connecticut residents aged 12 and above use alcohol at a high rate (59% or 1.6 million people using in the past 30 days) that, while declining slightly in recent years, continues to be both above the national average and higher than the use rate of any other substance of abuse. Use rates for Connecticut 8th graders (24% using in the past 30 days) are also higher than the national average, with the age of initial use as early as eight years old and averaging 11 years old. The 18-to-25 year-old population has the highest rate (69%) of use of any age group in the state. Data also indicate high rates of binge drinking, especially among young adults (46%). More than one-in-five (22.5%) 12-20 years olds (underage) in Connecticut report binge drinking in the past month, placing Connecticut among the highest 15 state rates in the nation.²

Connecticut's underage alcohol use is linked with serious health consequences including injuries, motor vehicle accidents, violence, unsafe sex and suicide. Consequence data indicate a high percentage of driving under the influence (DUI) of alcohol (30% of college students). Nearly one-half (45.2%) of all motor vehicle incidents resulting in fatalities were alcohol-related, also placing Connecticut among the "fatal 15" states. In Connecticut, underage drinking costs the state an estimated \$600 million annually. According to 2004 data, men drink in a 30-day period more often than women (69.9% and 61.1% respectively); however, men (22.4%) are significantly more likely to binge drink than women (8%). Whites tend to drink more often, have the highest rates of heavy drinking, and include the highest percentage of binge drinkers, compared to blacks and Hispanics.

Underage drinking is accentuated on college campuses where it has been largely accepted and anticipated by society for decades. Youth enter these environments during their late-teen years, experiencing a sudden and often dramatic increase in freedom -- with most living away from their families for the first time. They are exposed primarily to large numbers of young people

² Source: National Survey of Drug Use in Households (NSDUH) 2005

living close together without the parental constraints of home. Binge drinking, risk taking, drug experimentation and sexual contact are more pronounced on college campuses where the goal of preventing underage drinking presents unique and daunting challenges. Alcohol is a primary factor in the deaths of an estimated 1,400 college students per year in the United States.

Much has been learned in recent years about underage drinking, associated negative consequences, and prevention and early intervention strategies (including harm reduction); and – of particular interest to the ADPC – effective, evidence-based public policies. In concert with the State Leadership Team, the ADPC continues to strongly urge the adoption of public laws, State agency policies and practices, and continued, comprehensive, environmental strategies across all branches of State government – aimed to further reduce underage drinking in Connecticut.

Background

The case for reducing underage drinking is compelling and grounded in a substantial body of research. Scientific research in recent years has made remarkable advances toward understanding how the brain develops, how early exposure to alcohol results in higher incidence of binge drinking and related unhealthy choices, and how these lead to later alcohol dependence and a wide range of adverse health consequences. Social research has led to a deeper understanding of the epidemiology of alcohol use, social factors that influence initiation and continued use, economic and cultural factors that encourage underage drinking, and effective prevention strategies. Finally, international public policy research has identified both effective and ineffective approaches that inform both policy and practice.

Research has clearly established that the human brain continues to develop through adolescence (up to age 21) into early adulthood (approximately age 24). The areas of the brain that develop the most during adolescence include the frontal lobes, as they benefit from learned experience. This section of the brain is responsible for executive functions such as planning, anticipating consequences of choices, controlling impulses and the like. Alcohol has been shown to inhibit frontal lobe development in adolescents and to diminish frontal lobe functioning in adults who drink heavily. Early exposure to alcohol is associated with diminished cognitive functioning (e.g., memory) and increased likelihood of future alcohol abuse and dependence. Retrospective studies have found that the likelihood of future alcohol-related problems becomes virtually nil when individuals delay initiation to alcohol until at least age 21 -- lending empirical support for laws and public policies that prohibit and dissuade underage drinking.

