

Staff Briefing

Substance Abuse Treatment for Adults

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Legislative Program Review
& Investigations Committee

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STATE SUBSTANCE ABUSE TREATMENT FOR ADULTS

In April 2008, the Legislative Program Review and Investigations Committee voted to undertake a study of the state substance abuse treatment system for adults. The Department of Mental Health and Addiction Services (DMHAS), as lead state agency for substance abuse prevention and treatment, has primary responsibility for this system. Two other state entities, the Department of Correction (DOC), and the Court Support Services Division (CSSD) of the Judicial Department, also have major roles in providing treatment services for adults with alcohol and drug abuse problems who are involved in the criminal justice system.

The study is focused on how DMHAS carries out its mission related to alcohol and drug abuse treatment for adults, including its responsibilities for coordinating all publicly funded services in the state. It is also examining the adult substance treatment programs and services administered the Department of Correction and the Court Support Services Division. Another area of analysis is how DMHAS monitors and evaluates the effectiveness of various state treatment programs and services for adults with substance use disorders.

Initial staff work has been concentrated on the criminal justice components of the service system; more in-depth analysis of DMHAS activities is just beginning. At this phase of the research process: information about nature and prevalence of substance abuse and the basis of the different treatment models has been reviewed; the major programs and services that make up the system have been identified; and the main steps in each agency's treatment process also have been identified.

Report themes. Although formal findings are not part of this briefing document, a number of themes emerge when examining Connecticut's approach for delivering substance abuse treatment services to adults. They include the following points:

- Increasingly addiction is viewed as a chronic disease, which requires continuing care strategies, instead of an acute condition.
- The rate of addiction in Connecticut has not changed in the last five years.
- The system has limited capacity; the latest figures available (2006) indicate that over 200,000 Connecticut adults who needed treatment for alcohol or drug dependency did not receive it.
- Government is a primary financier of substance abuse treatment but the majority of treatment services are delivered through contracted private non-profit providers.

- The state views addiction as a public health issue and a public safety issue.
- The Department of Mental Health and Addiction Services (DMHAS) is the statutorily designated lead agency for substance abuse treatment but multiple state agencies are independently involved in planning, funding, and delivering substance abuse treatment services. The coordination of client care remains a challenge.
- Clients enter the system through different agencies and for different reasons, but all have assessments performed that drive the type of treatment received.
- State agencies have different approaches to requiring best practices for substance abuse assessments and treatment.

Issue areas. During the next phase of research, program review staff will be examining a number of issues in the formulation of findings and recommendations. Among the key areas identified at this time are:

- *Planning and coordination activities of DMHAS.* Staff will examine DMHAS role as the principal architect of substance abuse treatment services.
- *Access to substance abuse treatment services.* Staff will examine access to substance abuse assessment and treatment services, including unmet needs and duplication of effort by different state agencies.
- *Quality assurance and quality improvement activities.* Each agency's quality assurance and quality improvement processes will be reviewed.
- *Analysis of outcome information.* Staff will obtain and report all relevant state agency performance and outcome information relating to substance abuse treatment effectiveness.

Research methods. To date, PRI staff have conducted interviews with, and collected background data on programs and clients from, each major state provider of adult substance abuse treatment services: DMHAS; the Judicial Branch, primarily the Court Support Services Division; and DOC, regarding both its institutional and community-based (parole) programs. Staff also have visited treatment programs at several DOC facilities and at a parole office, observed CSSD staff at Hartford Superior Court, and met with DMHAS substance abuse treatment staff during a tour of Connecticut Valley Hospital. Several meetings with representatives of private provider agencies that operate substance abuse treatment programs have been held, and additional interviews with service providers, experts, and stakeholders, as well as more program field visits, are planned.

Report organization. Background information on the nature of substance abuse and the prevalence and rate of alcohol and drug abuse problems along with treatment data are presented in Sections I and II, respectively. Section III provides an overview of the wide array of programs and services aimed at treating substance abuse and the current research on treatment effectiveness.

Connecticut's publicly funded substance abuse treatment system is described in Section IV, which also summarizes DMHAS's role as the state lead agency for substance abuse prevention and treatment. The last two sections describe the substance abuse treatment activities carried out for adults involved in the criminal justice system by CSSD (Section V) and DOC (Section VI).

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THE NATURE OF SUBSTANCE ABUSE, DEPENDENCE, AND ADDICTION

Substance abuse refers to the misuse of alcohol, tobacco, and other legal and illegal drugs. In general, individuals are considered to have a substance abuse problem when there is a pattern of alcohol or other drug use causing harmful consequences (e.g., missing work or school, driving while intoxicated, getting arrested, fighting with family, etc.). In its most severe form, described below, it is defined as dependence or commonly referred to as addiction. A growing recognition of addiction as a chronic, relapsing illness needing continual care has influenced substance abuse policies and treatment approaches at the state and federal level in recent years.

Brain disease. Addiction is a complex phenomenon. The key distinguishing characteristics of addiction include uncontrollable and compulsive drug craving and use even in the face of damaging health and social consequences. The concept of addiction has evolved over time and away from the notion that drug addiction results from a failure of will. Although the initial use of drugs is voluntary, current research has identified addiction as a chronic but treatable brain disease. The repeated abuse of drugs leads to fundamental changes in the structure and function of the brain. These modifications to the brain can persist for many years even after an individual stops using drugs.

Generally, addiction occurs over a period of time. Many people start as casual drug and alcohol users and stay that way. However, others can move from experimental use to regular or risky use to addictive and uncontrollable use. No single factor can predict if a person will become addicted to drugs or alcohol. The interaction of biological and environmental factors influences the progression to addiction and makes treatment challenging. The identified risk factors for addiction include a person's genetic makeup, mental illness, social environment, childhood trauma, and the early use of drugs. Stress is also associated with addiction. Experts have pointed out that for most people addiction is at the end of a long series of substance use problems and it is important to treat those problems at the earliest stages. Contrary to popular mythology, a person does not need to hit rock bottom for treatment to be effective.

Criteria. There are established criteria that determine when substance use has developed into dependence. Connecticut state statutes¹ define alcohol dependence and drug dependence in terms of the psychiatric profession's manual for diagnosing mental health and substance use disorders.² The criteria are presented in Table I-1. Essentially, a clinical diagnosis of dependence requires the presence of three or more factors, over a 12-month time period, from a group that includes five behavioral factors (like being unable to stop alcohol or drug use or exceeding self-imposed limits) and two physiological factors, which include symptoms of tolerance and/or withdrawal.

¹ C.G.S. Sec. 17a-680

² The American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Disorders." The most recent is the 4th edition, Text Revision (DSM-IV, TR).

Table I-1. American Psychiatric Association Criteria for Substance Dependence

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following factors, listed below, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for the substance.
 - b. The same (or a closely related) substance is taken to relieve or avoid symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. The person experiences a persistent desire (or unsuccessful efforts) to reduce or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision

Co-occurring disorders. Further complicating the understanding and treatment of addiction is the prevalence of co-occurring mental health disorders. A significant portion of people with substance use problems also have other mental illnesses, such as attention deficit hyperactive disorder, bipolar disorder, depression, post-traumatic distress disorder, and schizophrenia. Some people with untreated mental health problems start using drugs or alcohol as a way to self-medicate, while others develop symptoms of mental illness after using drugs. The National Institute of Mental Health has provided some estimates (Table I-2) of the increased risk for substance abuse given a particular psychiatric disorder. Concerns are raised when health care practitioners treat one disorder without treating or being aware of the other. The best

chance at success and recovery requires that both disorders be treated at the same time. If not, both disorders often get worse. In addition, individuals with addictions also tend to suffer from one or more accompanying physical medical issues, including lung and cardiovascular disease, stroke, and injection-related illness such as HIV/AIDS and hepatitis.

Psychiatric Disorder	Increased Risk For Substance Abuse
Antisocial personality disorder	15.5%
Manic episode	14.5
Schizophrenia	10.1
Panic disorder	4.3
Major depressive episode	4.1
Obsessive-compulsive disorder	3.4
Phobias	2.4

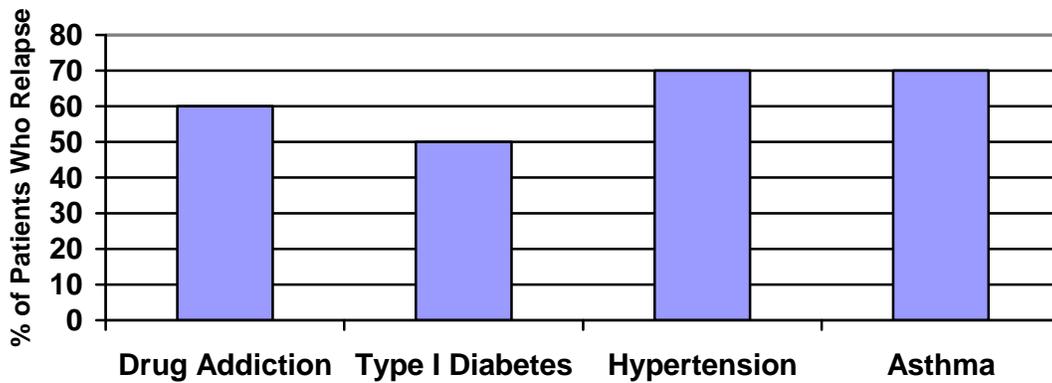
Source: National Institute of Mental Health

Chronic illness. Increasingly, drug and alcohol addiction is described as a chronic medical illness. Drug addiction shares many characteristics of chronic illnesses, such as hypertension, diabetes, and atherosclerosis. These illnesses can begin with unhealthy voluntary behaviors (e.g., poor nutrition, lack of exercise) that cause biological changes and result in a chronic lifelong condition. These diseases are largely incurable but can be effectively treated and managed through medications and lifestyle changes. The implications for the acceptance of addiction as a chronic illness can be far reaching. Drug dependence has often been treated as an acute illness calling for brief interventions. However, a chronic condition requires long-term care strategies for the management of medication and continued behavioral monitoring to ensure long-lasting benefits.

