Facilitated Discussion Notes
Substance Abuse and Recovery
May 13, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Location: Value Options, 3rd Floor Hartford Room

Question 1: Strengths

- CT does well developing a recovery oriented system of care (ROSC) for the adult population.
- Juvenile probation officers are doing an effective job identifying youth who need intervention. They tend to be a primary referral source for treatment.
- CT has a strong community and family based intervention system for adolescents. We provide more Multi-systemic Family Therapy (MSFT), per capita, than anywhere else in the US. Other great evidence based interventions that CT has include: Multi-Dimensional Family Therapy, Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC)
- We have strong quality assurance and monitoring systems in place.
- We have a strong system in terms of transitioning older adolescents into the Young Adult Services of the Department of Mental Health and Addiction Services (DMHAS). We are a leader nationally in our treatment efforts for this population.
- CT is a small state and has a lot of community based resources that we can build on to better serve our youth. There are opportunities to make community based resources more effective.
- DMHAS has combined services. We use the "Dartmouth-based model", which is an evidence based practice. There is a family component to it and it is associated with the Stages of Change Theory (Trans-theoretical Model of Change).
- DCF and DMHAS have been encouraging outpatient programs to assess substance abuse even if they refer on to other services versus being able to provide treatment services directly. They can't always do both (assessment and treatment) and see them as separate services.
- Mental health and substance abuse issues for adolescents cut across all three areas of responsibility for DCF focuses. There has been a level of collaboration between the three areas: (1) child welfare, (2) juvenile justice, and (3) behavioral health. Having all of these services under one department also helps with coordination.
    - There is a unique organization and structure here that doesn't exist in other states.
    - There is a clear focus on the children and their needs regardless of which of the three areas they are under. DCF looks at children and families first.
- State insurance covers substance abuse treatment. It's easier to get coverage through Husky than through private insurance.
- Court Support Services Division (CSSD) has a program for females and males dealing with substance abuse and they have a follow up component using MDFT. That seems very well utilized with the perception of good outcomes from that program.

- There has been an improvement in probation officers' approach to adolescents. We are seeing that they view MSFT and MDFT as a gold standard and encourage treatment.
- We've started teaching mental health and substance abuse screening and referral protocols to primary care providers.
- DMHAS is utilizing the SAMHSA-funded Screening, Brief Intervention, and Referral to Treatment (SBIRT) resources within CT.
- DCF is sharing quality assurance costs with CSSD and DMHAS on EBPs, which is good.
- There is a lot of strong grassroots activity on adolescent substance abuse in the state. For example: there is a task force in Torrington to deal with heroin abuse.

Question 2: Concerns

- CT needs to strengthen its response to prescription drug abuse. Other states have a more aggressive approach.
- There is likely a connection between the number of pharmaceutical companies in CT and the lack of response to prescription drug use. We should pursue the polarized interests to see where the conflicts occur.
- We need to do a better job at getting the word out to the general public about programs in CT. People don't know about the evidence based programs. In addition to the general public, we need to get the information out to the people/providers who are referring youth to programs.
- CT Turning to Youth and Families (CTYF) is working on a project to get a central database together that would have resources listed. They could use some funding for that initiative.
- On the public sector side, there is a lot of insurance coverage for innovative evidence based treatment but on the private side, those treatments are not covered.
- The numbers who do not know about these evidence based programs is significant. There are huge problems with private insurance companies not reimbursing for evidence based services.
- In rural areas, accessibility and knowledge of the evidence based services is even more limited.
- Parents call to say their kids are using substances and they don't know what to do. There are a lot of good programs but the average person does not know where to go and who to call. The pediatricians are the least trained.
- Kids can become addicted so quickly. First, parents are in denial and then it takes a while to find out what to do. We need to find a way to move kids through more efficiently. Pediatricians need to be better prepared for screening and referring.
- When commercial insurance authorizes a youth to participate in intensive care, they may approve a few weeks of care versus the several months that it takes, which Medicaid will approve. Also, commercial insurance companies require licensed providers and this is hard for a non-profit to afford. In addition, Medicaid will pay for families to use a taxi to get to services which is critical and commercial insurance won't do that.
- Parents look at their own life experience of substance abuse and don't have the education they need. A parent is likely the first person who could recognize a problem with their child but they often don't know how to identify the substance abuse problem. Too often, parents can't identify substance use yet alone get their kids into treatment. Parents need more education on how to talk to their kids about drugs.
- Private insurance defines "Medical Necessity" in a way that patient need to be high on drugs in order to be able to get into facility. That is wrong on so many levels. Managed care has brought this to us.