Efforts to reduce underage drinking face considerable socio-cultural and economic challenges. As mentioned earlier in this brief, underage drinking has been tacitly accepted in the American culture for decades. It is one of the most frequently used behaviors of experimentation by adolescents to explore what is considered ‘adult-like’ and has largely remained an accepted practice among adolescents themselves. Accessibility remains high as older siblings and friends are able to obtain alcoholic beverages for younger, novice drinkers – and more than one-half of households have beer, wine or liquor within reach of adolescents. Attitudes toward drinking are influenced by many factors, including active promotion through the multi-billion dollar alcoholic beverage marketing industry, that has increasingly returned to the television, movie and video game markets through direct advertising and product placement strategies. Flavored liquors have been added to the market in order to attract new, and younger, drinkers.

Recommendations for Further Reducing Underage Drinking in Connecticut

The *January 2007 Alcohol and Drug Policy Council Report to the Governor and General Assembly* identified underage drinking as one of its top priorities and formulated policy and practice recommendations which were endorsed by many of the state's experts, advocates and practitioners in the field of substance abuse. Underage drinking was a top priority because of the seriousness of the problem in the state. As the state's primary coordinating body for reducing underage drinking, the Connecticut Leadership Team with its goal of improving, consolidating, promoting and strengthening statewide efforts to reduce underage drinking was charged with implementing the following recommendations.

- Build on current leadership of the Governor's Office, the ADPC and the Legislature to implement evidenced-based policies and programs.
- Increase the price of alcoholic beverages sold in Connecticut in order to further reduce underage drinking – by passing legislation that raises beer and liquor excise taxes to a point that will significantly affect accessibility of alcoholic beverages by minors.
- Use dollars raised from the increased alcohol excise tax to fund substance use prevention, intervention and treatment programs.
- Provide support to professionals and advocates in communities and social and health care agencies with appropriate training and management skills.
- Encourage legislative leaders to educate other legislators about underage drinking, and the importance of supporting evidence-based policies and practices.
- Review Connecticut's alcohol control regulations, taxes and pricing currently in place, and data available on principal alcoholic beverage use abused by young people.
- Engage the media and support marketing campaigns to raise public awareness about the problem and associated consequences of underage drinking.

Resources Currently in Place to Address the Problem

Legislative Action or Interventions currently in place:

The following environmental policy level interventions or legislative actions have demonstrated effectiveness:

- Social Host Laws - laws holding homeowners, parents and others accountable for providing alcohol to minors have reduced binge drinking and drinking-and-driving among all drinkers. A social host law was passed in Connecticut in 2006.
- Registration and Notification of Beer Keg Purchases – this practice deters 'keg parties' where underage self-service and binge drinking are common; and forewarns local law enforcement of potential incidents.
- Limiting Alcohol Promotion – at sports and community events, especially on public property, reduces opportunities for youth drinking.

- Enacting Zero-Tolerance Laws - all States have laws making it illegal for minors (under 21) to drive after any drinking. The first ‘zero-tolerance’ States saw a 21% reduction in single-vehicle, night-time, fatal crashes involving drivers under age 21.
- Increasing Enforcement of Existing Laws - despite their demonstrated benefits, legal drinking age, social host, zero-tolerance and similar laws generally have not been vigorously enforced. Resources must be made available for enforcing these laws.
- Promoting Responsible Beverage Service Training Program – this approach holds merchants accountable for serving to intoxicated patrons and minors – reducing drinking-while-intoxicated, accidents and acts of violence.
- Restricting time, place and density of alcohol outlets – research suggests that underage use is reduced by restricting the physical availability of alcohol.
- Random Breath Testing – motorists are stopped at random and required to take a preliminary breath test. Because this is a highly visible test, it can have a sustained effect on reducing drinking-and-driving and related crashes, injuries and deaths.
- Graduated License Privileges for Young Drivers – limiting times and other conditions of driving during the first few years, when teens are at highest risk for accidents.

Recommended Legislative Action: Raise the Price of Alcohol

A substantial body of research has clearly demonstrated that higher prices (accomplished primarily by increasing excise taxes on beer) for alcoholic beverages are associated with lower levels of alcohol consumption and alcohol related problems, especially among young people. This legislative action has been strongly supported by the ADPC membership and the State Leadership Team on Underage Drinking.