Relapse. Like other chronic illnesses, people who are addicted often have relapses or a return to the abuse of drugs and alcohol after a period of abstinence. Paradoxically, a relapse episode is not viewed as a failure by many practitioners in the field. Rather a relapse is thought to be a sign that treatment needs to be reinstated or adjusted to help the individual recover. For many, successful treatment may involve several interventions and attempts at abstinence. As shown in Figure I-1, researchers have demonstrated that the rate of relapse among those addicted to drugs (between 40 to 60 percent) is similar to other chronic diseases.³ The road to recovery from drug and alcohol addiction often includes relapse.

³ A relapse for other chronic diseases means that the patient experiences a recurrence of symptoms to the point where they require additional medical care to reestablish symptom remission because of a lack of adherence to medical schedules or behavioral or diet changes.

Figure I-1. Relapse Rates for Drug Addiction and Other Chronic Illnesses



Source: McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689-1695, 2000. The study provides a range for relapse for each illness. Just the high end of the range for each illness is presented here.

Relapse is possible regardless of how long a person has been abstinent. This is because an addicted person can be affected by certain triggers that create cravings and possibly lead to substance abuse. Triggers are warning signs that relate to changes in behavior, attitudes, feelings, and thoughts. These changes can be initiated by various things that remind an individual of their past drug use, like being in an old neighborhood where an individual abused drugs or a conflict with a spouse. The point for someone in recovery is to recognize the warning signs which precede the relapse and develop a coping strategy to prevent it. Many practitioners maintain that as long as the person in recovery is making efforts to maintain sobriety and adhere to treatment, progress in the process is being made.

PREVALENCE, ABUSE, AND TREATMENT

In this section a variety of state and federal data sources are combined and analyzed to obtain an understanding of the prevalence of psychoactive substance use, abuse, and dependence in Connecticut. In addition, the trends in access to and use of treatment services in the state are also examined. PRI staff analysis of this information is summarized below.

- Connecticut has a higher rate of alcohol use, binge drinking, and illicit drug use than the national average. Connecticut's rate of substance abuse or dependence (10.1 percent) is higher than the nation as a whole (9.2 percent) and appears somewhat higher than it was in 2002 (8.6 percent).
- While marijuana is the most frequently used illicit drug in Connecticut and alcohol is the most frequently abused substance, the biggest problem substances for adults at time of admission to treatment are heroin and other opiates, followed by alcohol, cocaine, and marijuana.
- The non-medical use of prescription drugs (especially synthetic opiates) has been increasing in Connecticut. Opiates, particularly heroin, are more often the reason for treatment, and stimulants (like methamphetamine) are less often the primary problem at admission than in the nation as a whole.
- The number of adults in Connecticut age 18 and older estimated to have a current need for treatment for substance abuse or dependence is 268,000. Rates of access to substance abuse treatment vary among different state agency populations and DMHAS estimates many groups are underserved. It appears less than half of those involved in the criminal justice system needing treatment are admitted to services and access can vary by race.
- The population groups identified with a greater *risk of substance dependence* were males, young adults, non-Hispanics, and those with less than a high school education. However, clients *admitted to treatment* are older with an average age at time of admission of 35.5 years.
- Detoxification and outpatient services, both regular and intensive, are the most used types of treatment for substance abuse in Connecticut followed by the various types of residential rehabilitation and opioid replacement therapies (ORT). Connecticut has a higher use of detoxification and ORT than does the nation as a whole.

- Many adults admitted for substance abuse treatment in Connecticut are served by other state agencies, with the largest percentages involved with social service programs (e.g., Food Stamps, State Administered General Assistance, Medicaid) and with the criminal justice system.

Prevalence and Abuse

In order to analyze the prevalence of substance use and the rate of substance abuse and dependence within the state, PRI staff used two data sets. The National Survey on Drug Use and Health (NSDUH) was analyzed to examine trends over time and to compare Connecticut to the national and regional experience. The NSDUH is the primary source of statistical information on the use of licit and illicit substances by the U.S. civilian population age 12 and older conducted by the federal Substance Abuse and Mental Health Services Administration on an annual basis. The national survey represents the best data currently available.

Most of the statistics presented in the NSDUH aggregate adults and adolescents (age 12 to 18) together. The latest edition contains substance use and abuse data for 2006.⁴ It should be noted that the sample size of the NSDUH may affect the comparisons of differences between years. The difference between years (2002 versus 2006) has not been tested for statistical significance.

To obtain a more detailed understanding of the demographics of substance use and abuse in Connecticut, the DMHAS-sponsored Substance Abuse Treatment Need and Demand in Connecticut: 2003 Adult Household Survey (AHS) is also used in this report. Data collection for this survey was conducted by telephone between July 2003 and March 2004 and is the most recent detailed information available about Connecticut citizens.

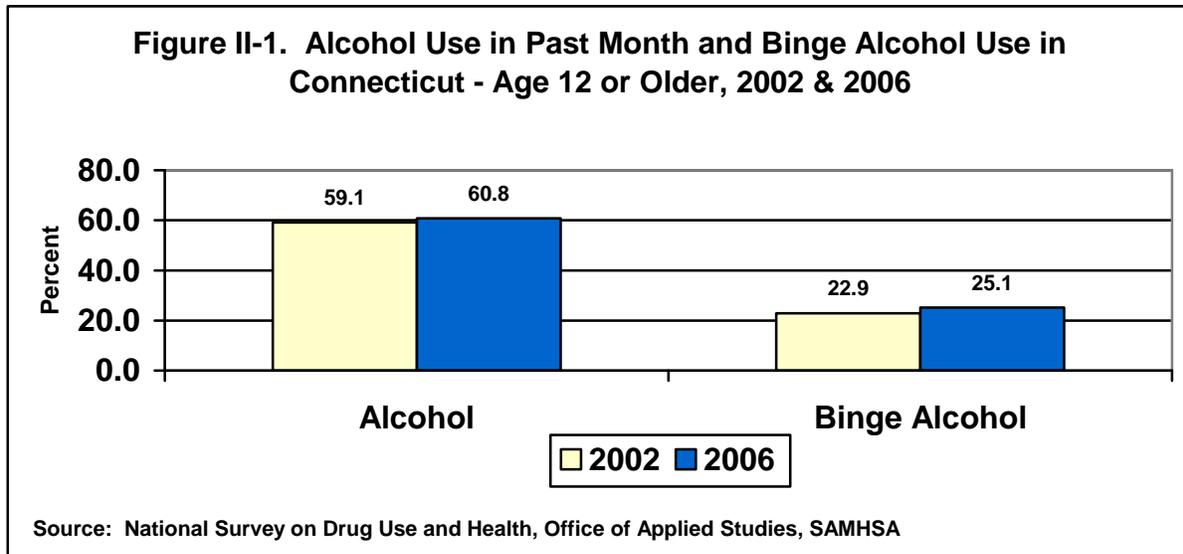
Alcohol

As defined in the national survey, “alcohol use in the past month” is the consumption of at least one drink during the past 30 days (including binge use). Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the 30 days prior to the survey.⁵

Alcohol is the most commonly used psychoactive substance in the United States. Nationally, about half (51.4 percent) of Americans age 12 or older reported being current (past month) drinkers of alcohol in 2006 and the same percent reported current use in 2002. Connecticut’s use of alcohol is higher than the national average with past month use of alcohol at 60.8 percent in 2006. As Figure II-1 shows, the rate of use in Connecticut has not significantly changed in the last five years, as has been the case nationally.

⁴ The annual estimates are actually based on a two-year moving average of NSDUH data in order to enhance the precision for states with smaller samples.

⁵ A "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Respondents are asked to exclude occasions when only a sip or two is consumed from a drink.



Nationally, 22.8 percent of all persons age 12 or older participated in binge use of alcohol in the past month in 2006. This rate remained relatively unchanged from 2002. Binge use in Connecticut (25.1 percent) was slightly higher than the national average in 2006 and appears higher since 2002 (22.9 percent).

According to the state 2003 Adult Household Survey, alcohol use was most likely to be reported by men, adults age 35 to 44 years old, non-Hispanics, Whites, those with a college education or more, high income earners, and those employed full time.⁶

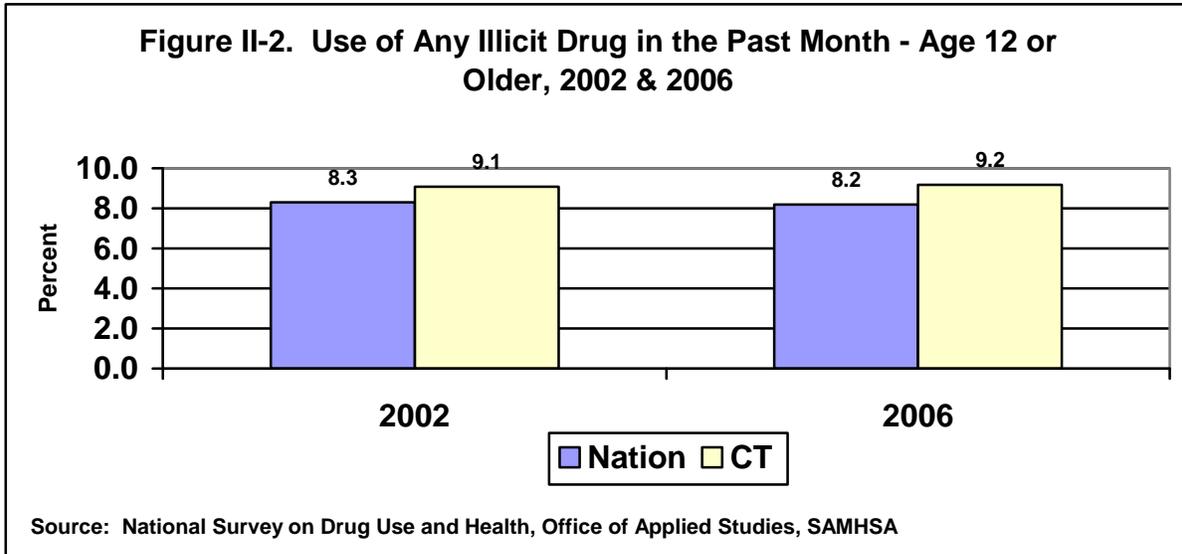
Illicit Drugs

The national survey includes information on nine different categories of illicit drug use: marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.