- Most private insurance companies don't think rehabilitation is necessary and that only detox is necessary. At the end of detox, the detox team usually has to say that your insurance wouldn't pay for rehabilitation so you need to come pick them up.
- It is a weakness that youth have to transition from DCF to DMHAS. Kids fall through this gap. Who covers this kid? The substance abuse issues require a broader look.
- The court system is a huge problem. If you are a white kid with a lawyer, you will get your case dismissed. These kids think getting arrested for drugs is a joke. They get community service, etc. and not real consequences. Also, kids learn to work the court system—they stop using marijuana because it stays in systems longer—so they use harder drugs which get out of system quicker. Now they went from having a marijuana problem to a worse problem.
- There are grant federal dollars that are not pursed by CT because DCF says it's not their domain and DMHAS says it's not their domain--missed opportunities.
- There is not an excellent system of recovery (ROSC) for kids. We have the ability to do it but it's not happening.
- CT gives 16 year olds too much power. If you are 16, you can't be involuntarily placed and sometimes it is in your best interest. 16 year olds have rights that they probably don't deserve at such a young age.
- With private insurance, there are barriers to getting on their provider panels.
- With the new legalization of marijuana in some states, the kids are not getting the message about the dangers of marijuana.
- The private insurance doesn't support vocation or other options. State services give you a "package of treatment" which helps fit the right treatment for each person. We need to tell the private insurance companies that we need an array of services not a single service.
- There is misinformation about how many people are using drugs. We should record numbers and share them with the public. It's the #1 health problem in the state.
- They should make it mandatory for emergency departments to make referrals to treatment if they have a youth with a substance abuse problem.
- Sometimes parents approach treatment for substance abuse as something the kids need to be sent away for. In CT, that would mean being sent out of state because we don't have residential SA care in the state. Parents want to send their kids away to get "fixed" but that may not be the best approach.
- Some people have seen discharge plans for youth presenting at an emergency departments for substance abuse, that don't even include a recommendation for substance abuse treatment.
- Seeing very young kids using very high-end drugs. Heroin is a big problem. No one is screaming about this. They are not creating more services to address this problem.
- Services do not sufficiently take family-based care into account. Providers often require the youth to self-identify as the "patient" and deny a family who is seeking care for their child.

Question 3: Recommendations

- DCF needs to develop a global way to market to families about the SA services we have.
- Extended day treatment program are good for substance abuse but we can't have kids in that program if substance abuse is the primary presenting problem. We would like to be able to change those contracts to serve more youth with substance abuse problems.
- We need to build the ROSC for youth. It has to be local. There already is a certification for recovery support services.
- We need to get peer support as part of what the treatment offers.

- Develop online recovery services. Up the level of technology platform to help reach the kids.
- CT already has the infrastructure to deliver the needed services. It can be integrated with mental health services. Pull systems of care and recovery services together. It can happen through schools. We need State level support but communities can do it.
- "Youth Mental Health First Aid" is a training initiative that should be implemented. This is training for people who spend a lot of time with the youth to help them identify if there are mental health problems. We are training the school safety climate coordinators to do this. It educates the line-staff about how to develop relationships and then refer for services. It's designed for parents too, in part to teach them about the drugs. We need trainers in school systems to train coaches and social workers.
- We need health and wellness/strength based approaches rather than a deficit approach. Parents don't want to say their kid has a mental health issue or substance abuse issue but rather that "they need help." We don't want to create stigma for the child or parents. We can promote approaching care as "I want my child to be as healthy as they can be."
- Try to reduce incarceration for drug problems and replace with treatment:
    - DMHAS currently has a program—we are training our CIT (Crisis Intervention Teams) clinicians. They have "ride-alongs" with police. The police are always looking for information from the clinicians.
    - Danbury has a unique program where a counselor goes with a police office to reduce the risk of incarceration.
- Adults shouldn't promote drinking among themselves - it doesn't set a good standard.
- Department of Insurance should require commercial and private insurers to cover evidence based treatments and other recovery treatments and vocational services. They will respond to the mandates. It's complicated and involved but that's how we get it done. We have Medicaid that covers a lot of this stuff, so follow the Medicaid example. Department of Insurance can't mandate insurance companies to cover non-medical conditions. But they may need to change the definition of "medically necessary" to make it happen.
- There is no funding for getting youth connected to prosocial activities (e.g., softball team). Kids need social activities to be healthy. Communities may help, but they don't have the resources.
- We need to address the element of shame that goes along with substance abuse.
- We need a clearinghouse of resources that is advertised. Maybe through 211 Info-Line?
- Funding should go to CT Turning to Youth and Families to provide a statewide and community based mapping of services available.
- Mass. declared a public health emergency around opiate use. For CT it would be the public health department that can declare a public health emergency.
- Prescription drug abuse is an epidemic. Most kids started with cigarettes, pot, and alcohol. We need to get to kids early, so we don't get to the point of heroin use. Pediatricians can intervene with kids early.

<u>General Feedback on the Discussion</u>

- Helpful to have questions ahead of time. We appreciated it.
- We are grateful you had this process.