Progress on State Agency Policy and Initiatives:

During 2007, the CT Leadership Team to Reduce Underage Drinking expanded its membership to include other state partners and continues to revisit its purpose and connection to the ADPC. The inventory of underage drinking prevention resources and programs will be revised and only evidence-based programs will be promoted. In addition to helping to facilitate passage of legislation that addresses alcohol pricing as recommended by the ADPC, the Leadership Team will develop a work plan that builds awareness and coordinates existing state and local efforts. Such efforts will continue to include:

- The implementation of policies, programs and practices that reduce underage drinking and collect data to assess the effect of these efforts via the DMHAS Strategic Prevention Framework State Incentive Grant (SPF SIG) initiative;
- The continuation of compliance checks of establishments that sell alcohol in order to reduce the number that sell to underage youth;
- Following up with statewide College Presidents of the Connecticut Healthy Campus Initiative and local Town Hall Meetings to engage and mobilize others around this issue, and;

- Soliciting funding from foundations and Join Together to sustain efforts and expand the charge of the state plan to include public and private sectors such as insurance companies, the Connecticut Hospital Association, the State Medical Society, the Connecticut Association of Addiction Medicine, and the Connecticut Psychiatric Association.

Resources:

Below are the resources and efforts that will be built upon to address the ADPC recommendations:

- Statewide Healthy Campus Initiative - a collaborative of over 30 colleges and universities, DMHAS, the Dept. of Higher Education and the Governor's Prevention Partnership, developed a statewide action plan to foster campus-community cultures that reduce high-risk alcohol use, and address consequences of high-risk behavior.
- Strategic Prevention Framework - State Incentive Grant (SPF-SIG) – this federally funded project is a comprehensive approach to combat underage drinking. Twenty-eight coalitions are funded across Connecticut to establish or enhance comprehensive community strategies that reduce underage drinking.
- Support for Comprehensive Approach to Combating Underage Drinking Program - federally funded, and managed by OPM, supports efforts of the Connecticut Coalition to Stop Underage Drinking (CCSUD) to support local agencies in their comprehensive approach to combat underage drinking.
- Departments of Transportation and Public Safety - conduct the alcohol-impaired driver /DWI compliance check program to reduce alcohol-related motor vehicle crashes.
- Department of Consumer Protection, Liquor Control Division - conducts inspections of retail outlets, retailer education, compliance checks, investigation of non-compliance, and tracking of state and local enforcement of alcohol laws.
- Drug Free Communities Support Program – using Federal funds, supports 18 Connecticut grantees to reduce substance abuse among youth, and strengthen collaboration among communities, private nonprofit agencies, and Federal, State and local governments.

Subcommittee Membership

Rep. David Scribner, State Representative
 Peter Rockholz, DMHAS
 Dianne Harnad, DMHAS
 J. James Boice, Dept. of Transportation
 Scott Newgass, Dept. of Education
 Val LaMotte, Office of Policy & Management
 John Suchy, Dept. of Consumer Protection
 Walter Bernstein, Ed.D., Western CT State University
 Lt. Peter Wack, Dept. of Public Safety
 Julia O'Leary, Office of Court Support Services
 Susan Naide, Office of the Chief State's Attorney

Policy Brief #5: Special Populations

5a. Special Populations - Older Adults

Background:

Persons aged 65 and older constitute the fastest growing segment of the American population (and that of Connecticut). Although the incidence and prevalence of alcoholism and drug abuse and addiction in older people is debated, most agree that its diagnosis and treatment are going to become increasingly important as our population ages. Alcoholism and other addictions in older people are often neglected by families, doctors and the public because alcohol problems among older persons are often mistaken for other conditions associated with the aging process. Alcohol abuse in this population may go undiagnosed and untreated or be treated inappropriately.