In 2006, as Figure II-2 shows, 8.2 percent of the U.S. population age 12 or older had used an illicit drug in the past month, compared to 9.2 percent in Connecticut. States in the Northeast region had a higher average rate of illicit drug use (8.9 percent) than the national average.⁷ For both the nation and Connecticut, the rate of illicit drug use has shown no change since 2002.

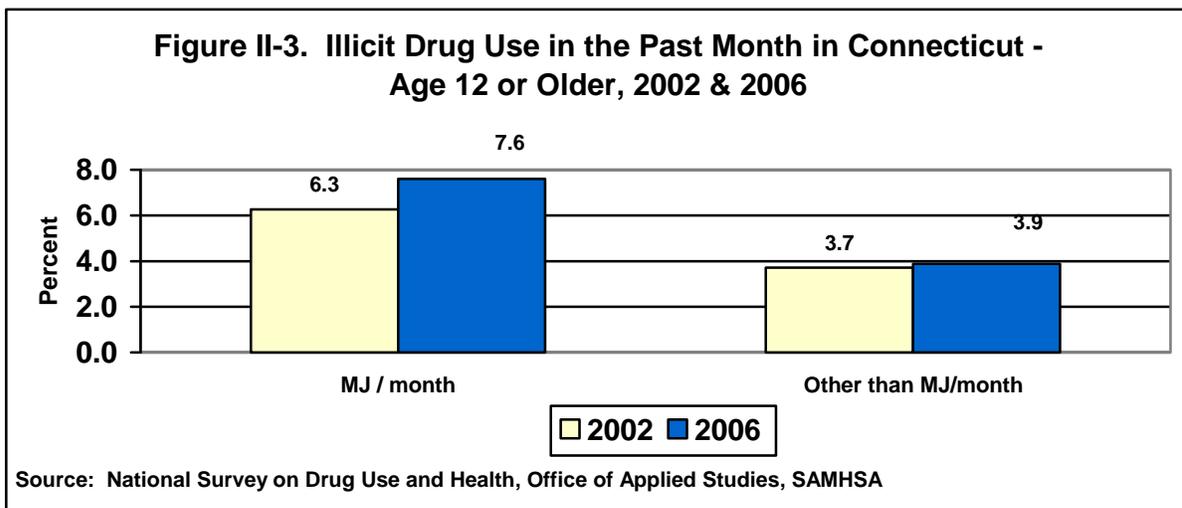
⁶ The AHS surveyed adults age 18 and over, while the NSDUH surveyed people age 12 and older.

⁷ Northeast Region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.



Marijuana is the most frequently used illicit drug both nationally and in Connecticut. As shown in Figure II-3, marijuana was used in the past month by 7.6 percent of Connecticut citizens in 2006 and 6.3 percent in 2002. Nationally, in 2006, 6.0 percent of all persons aged 12 or older reported marijuana use in the past month.

The 2003 state Adult Household Survey noted that higher rates of marijuana use were associated with being male, a young adult aged 18 to 25, non-Hispanic, Black, not well educated, lower income, unemployed, and never being married.

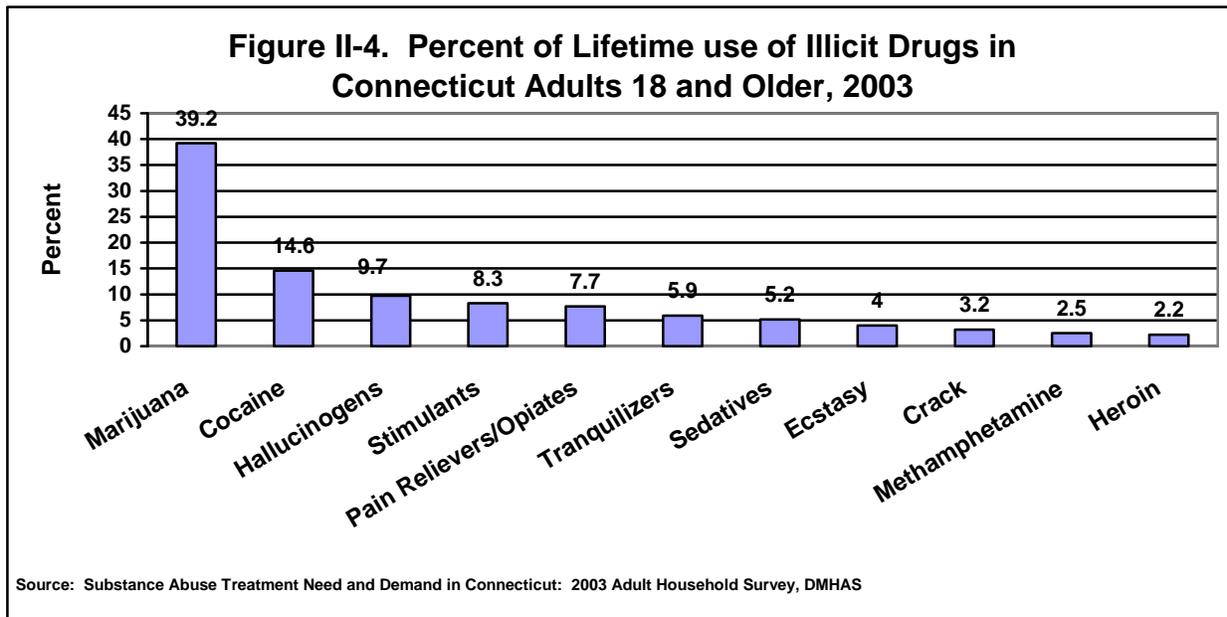


The national use of illicit drugs *other than marijuana* in the past month for persons age 12 or older was 3.8 percent in 2006. As presented in Figure II-3, Connecticut's use of illicit drugs other than marijuana was 3.9 percent in 2006.

The figure also shows an apparent increase (from 6.3 to 7.6 percent) in the use of marijuana (in the last month) between 2002 and 2006. There appears to have been little change

in the overall use of illicit drugs other than marijuana in Connecticut over that same time period (about 4 percent).

The 2003 state Adult Household Survey reports on the lifetime use of various illicit drugs among Connecticut adults.⁸ Figure II-4 shows that marijuana is by far the most used illicit drug followed by cocaine and hallucinogens.



The non-medical use of prescription medicine, and in particular pain medication, in Connecticut by individuals age 12 and older in the last year appears to have risen according to the NSDUH survey -- from 4.0 percent in 2003 to 5.2 percent in 2006. The national estimate for the non-medical use of prescription medicine in 2003 was 4.8 percent, and in 2006 it was 5.0 percent.

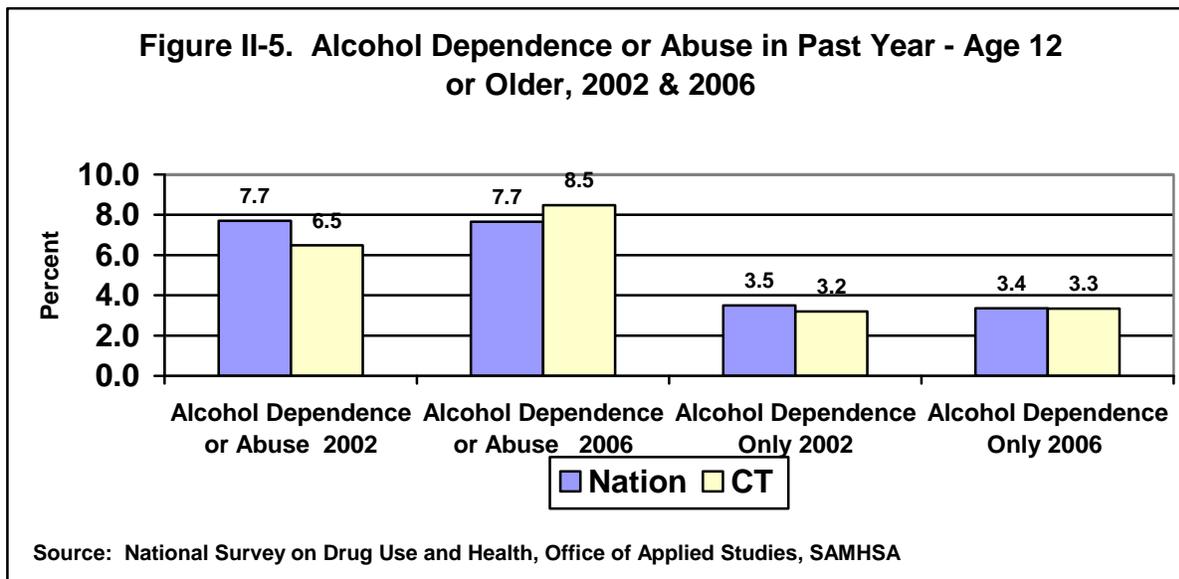
Substance Abuse and Dependence

The NSDUH contains a series of questions to assess the prevalence of substance use disorders (i.e., dependence on or abuse of a substance) in the past 12 months. Substances include both alcohol and illicit drugs. These questions are used to classify persons as being dependent on or abusing specific substances. As discussed earlier, dependence reflects a more severe substance problem than abuse.

Alcohol dependence or abuse. Nationally in 2006, 7.7 percent of the population age 12 or older was classified with dependence on or abuse of alcohol in the past year. As illustrated in Figure II-5, Connecticut's rate (8.5 percent) was higher than the national rate of alcohol abuse or dependence in 2006. Connecticut's rate of abuse or dependence was lower in 2002 (6.5 percent),

⁸ Lifetime use refers to the using the substance at least once over the course of one's life.

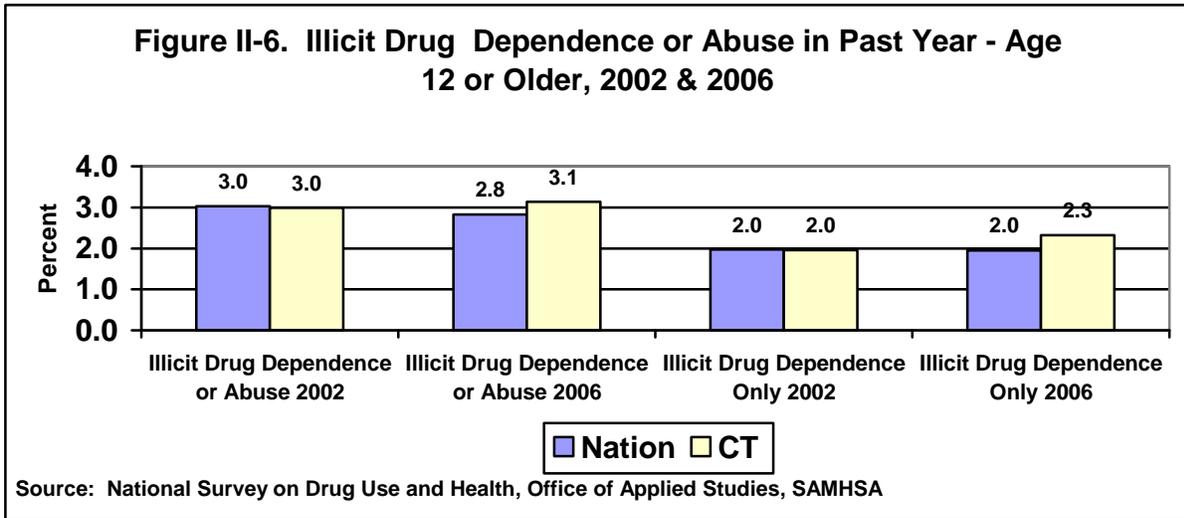
while the nation's total was unchanged. In 2006, persons aged 18 to 25 had the highest rate of alcohol dependence or abuse (17.6 percent) in the nation and in Connecticut (23.1 percent).



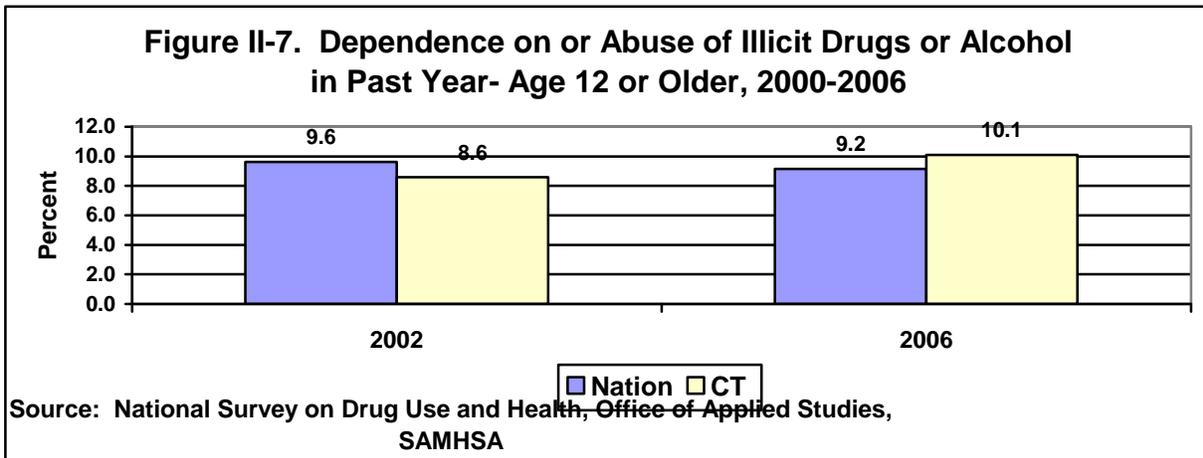
Alcohol dependence only. In 2006, 3.4 percent of persons age 12 or older nationally were estimated to be dependent on alcohol in the past year. This represents about 44 percent of those in the category of dependent on or had abused alcohol in the past year. In Connecticut, 3.3 percent of individuals aged 12 or older were dependent on alcohol in the past year, representing about 39 percent of those in the category of dependent on or abused alcohol. The highest rates for alcohol dependence were among the 18-25 year olds in Connecticut (8.5 percent) and the nation (7.4 percent). Compared to five years ago, there has been little change in the rate of alcohol dependence.

Illicit drug dependence or abuse. With regard to Connecticut's rate of illicit drug dependence or abuse, there has been little change over the last five years within Connecticut or in comparison to the national rate. For 2006, as shown in Figure II-6, about 2.8 percent of persons age 12 or older nationally were dependent on or had abused illicit drugs in the past year, compared to about 3.0 percent in 2002. In Connecticut, the comparable figure for 2006 was 3.1 percent and for 2002 it was 3.0 percent.

Drug dependence only. Nationally, the percentage of persons in 2006 estimated to be dependent on illicit drugs in the past year was about 2.0 percent or about 66 percent of those who were estimated to be dependent on or had abused illicit drugs in the past year. In Connecticut, 2.3 percent were estimated to be dependent on illicit drugs in the past year, representing about 74 percent of those who were estimated to be dependent on or had abused illicit drugs in the past year. Similar to the rate of alcohol dependence, the highest rates for illicit drug dependence were among the 18-25 year olds in Connecticut (9.2 percent) and the nation (5.6 percent).



Alcohol or illicit drug dependence or abuse. Because a person could be abusing or dependent on both alcohol and illicit drugs, the NSDUH provides data on the overall rate. As with other measures, the rate in Connecticut is higher than in the nation as a whole. As shown in Figure II-7, the national rate in 2006 for past year dependence on or abuse of alcohol or illicit drugs among persons aged 12 or older was 9.2 percent, apparently a slight decrease from the 2002 rate. In Connecticut, the rate increased from nearly 8.6 percent in 2002 to 10.1 percent in 2006.



This means that the number of people in Connecticut age 12 and older estimated to have a current need for treatment for substance abuse or dependence based on the 2007 NSDUH survey is 295,000. As noted with the other dependence measures, 18 to 25 year olds had the highest rates of dependence on or abuse of alcohol or illicit drugs in Connecticut (29 percent) which was higher than the overall national rate (22 percent). Based on the 2007 NSDUH survey, the number of *adults* in Connecticut aged 18 and older estimated to have a current need for treatment for substance abuse or dependence is 268,000.

Demographic Information for Substance Abuse and Dependence

The 2003 state Adult Household Survey provides additional demographic detail about individuals with substance dependence or abuse, which is not available with NSDUH due to its smaller sample size.⁹ It should be noted that there were differences between the two studies. The AHS targeted older persons (18 and older versus 12 and older) was administered differently (i.e, telephone survey for the AHS versus face-to-face), and was a larger sample.

<i>Demographic Characteristic</i>	<i>Percentage Meeting Criteria</i>	<i>Demographic Characteristic</i>	<i>Percentage Meeting Criteria</i>
Gender		Ethnicity	
Male	16.9	Hispanic	7.7
Female	5.9	Non-Hispanic	11.3
Race		Age Group	
Black	11.5	18-24	17.4
White	11.3	25-34	20.9
Asian	7.5	35-44	15.4
American Indian/Alaskan ¹⁰	12.2	45-64	7.3
Other	6.8	65 and older	1.7
Educational Reference Group¹¹		Income	
A-B	11.3	\$0-\$9,999	9.8
C-D-E	10.1	10,000-19,000	7.3
F-G	13.8	20,000-29,999	7.4
H	14.8	30,000-39,999	14.5
I	10.1	40,000 or more	13.7
Education		Current Employment	
< High School	13.7	Full Time	13.8
High School	11.7	Part Time	11.4
Some College	11.3	Unemployed	23.6
College Grad. or more	9.3	Not in Labor Force	4.4

Source: 2003 Adult Household Survey, DMHAS

⁹ The estimates provided are based on AHS Table 18 which includes estimates of the percentage of adults meeting past year DSM-IV criteria for substance abuse or dependence that were adjusted from the initial Center for Substance Abuse Treatment (CSAT) protocol estimates. The federal funding agency required the state to follow the CSAT protocols for the survey. The CSAT had made some modifications to the NSDUH survey, which the Connecticut survey was based on. Some of the questions required by the CSAT protocol appear to have inflated the (unadjusted) estimates for abuse and dependence. A detailed explanation may be found in the 2003 AHS.

¹⁰ While dependence for American Indians/Alaskan Natives appears high, the sample was too small to obtain an accurate assessment of this population.

¹¹ Educational Reference Groups (ERG) refer to the assignment of Connecticut's municipalities into one of nine groups that are determined according to socio-economic status and other factors. The more affluent towns begin in ERG A, the least in ERG I.