The effects of alcohol vary with age. Slower reaction times, problems with seeing and hearing, and lower tolerance put older people at higher risk for falls, car crashes and other types of injuries resulting from drinking. Some people increase consumption later in life often leading to late onset alcoholism. Older people also tend to take more medications than younger people. Mixing alcohol with over the counter or prescription medications can be dangerous or even fatal. More than 150 medications interact harmfully with alcohol. Additionally, alcohol and other substance abuse can make many medical conditions common in older people more serious.

Late onset alcoholism or chemical dependency may be due to situational factors such as retirement, lower income, failing health, loneliness, or death of friends or loved ones. New studies reveal that the fastest growing demographic of drug abusers is white, middle-aged and well-to-do. A 2005 study of drug abuse and health found illicit drug use among Americans in their 50's is up 63% since 2002. Almost 4½% of American baby boomers say they have used illicit drugs – methamphetamine, cocaine, heroine or crack in the past month, up from 2.7% in 2002. Among adults in their 40's and 50's illicit drug use is up over 800% since 1990. Substance abuse among teens declined by 15% between 2002 and 2005 while it was increasing for older adults. The overall percentage of older adults battling addiction may not have changed much, what is changing is the sheer size of that segment of our population and the nature of the drugs that are being abused. Whereas 20 years ago people in their 60's would have been abusing alcohol or prescription medications, now we are seeing drugs of choice among 50 and 60 year olds being harder and more potent. The number of baby boomers using drugs is probably even higher than we suspect since they are more likely than younger users to go undiagnosed. At the Hartford Dispensary the percentage of patients served between the ages of 51 and 60 rose from 5% in 1996 to 16% in 2006. The total number rose from 119 to 977. On a statewide basis the number of older methadone maintenance patients increased from 561 in 2004 to 817 in 2006 (a 46% increase in less than two years).

As one gets older, it is harder to hold things together. Older substance abusers pose a special treatment concern that many facilities and indeed our system as a whole are not currently trained or equipped to deal with. Older patients will come in after being medically compromised or medically mismanaged by their physicians who have been trying to provide care for problems caused by drug abuse but have not diagnosed the underlying cause.

If alcoholism and drug abuse are difficult to diagnose in the elderly, co-occurring disorders are even more challenging. Older alcoholics are at greater risk of suicide. According to one study at least 1/3 of “older people” who committed suicide also met the criteria for alcohol abuse or dependence.

Compulsive gambling amongst seniors is also increasing and becoming an area of concern. Many senior centers report that bus trips to the casinos are their most popular events. A federal study of adults 65 and older showed that those who gamble rose from 20% in 1974 to 50% in 1998. A recent study of 7,000 older adults ranked bingo as the number one form of entertainment followed closely by casinos. Both surpassed all other categories including going to movies and plays, going out to lunch with friends, shopping or playing golf. The National Council on Problem Gambling examined help line calls from seven states (AZ, CA, CT, DE, FL, LA, NJ). All seven states reported a significant number of calls from older adults (range = 6.2% to 33%); each state also reported a dramatic increase in calls from this population. A survey of senior centers in Connecticut found that more than half (55%) expressed moderate or high concern about problem gambling among seniors and almost half (48%) suspected or knew of clients who had a problem.

Issues:

- With the exception of nominal cost of living increases every few years, the funding for specialized substance abuse treatment and engagement services has not increased in 20 years.
- The Connecticut substance abuse treatment system is primarily geared toward young to middle age adults.
- Most facilities structures are not well-suited for seniors with some degree of physical disability.
- Although 70% of older adult hospital admissions are alcohol-related, few, if any, organized intervention efforts are supported despite the obvious medical cost offset of preventing re-admissions.
- While not alcohol or drugs per se, compulsive gambling is recognized as an addiction by the Department of Mental Health and Addiction Services and comes under its purview for treatment and prevention. For this reason and the serious and increasing nature of gambling as a concern for seniors, this is being identified as an important issue.