Table II-1 shows certain demographic characteristics that are more likely to be associated with substance abuse or dependence than others based on criteria for lifetime substance dependence. Lifetime dependence means that an individual is currently dependent or has been dependent at some point in his or her lifetime.

Men were more likely to have higher rates of lifetime substance dependence than women, as were younger adults. Non-Hispanics had higher rates than Hispanics, while Blacks and Whites were more likely to report lifetime substance dependence than other racial groups. (While dependence for American Indians/Alaskan Natives appears high, the sample was too small to obtain an accurate assessment of this population.)

Lifetime substance dependence was also associated with those with less than high school education as were the unemployed. However, higher incomes (\$40,000 or more) were also more likely to meet the criteria for lifetime substance dependence. The second lowest and intermediate socio-economic levels, based on Educational Reference Groups, had the highest levels of lifetime substance abuse.

Connecticut Treatment Data

Federal and state information systems to collect data about substance abuse treatment, in terms of services provided, client characteristics, and treatment outcomes, were initiated in the 1990s. The two main federal sources of treatment data for Connecticut are:

- the *Treatment Episode Data Set (TEDS)*, which contains year-to-year, standardized information on publicly funded substance abuse treatment services and clients in every state; and
- the *National Survey of Substance Abuse Treatment Services (N-SSATS)*, which compiles annual information about all licensed, certified, and/or state-administered substance abuse treatment facilities in each state.

Both TEDS and N-SSATS are overseen by the Substance Abuse and Mental Health Services Administration. As noted earlier, SAMHSA also conducts the National Survey on Alcohol and Drug Use (NSDUH) each year that provides some information on treatment needs on a state-by-state basis, as well as extensive prevalence data.

At the state level, the Department of Mental Health and Addiction Services has developed a comprehensive database on state alcohol and drug treatment called the *Interagency Substance Abuse Treatment Information System (SATIS)*. At present, client-level admission and discharge information is reported to SATIS by all private substance abuse programs licensed by the state Department of Public Health and by treatment programs operated by DMHAS and DOC.

In 1999, the General Assembly mandated comprehensive information on substance abuse prevention, intervention, and treatment be compiled, analyzed, and reported by DMHAS. Every two years, DMHAS, in collaboration with other state agencies, prepares a report based on SATIS

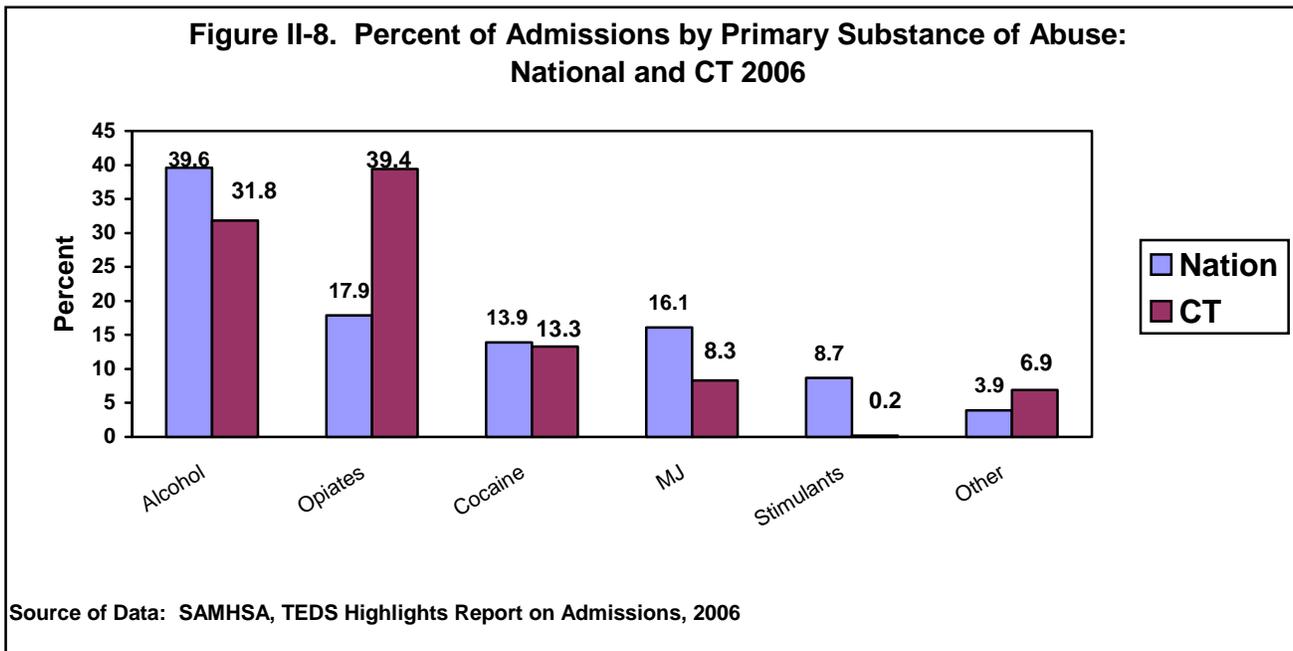
data, and submits it to the legislature, OPM, and the State Alcohol and Drug Policy Council. By law, this biennial report must include a summary of:

- client and patient demographic information;
- trends and risk factors associated with alcohol and drug use, abuse, and dependence;
- service effectiveness based on outcome measures; and
- a state-wide cost analysis.

The most current biennial report, which presents substance abuse treatment data as of state fiscal year 2005-06, was published in June 2007.

- All three data systems are described in more detail in Appendix A. Taken together, data from these sources allow examination of trends in substance abuse treatment, as well as comparison of services and clients, at a state and national level.

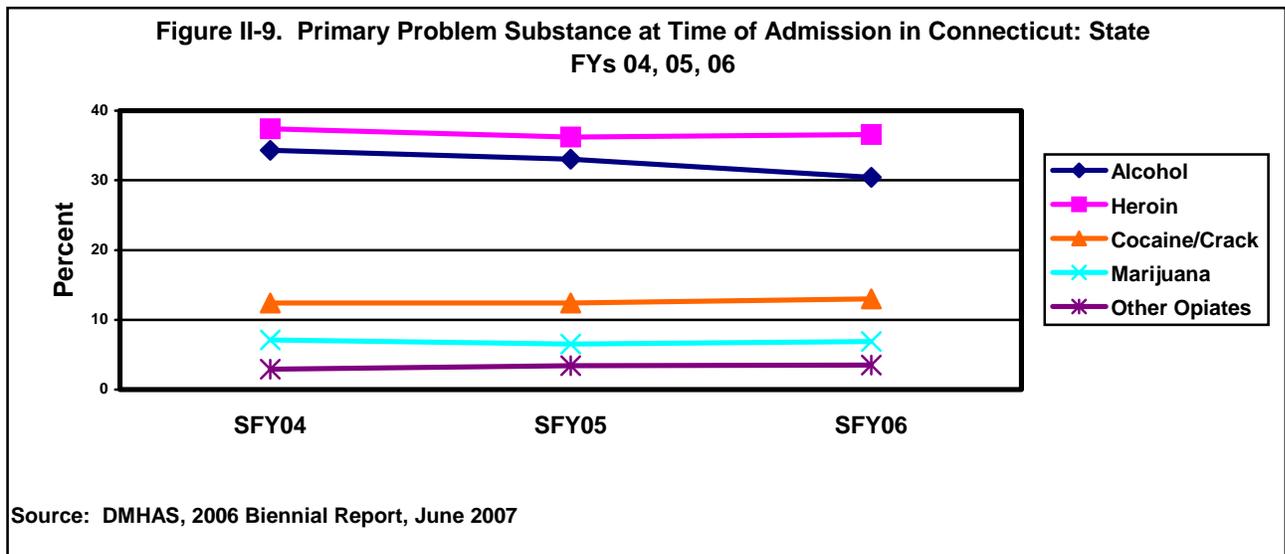
Primary problem substance. Data on primary problem substance at time of admission for treatment in Connecticut is compared to national statistics in Figure II-8. A smaller portion of Connecticut admissions report alcohol as their primary substance problem than for the nation as a whole (31.8% vs. 39.6%). Compared to national figures, the percentage of admissions in Connecticut reporting opiates (heroin, morphine, etc.) as the primary problem substance is very high (39.4% vs. 17.9%) while the percent of admissions reporting the primary problem as stimulants is very low (0.2% vs. 8.7%).



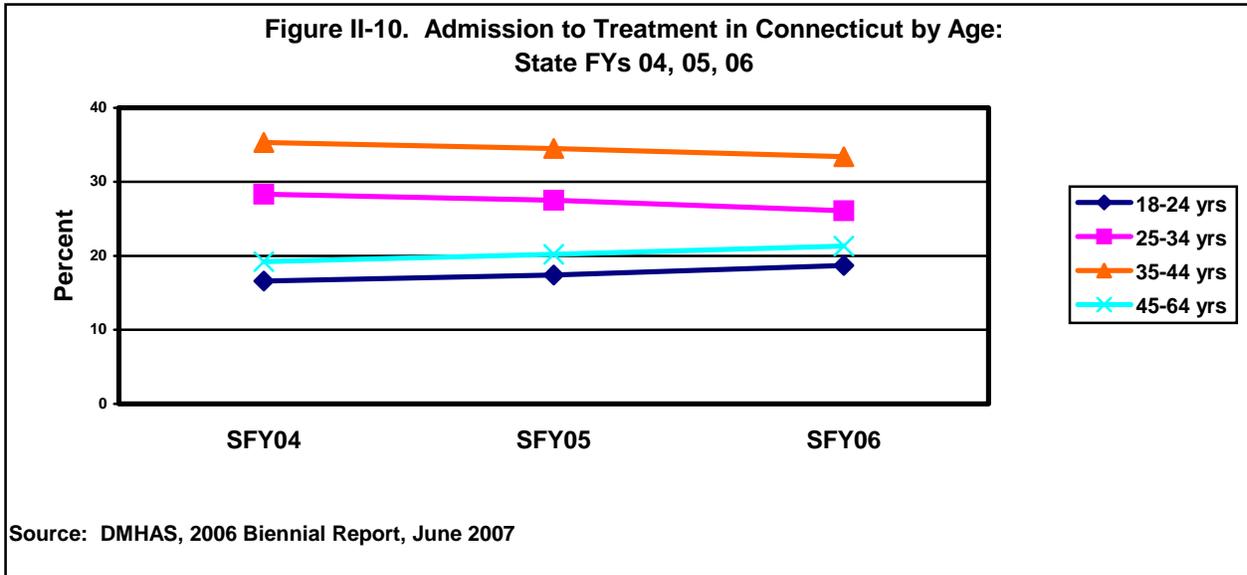
Data on trends in primary substance abuse problem at the time of admission over a recent three-year period in Connecticut is summarized in Figure x-2. As DMHAS points out in the 2006 biennial substance use report, there has been a downward trend in the percentage of clients reporting alcohol as their primary problem substance over this time period. Admission for cocaine (powder and crack) increased slightly during the first two years shown but then leveled off in FY 06. There has been very little change in the portion of admissions for problem marijuana use.