Recommendations:

1. A demonstration or pilot project should be developed, funded and evaluated to determine the efficacy of a specialized track and program for seniors in one or more methadone clinics in the state.
2. All substance abuse treatment programs should be surveyed to assess their degree of readiness/ability to serve an aging client population.

3. A national search should be conducted to identify model state approaches and program level best practices for servicing older adults in all levels of care including prevention. “A practice improvement collaborative” should be initiated to address services for seniors.
4. The total funding for specialized treatment and engagement services for seniors is \$738,000. That funding level should be doubled in next year’s budget in order that the previous recommendations can be implemented including creating case managers to service seniors coming out of residential treatment and engaging seniors in hospitals, courts, senior housing and centers, and collaborating with visiting nurse associations and area agencies on aging. Implementation on a pilot basis of one or more of the best practices that are identified could be funded with this increase.

Subcommittee Membership

Joseph Sullivan, MCCA
James Donagher, DMHAS
Larry Pittinger, Hartford Dispensary
Laurel Reagan, DMHAS
Barbara Lanza, Judicial Branch - CSSD
Marilyn Lukie, DMV

Policy Brief #5: Special Populations

5b. Special Populations - Medication Assisted Treatment

[referencing the existing ADPC Policy Brief – January 2007]

1. Buprenorphine can be an appropriate medication for opiate abusing or dependent youth in that it has proven efficacy and safety; especially for opiate users who have had relatively modest exposure to opiate drugs. The subcommittee endorses an emphasis on treatment engagement rather than detoxification. The subcommittee recognizes the need for triage guidance; currently providers lack accepted protocols which help determine when medication assisted therapy may be most appropriate (this is a particular concern with those persons under the age of 19). The recommendation of the subcommittee in those cases where the use of medication assisted therapy is indicated it should be offered in the context of the youth's local community and imbedded with other supportive therapies such as individual, group, and family counseling. Community based buprenorphine maintenance treatment services for opiate abusing or dependent youth would reduce the level of disruption to other activities important to recovery (such as school) and promote maintaining support networks (such as families) all while all while engaging the youth in services appropriate to the treatment of opiate abuse or dependence. Another aspect of the context of the services offered to youth is that most youth need to be treated apart from persons who are older than 18. There is significant concern for the unintended and undesirable "learning" that such client mixing can produce.
2. In the opinion of the subcommittee if the state implements the use of buprenorphine or methadone for offenders with histories of opiate abuse or dependence prior to release (as has been proposed) it becomes critically important to have appropriate follow-up services and referrals in place **prior** to discharging the ex-offender into the community. Initiating buprenorphine or methadone based treatment while still incarcerated would be inappropriate unless it is certain that the ex-offender can be assured of a seamless transition to a community-based buprenorphine or methadone treatment provider.
3. In the opinion of the subcommittee policies and procedures need to be developed that include flexible buprenorphine dispensing arrangements from pharmacies [and possibly DPH regulation]; so as to allow community based providers or clinics a range of options designed to promote medication safety, reduce diversion risk, reduce client cost, and promote client engagement in services. In addition rate structures, for those clients receiving entitlement-based healthcare coverage, must be sufficient to cover the costs of the provider and/or client.
4. The subcommittee, with the additional suggestions or clarifications listed above, endorses the recommendations listed in the January 2007 Report [see below].
5. If the subcommittee is retained beyond the November 2007 meeting it is our recommendation that the following MAT issues be reviewed: 1) working to reduce or eliminate barriers to treatment experienced by clients who are receiving MAT (specifically including those clients receiving agonist, antagonist, or psychiatric medications), 2) the use

of medications in adjunct therapies [e.g., naltrexone, acamprosate], 3) the use of medications for substance abusing or addicting persons who require pain management care, and 4) developing effective mechanisms to screen for the use of OTC medications by clients who are receiving substance abuse treatment services.