Figure II-9 also shows the rate of primary heroin admissions to treatment continues to be significant, although in contrast to steady increases in prior years, this rate dropped and began to level off during FYs 05 and 06. However, the percentage of admissions related to other problem opiates, such as the prescription pain medications oxycodon and vicoden, shows a slow but steady rise.

In the 2006 biennial report, DMHAS also notes what it considers a disturbing increase in admissions for heroin treatment among young adults (those age 18-24). The department believes the growing non-medical use of synthetic opiate pain relievers, particularly among young persons, in Connecticut and across the country may be contributing to such trends in treatment admissions.



Client characteristics. Information on age at the time of admission for Connecticut adults is summarized in Figure II-10. The percent of treatment admissions by two groups, young adults (age 18 to 24) and those age 45 years and older, continued to increase over the three-year period shown in the figure; the percent of admissions for the other two groups (25-34 years and 35-44 years) dropped. (Admissions by those age 65 years and older account for 0.5 percent or less of annual totals and not represented in the figure.)



DMHAS notes further in the 2006 biennial report that the average age at admission has changed little over time, remaining fairly constant at 35.5 years. According to the department, this trend underscores the need to improve the availability of age-appropriate substance abuse services and to provide them to clients earlier.

Overall, clients served by the Connecticut substance abuse treatment system in FY 07 were about 58 percent White, 20 percent African American, and 24 percent Hispanic. DMHAS estimates men used about 70 percent of all treatment episodes it operated or funded that year.¹² Table II-2, which is based on the department's most recent SATIS data, summarizes key client characteristics of persons admitted to treatment in Connecticut by their primary problem substance.

Table II-2. Characteristics of Substance Abuse Treatment Clients in Connecticut, SFY 06

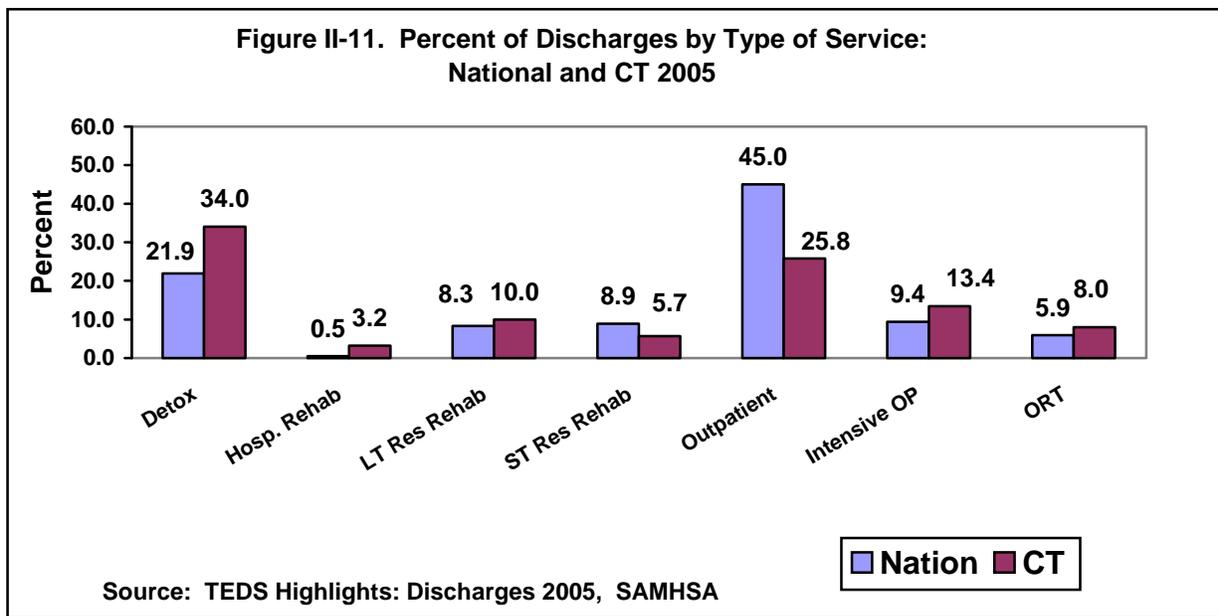
	Alcohol	Heroin	Cocaine	Marijuana
% Female	25.9	26.3	36.8	21.4
Avg. Age (yrs)	39.7	34.3	36.2	26.9
Race				
% White	69.0	57.9	46.5	39.3
% Black	18.7	11.9	36.9	38.4
% Other	12.4	30.2	16.6	22.3
Ethnicity				
% Hispanic	19.9	39.1	24.0	33.5
% Non-Hispanic	80.1	60.9	76.0	66.5

Source: DMHAS, 2006 Biennial Report, June 2007

¹² From the DMHAS SA block grant applications FY 2008, see p. 19

Table II-2 shows client characteristics vary with the reported primary problem substance. Those admitted to treatment for alcohol use disorder are predominately white, male, and older. Admissions reporting marijuana as their primary problem generally are younger and male while those reporting problem cocaine use are disproportionately female and black. As DMHAS discussed in the 2006 biennial report, the table also reflects the disproportionately higher admission rate for heroin treatment found among those who are Hispanic.

Type of treatment. At the national level, the best available information on the level of care received by individuals in need of substance abuse treatment comes from the federal TEDS discharge data. Information on the type of treatment at time of discharge for Connecticut clients in 2005 is summarized and compared to national figures in Figure II-11.



In Connecticut, detoxification was the most frequently reported level of care at time of discharge (34 percent). Nationally, the largest portion of treatment discharges was from regular outpatient services (45 percent). Connecticut also had higher rates of use for hospital and long-term residential rehabilitation services, intensive outpatient services, and opiate replacement therapy (ORT) than the nation as a whole. Greater amounts of clients receiving detoxification and ORT services is likely related to the fact that a larger portion of those admitted for treatment in Connecticut report heroin as their primary problem substance.

As noted earlier, the level of treatment received depends on the person's problem substance, along with the severity of the alcohol and/or drug dependence, and other individual characteristics. Information on types of services received by those admitted for treatment in Connecticut during FY 06 is presented by primary problem substance in Table II-3.

	Alcohol	Heroin	Cocaine	Marijuana
% Residential Detoxification	31.1	37.3	5.4	0.0
% Residential Rehabilitation	19.4	17.2	32.6	11.5
% Outpatient Services	49.3	15.9	61.5	88.5
% Methadone Services	0.0	24.5	0.0	0.0
% Ambulatory Detoxification	0.2	5.1	0.5	0.0

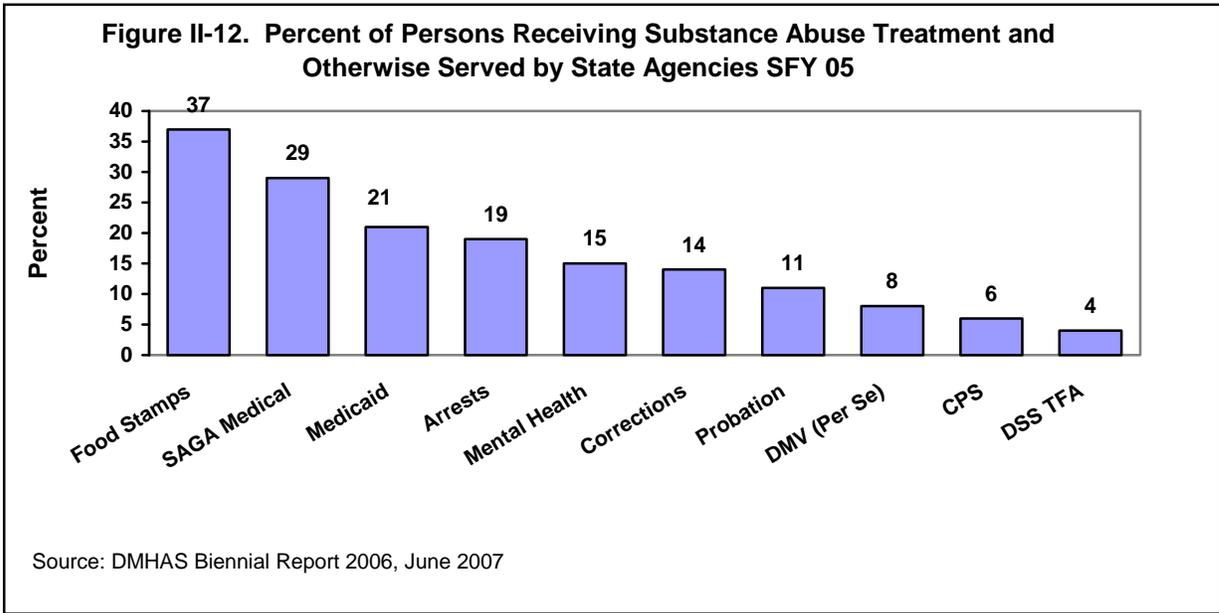
Source: DMHAS, 2006 Biennial Report, June 2007

The table indicates those admitted with alcohol use disorders and heroin addiction mainly used residential detoxification services followed by ambulatory services (i.e., outpatient and methadone treatment). Persons with cocaine addiction were treated mostly in residential rehabilitation and outpatient settings and the vast majority of those admitted for problem marijuana use received outpatient services. (As expected, methadone services were only received by those reporting heroin as their primary problem substance.)