Existing State Agency Policy and Procedure MAT Recommendations [2007]

*[Extracted here are only those recommendations relevant to the
ADPC-MAT Subcommittee – from the January 2007 report]*

1. DCF and DMHAS should develop effective, early identification and engagement approaches, particularly with young and novice opioid (e.g., oxycodone, hydrocodone, heroin) users.
2. DCF should purchase detoxification services and encourage providers to incorporate buprenorphine into outpatient and residential adolescent programs.
3. DSS should develop a ‘bundled’ rate for buprenorphine treatment services that ensures diversion control, professional substance abuse counseling, and periodic and random urine drug screening.
4. DMHAS should develop an enhanced rate structure for existing non-profit OTPs to cover the increased cost of Suboxone over methadone.
5. DMHAS, in collaboration with DOC, CSSD and DCF, should work through the collaborative contracting project to add buprenorphine (i.e., medication-assisted treatment) to existing private, non-profit residential program contracts.
6. DOC and DMHAS should enter into a Memorandum of Agreement (MOA) to develop dedicated continuing care for Suboxone-induced prisoners released from DOC facilities to the community.

Subcommittee Membership

Paul McLaughlin, Hartford Dispensary

John Hamilton, Regional Network of Programs, Inc.

Samuel Silverman, M.D.

Mark Kraus, M.D.

Ronald Fleming, Alcohol & Drug Recovery Centers and representing the Connecticut Association of Nonprofits (CAN)

Policy Brief #5: Special Populations

5c. Special Populations - Adolescent Substance Abuse Treatment

Background:

It is estimated that in Connecticut 29,000 adolescents between the ages of 12-17 meet criteria for alcohol or illicit drug dependence or abuse. Statewide an estimated 16,000 adolescents need treatment for illicit drug use, and 18,000 adolescents need treatment for their use of alcohol use but they do not receive it.¹ Families who are able to get services for an adolescent child with problems related to substance use report that services are often oriented toward treatment for adults and fail to involve families as essential to the treatment process.²

Capacity is just one challenge to providing services to adolescents. Services must be developmentally appropriate, family-centered, and broad enough to address the multiple problems of adolescents. Effective treatment includes outreach, progressive assessment and comprehensive services, building a continuum of care that includes recovery management, strategies the engage and retain adolescents, and interventions adapted or developed specifically for adolescents.³

There is evidence that substance abuse treatment is as medically- and cost-effective as other common health care treatments including treatment for diabetes, asthma and hypertension. Studies indicate that substance abuse treatment reduces drug use and crime by 40-60%. For every \$1 spent on treatment there is a return of \$4-\$7 in the form of savings in costs related to drug-related crime, criminal justice costs and theft.³

Recommendations:

Create a Standing Committee on Adolescent Treatment within the ADPC

The workgroup recommends creation of a standing committee on adolescent treatment within the ADPC organizational structure that includes broad representation of providers, State agencies, youth and families. The standing committee will be responsible for implementing the following additional recommendations:

1. Develop a comprehensive resource map of all publicly-funded adolescent substance abuse treatment services including service capacity and geographic dispersion, financing, and data-collection.
2. Review Connecticut's regulatory statutes to identify barriers to family involvement in treatment, delivery of services including co-occurring, transition from adolescent to adult services and maximizing reimbursement along a continuum of care.

¹ National Survey on Drug Use and Health, 2004-2005, Connecticut State Data Tables.

² Blamed and Ashamed. The Treatment Experiences of Youth with Co-Occurring Substance Abuse and Mental Health Disorders. Federation of Families for Children's Mental Health.

³ Adolescent Substance Abuse: A Public Health Priority. Physician Leadership on National Drug Policy. August 2002.

3. Coordinate with CSSD and DCF on the Juvenile Justice Strategic Plan to expand and enhance community-based treatment and support services for adolescents and families.
4. Develop statewide family standards of care for adolescent substance abuse treatment. Consistent with the ADPC Policy Brief on adolescent substance abuse treatment and recovery, the workgroup recommends developing standards of care to better integrate youth and families into the design and delivery of treatment services. The standards would guide and standardize integration of youth and families across state agencies providing substance abuse treatment services to adolescents.