In the 2006 biennial report, DMHAS points out the use of costly acute care services like detoxification has been decreasing since FY 03. The department attributes this to greater emphasis on connecting clients to residential treatment and outpatient services. Better care coordination and more use of medication-assisted therapies for opiate-dependent persons has been found to reduce relapses and repeated need for detoxification.

Population overlap. As discussed earlier, needs assessments and other substance abuse research indicate many within the criminal justice, welfare, and child protection systems, as well as large numbers of mental health clients, also require treatment for alcohol and drug dependence. Analysis of this “population overlap” among the substance abuse and other service systems can help to improve access to and quality of treatment.

Substantial progress has been made in linking state agency information to share data on clients but it is still not possible to easily track individuals across service systems. At present, DMHAS uses a statistical technique called PPE (probabilistic population estimation) to measure the overlap of clients among state agencies. The most recent PPE information on what other state programs persons in treatment for substance abuse were involved with during FY 05 is summarized in Figure II-12.

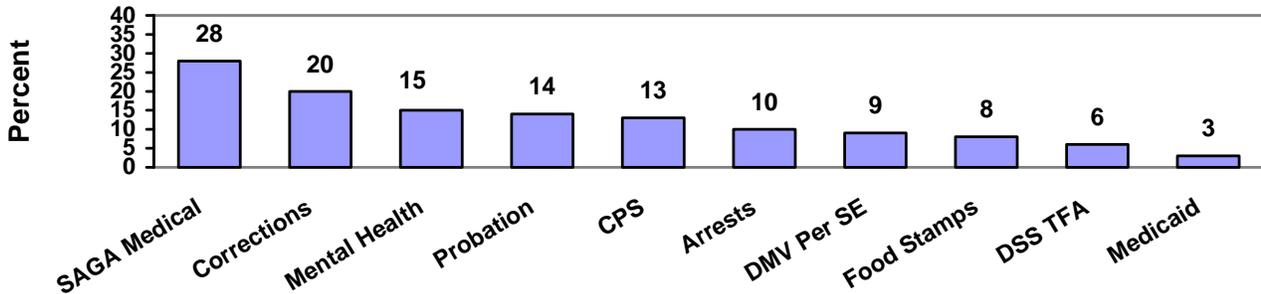


As Figure II-12 indicates, large proportions of those receiving substance abuse treatment are also served by programs administered by the Department of Social Services -- Food Stamps (37 percent), the State Assisted General Assistance (SAGA) Medical program (29 percent), Medicaid (21 percent), and to a much lesser extent, Temporary Family Assistance (TFA, 4 percent).

Overlap with the criminal justice system through arrests, probation, and correction (incarceration and parole) is also significant (14 percent to 19 percent). About 15 percent of the substance abuse treatment population was also receiving DMHAS mental health services in SFY 05 and an estimated 6 percent were involved in the state child protective services (CPS) system. Another 8 percent of those receiving alcohol or drug treatment were participants in the Department of Motor Vehicles "Per Se" program for drivers subject to license suspension because of arrests for driving while intoxicated.

Figure II-13 shows the portion of clients receiving substance abuse treatment, or the treatment access rate, for various state agency populations during state fiscal year 2005. The SAGA medical program population, with 29 percent of all clients receiving alcohol or drug treatment, has the highest access rate; Medicaid and TFA client populations had the lowest rates (3 percent and 6 percent respectively).

Figure II-13. Percent of State Agency Program Populations Receiving Substance Abuse Treatment, FY 05

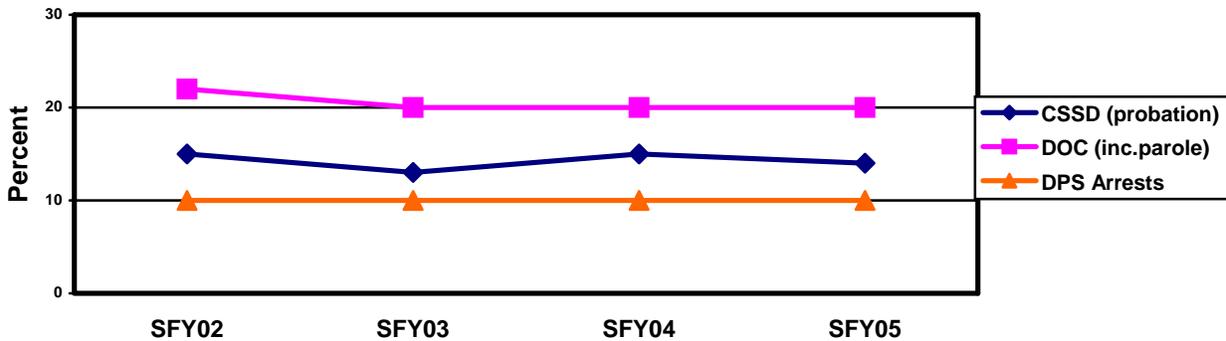


Source: DMHAS Biennial Report 2006, June 2007

Criminal justice population. DMHAS has given special attention to studying access to care for alcohol and drug dependence among the criminal justice population as research repeatedly demonstrates the many benefits of treatment for offenders include reduced recidivism. Two studies conducted by Yale University for the department have indicated 50 to 60 percent of those involved in the criminal justice system need substance abuse treatment. Comparing these treatment need rates to the treatment access rates presented in Figure II-14 for those arrested (10 percent), on probation (14 percent) or in DOC custody (20 percent), clearly shows these populations are underserved.

Figure II-14 illustrates trends in treatment admission rates for individuals arrested, serving probation, or admitted to or released from the correction department over a four-year period. Rates have remained about the same from FY 02 to FY 05 with the exception of the correction population, which dropped from a high of 22 percent in the first year shown in the figure and then leveled off at 20 percent for the remaining years.

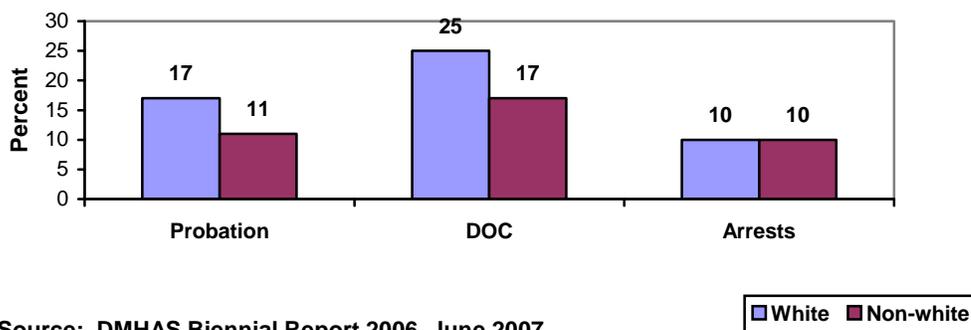
Figure II-14 Percent of Criminal Justice Involved Persons Receiving Substance Abuse Treatment FYs 03 - 05



Source: DMHAS, 2006 Biennial Report, June 2007

Additional analysis by DMHAS presented in the 2006 biennial report also shows access to substance abuse treatment by persons involved in the criminal justice system varies by race. As Figure II-15 indicates, in state fiscal year 2005, non-whites in the probation and DOC populations were less likely to receive treatment for alcohol and drug dependence. Among those arrested, there was no difference based on race.

Figure II-15. Criminal Justice Involved Persons Receiving Substance Abuse Treatment by Race, SFY 05



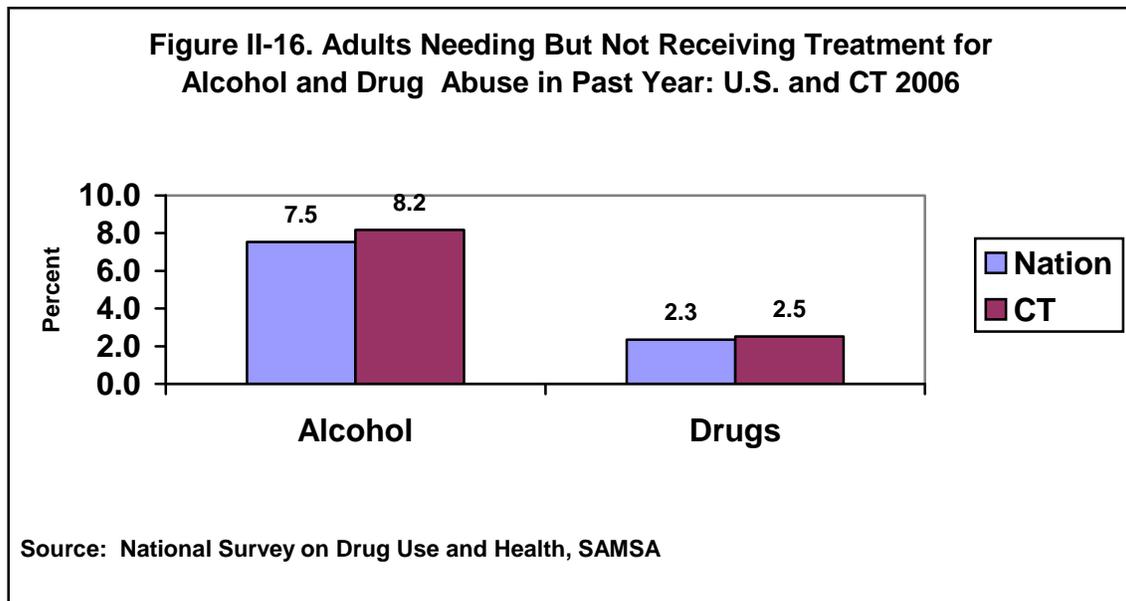
Source: DMHAS Biennial Report 2006, June 2007

Treatment gap. Data comparing those in need of substance abuse treatment and those receiving it, or what is called the “treatment gap,” is collected by the federal government each year through SAMHSA’s National Survey on Drug Use and Health. Treatment gap estimates are

developed for each state and the most recent information for Connecticut is presented in Figure II-16. Rates of unmet need are shown separately for alcohol and for drug dependency and compared to rates for the U.S. as a whole. (As treatment gap data for adults are available for just two years at this time, trends are not discussed.)