Subcommittee Membership

Peter Panzarella - DCF
Heather Gates - CHR
Julie Revaz - CSSD
Melissa Sienna - UCHC
Mike Williams - ABH
Dan Rezende - CJR
Vicki Barbero – Perception Programs
Martin Jackson - Children’s Center
Ann McIntyre Lanner – DCF JJ
Jane Ungemack - UCHC ADOL
Terry Nowakowski - DMHAS
Donna Aligato - FAVOR (Parent)
Hal Gibber - FAVOR (Parent)

Policy Brief #5: Special Populations

5d. Special Populations - Family Based Treatment

Problem Statement:

Connecticut's current system of substance abuse treatment services is fragmented and operates in a manner that is inconsistent with what we know regarding the needs of families. Specifically, clients and families benefit when services are able to operate within the context of the client's natural ecology. Current policy and regulations drive practice that is geared toward working with clients as individuals, and not as members of families involved with multiple systems.

The primary ecology/recovery environment that must be addressed is the client's family (SAMSHA TIP 39). Effective intervention must insure that the complex treatment needs of all family members impacted by the substance abuse are addressed in a closely coordinated and integrated way. Services that fail to operate in a manner that appreciates and intervenes within the client's ecology are ultimately less able to facilitate long term recovery. Failure in this regard ultimately results in increased burden and costs that must be borne by the adult clients, their children, and the public systems entrusted with their care. It is critical that treatment be able to occur within the client/families' natural ecology. In-home and community- based treatment employ this conceptual framework.

A variety of family based treatment models have been implemented across the State of Connecticut. Treatment providers and families identify the benefits of working within a family conceptual framework. The power and impact of family based treatment is exponentially greater. There are numerous systemic obstacles to operating in this manner, including regulatory, fiscal (reimbursement), workforce development and practice restraints. These obstacles greatly limit the number of families treated by these programs.

Recommendations:

1. Develop and adopt Family Treatment Standards at the State level to bridge the existing divide between child and adult services and systems. The adoption of Family Treatment Standards would establish regulatory and reimbursement policies to facilitate the provision and practices of substance abuse services to adults in their capacity as parents, with an aim toward enhancing their functioning in this role.
2. Create a multidisciplinary, interagency (public and private) work group that reports to the ADPC to develop strategies to overcome existing barriers. The scope of work of this group will include, but not be limited to:
 - systematically review existing care models available to these clients, and identify existing models and practices that effectively address the needs of clients within a family and ecological context.

- identify the measurable features of integrated family based approaches and develop an instrument to measure the degree to which existing programs provide such integrated family-based care.
- identify barriers to implementation or expansion of effective practices, particularly regulatory and policy constraints on addressing substance abuse needs within an ecological and family context.
- join with DSS, DCF, DMHAS and DPH to make concrete recommendations regarding needed changes or additions to existing regulations and reimbursement mechanisms.
- address workforce issues that place constraints on the implementation of practice consistent with this framework.
- develop academic partners, researchers and evaluators to work with state agencies and providers on development of integrated family models and supervision structures to support family centered treatment.
- develop the concept of family recovery centers that will provide ongoing supports and advocacy to families thus building upon recovery capital in the community.
- address issues of gender and culture in the family. Males are often overlooked in their role as parents in substance abuse treatment. There is a need for specific attention and focus on how to engage and address their role within a family context.

Subcommittee Membership

Peter Panzarella - DCF

Dr. Frank Gregory - DCF Behavioral Health

Catherine Morgan Mergin – Village for Children and Families

Barbara Geller - DMHAS

Karen Hanson -Yale Child Study Center

Kathi Legare - New Hope Manor

Robin Anderson Turner- Hartford Youth Project/ABH

Jennifer Barnett – Wheeler Clinic

Eizabeth Cannata – Wheeler Clinic

Chris Lau - DCF New Britain Area Office Director

Terry Nowakowski – DMHAS

ADPC Membership - 2007

Statutory Members

Name	Title	Organization
Honorable David Cappiello	State Senator	Connecticut General Assembly
Ralph Carpenter	Commissioner	Department of Transportation
Honorable Mary Ann Carson	State Representative	Connecticut General Assembly
Susan F. Cogswell	Commissioner	Department of Insurance
Honorable Kevin DelGobbo	State Representative	Connecticut General Assembly
Susan Hamilton	Commissioner	Department of Children and Families
Jerry Farrell, Jr.	Commissioner	Department of Consumer Protection
J. Robert Galvin	Commissioner	Department of Public Health
Robert L. Genuario	Secretary	Office of Policy and Management
David Guttchen		Office of Policy and Management
Honorable Mary Ann Handley	State Senator	Connecticut General Assembly
Honorable Toni N. Harp	State Senator	Connecticut General Assembly
Thomas A. Kirk, Jr., Ph.D.	Commissioner	Department of Mental Health and Addiction Services
Theresa C. Lantz	Commissioner	Department of Correction
Honorable William J. Lavery	Chief Court Administrator	Judicial Branch of the State of Connecticut
Honorable Michael P. Lawlor	State Representative	Connecticut General Assembly
Honorable Andrew J. McDonald	State Senator	Connecticut General Assembly
Mark K. McQuillan	Commissioner	Department of Education
Christopher Morano	Chief State's Attorney	Office of the Chief State's Attorney
Honorable Arthur O'Neill	State Representative	Connecticut General Assembly
Honorable Andrew Roraback	State Senator	Connecticut General Assembly
Mark Schaefer		Department of Social Services

Name	Title	Organization
Gerard A. Smyth	Chief Public Defender	Office of the Chief Public Defender
Michael Starkowski	Commissioner	Department of Social Services
Robert Ward	Commissioner	Department of Motor Vehicles

Chair-Selected Members

Babor, Ph.D., Thomas	University of Connecticut Health Center
Berkowitz, David Ph.D.	President/CEO, Wheeler Clinic
Boyle, Leonard	Commissioner, Department of Public Safety
Carbone, William	Executive Director, Judicial Branch, Court Support Services Division
Carey, Mari Jane	Women's Consortium, Inc.
Cash, Cinda	Women's Consortium, Inc.
Coleman, George	Deputy Commissioner, State Department of Education
Dowd, Judy	Budget Analyst, Office of Policy and Management
Farr, Robert, Hon.	Connecticut General Assembly
Gates, Heather	Executive Director, Community Health Resources, Inc.
Jones-Mauttee, Pam	Executive Director, Valley Substance Abuse Action Council
Kraus, M.D., Mark	CT. Chapter, American Society of Addiction Medicine
McGann, Marlene F.	CT Prevention Network
Merrill, Denise, Hon.	Connecticut General Assembly
Pesce, Joan	Morris Foundation, Inc.
Piccione, Paul Ph.D.	Department of Social Services
Rehmer, Patricia	Deputy Commissioner, Department of Mental Health & Addiction Services
Ristau, Stephen	CEO, Governor's Prevention Partnership
Rockholz, Peter	Deputy Commissioner, Department of Mental Health & Addiction Services
Rostenberg, Peter O. , M.D.	Physician
Sayers, Peggy	Connecticut General Assembly
Schottenfeld, Richard, M.D.	Yale University
Silverman, M.D., Samuel M.	Addictions Physician; Rushford Center, Inc.
Snyder, Karen	Department of Children and Families
Sullivan, Joseph	Midwestern CT Council on Alcoholism, Inc.
Talge, Kenneth	Executive Director, ADRC, Inc.
Ungemack, Jane	UCONN Health Center
Valentine, Phillip	Executive Director, CT Community for Addiction Recovery
Walter, Jeffrey L.	President, Rushford Center, Inc.
Wasserman, Julia	Connecticut General Assembly

Connecticut Alcohol and Drug Policy Council (ADPC)

2007 Meeting Schedule

MARCH 13, 2007

JUNE 12, 2007

SEPTEMBER 11, 2007

DECEMBER 11, 2007