The figure shows in 2006, 8.2 percent of persons age 18 and over in Connecticut needed but did not receive treatment for their alcohol use disorder and another 2.5 percent needed but did not receive treatment for an illicit drug use problem. These percentages represent approximately 204,000 and 66,000 Connecticut adults, respectively.¹³

The treatment gap in Connecticut for alcohol and for drug abuse problems was slightly larger than national rates of unmet need. Based on 2002 data (the most recent available for all states), Connecticut was among states in the middle range regarding percentages of those needing but not receiving substance abuse treatment



¹³ An individual needing but not receiving treatment for both alcohol and drug dependency would be represented in each category. The prevalence of adults with co-occurring conditions is not known; however, assuming all untreated persons with drug problems also had untreated alcohol problems, these figures indicate at least 138,000 adults in the state needed but did not receive substance abuse treatment in 2006.

SUBSTANCE ABUSE TREATMENT OVERVIEW

Substance abuse treatment includes a broad range of programs and services aimed at stopping harmful alcohol and drug use and returning individuals to productive functioning in their family, community, and work environments. Treatment is provided at varying levels of intensity and in many settings, from hospitals and other 24-hour care facilities to outpatient clinics and other community-based locations. This section provides an overview of the major types of treatment available for adults with alcohol and drug use problems.

What is Treatment?

Substance abuse treatment encompasses an array of clinical therapies designed to address psychological, social, behavioral and medical problems related to alcohol and drug dependency. It may involve behavioral therapies, pharmacological therapies (medications) or a combination of both approaches. Supplemental services that can support recovery and reduce relapse, such as help with employment, childcare, housing, education, transportation, and life management, are also an important component of substance abuse treatment.

In addition to many types of therapies and services for substance abuse, there is a broad range in treatment intensity. Intensity refers to treatment elements such as frequency and duration of therapy sessions, and the level of clinical and other supervision provided during care. Best practices require that treatment strategies be customized to take into account the nature and severity of the substance abuse problem as well as an individual client's personal characteristics and needs. The primary treatment approaches for adults with substance abuse problems are described briefly below.

Behavioral therapies. Professional counseling and other behavioral (“talk”) therapies are designed to help people modify their attitudes and behaviors related to drug and alcohol abuse and increase their life skills so they can stop using and sustain recovery. Behavioral therapies also can help individuals engage in the treatment process, stay in treatment longer, and make medication therapies more effective. Family therapy and couples therapy are often used in combination with individual counseling sessions during substance abuse treatment.

Among the successful behavioral approaches to substance abuse treatment are:

- *Motivational interviewing*: incorporates techniques that help individuals recognize the harm caused by their substance abuse and encourage them to take positive action toward recovery;
- *Cognitive therapy*: teaches individuals about the reasons for their addiction and skills for coping with cravings and relapse triggers; and
- *Positive incentives*: small motivational bonuses (gift certificates, affirmations, additional privileges) are provided when patients make treatment progress to help encourage and reward positive accomplishments.

Pharmacological therapies. In some cases, prescription medications are used to help people stop abusing alcohol or certain other drugs, stay in treatment, and avoid relapse. In addition to changing the brain activity involved in addiction, medications can help patients with stress, which may trigger relapses, treat co-occurring conditions (e.g., depression), and be used to suppress withdrawal symptoms during detoxification. At present, approved medications are available for treating alcohol and opioid dependence (see Table III-1). Promising research is underway to develop new pharmacological therapies, particularly for treatment of cocaine, marijuana, and methamphetamine abuse.

Table III-1. Medications Used for Substance Abuse Treatment.		
	Medication (Brand Name)	Date FDA Approved
Alcohol	Disulfiram (Antabuse)	1949
	Naltrexone (ReVia)	1994
	Acamprosate (Campral)	2004
Opiates (Heroin, prescription painkillers, e.g., OxyCotin, Percocet, Percodan)	Methadone	1973
	Buprenorphine (Suboxone, Subutex)	2002
	Naltrexone (ReVia)	1985
Source of Data: John Hoffman and Susan Froemke, eds., <i>Addiction: Why Can't They Just Stop</i> (New York: Rodale, 2007)		

Pharmacological treatment for heroin and other opiate addictions, while shown to be very effective, has a somewhat negative public image. Under the treatment approach known as opiate replacement therapy (ORT), addicted individuals receive a medication that blocks the “high” induced by opiates and eliminates cravings. However, patients remain dependent upon the replacement medication and must continue in maintenance programs, often for many months or even years. Some question the validity of long-term maintenance but addiction experts point out, when provided in conjunction with effective behavioral therapies, ORT is the most successful treatment approach for adults with an opiate dependency that has lasted more than a year.

Until very recently, replacement therapy with methadone was the primary treatment for opiate addictions. Methadone is a synthetic narcotic originally developed as a pain medication during World War II. Due to its high potential for misuse, it is one of the most strictly regulated drugs in the U.S. and requires careful medical supervision. Under federal law, as a treatment for opiate addiction, methadone can only be administered through a licensed clinic and for the most part, patients must receive daily doses of the medication at the clinic site.¹⁴ At this time, methadone is the most widely used and cost-effective treatment for opiate addiction in the United States. According to DMHAS, on average, it costs about \$90 per week to treat an adult in a Connecticut methadone maintenance program.

A new medication for treating opioid addiction, buprenorphine, has several advantages over methadone. It can be taken in pill form, be prescribed by a physician and distributed

¹⁴ Methadone clinics must meet extensive SAMSHA licensing standards and be DEA certified.

through a regular pharmacy, making its treatment more flexible and convenient for clients than daily visits to a methadone clinic. It also is less likely to cause an overdose and causes less physical dependence. The main drawback to buprenorphine is its price. The weekly rate paid for buprenorphine treatment under a DMHAS program called Access to Recovery is \$157.

Self-help support groups. Mutual assistance groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Smart Recovery are an important resource for many people with substance abuse problems.. Participation in such groups is not considered treatment for alcohol or drug dependence by most experts in the field but its valuable contribution to successful recovery is widely recognized. National studies show More people receive help for alcohol and drug problems through mutual assistance groups than though any type of formal treatment.

Self-help organizations like AA and NA provide members with a support network as well as a personal recovery process, often referred to as a 12-step program. The primary group activity is attending meetings, led by volunteers, where members are expected to discuss all aspects of dealing with recovery with honesty, respect, and confidentiality. Most groups have a spiritual component but not any religious element. In general, none employ therapists or other professional treatment staff and there are no fees or charges.

Treatment settings. The continuum of care for substance abuse includes very intensive hospital services, e.g., medically managed, 24-hour inpatient acute care and evaluation, and a series of residential treatment levels with decreasing amounts of clinical treatment and medical monitoring.¹⁵ For those who are able to live independently while receiving treatment, ambulatory or outpatient services also ranging in intensity are available. Ideally, completion of primary treatment is followed by a period of continuing care, generally on a less frequent basis, and supplemental, community-based services that support recovery.

Residential. Settings for residential care include general hospitals and 24-hour care facilities specializing in substance abuse treatment, as well as halfway houses and other supervised living arrangements that provide clinically managed services to residents. One of the most intensive types of residential treatment is the therapeutic community, a highly structured residential program with a planned length of stay of 6 to 12 months. Therapeutic communities are focused on helping individuals learn socially acceptable behaviors and develop personal accountability and responsibility with the support of the whole program community (staff and peers).

Ambulatory. In addition to regular and intensive outpatient treatment programs, ambulatory services include partial hospitalization and day (or evening) treatment programs. The latter programs incorporate more frequent and higher levels of care and medical supervision, usually serving as a transition phase for those leaving a residential placement. Both regular and intensive outpatient treatment involve evaluation, treatment, and recovery support services provided by addiction personnel and clinicians in the community; the main difference is

¹⁵ In general, medically managed care means medical staff are present on a 24-hour basis while medically monitored refers to the availability of medical staff, via phone or back-up service, on a 24-hour basis.

frequency of therapy (i.e., in general, regular is less, and intensive is more, than nine hours per week).

Treatment categories. While there are numerous therapies and many settings for treating alcohol and drug abuse, there are three main stages of treatment: detoxification and stabilization; rehabilitation; and aftercare, also called continuing care. Each stage is described briefly below and summarized in Table III-2.

Detoxification and stabilization. Detoxification is the process of helping a person dependent on one or more substances safely and comfortably withdraw from dependence and become free of toxins. Alcohol and other drugs with serious withdrawal symptoms (opiates and tranquilizers) usually require medically supervised detoxification services. In some cases, untreated withdrawal can be medically dangerous or even fatal.

Because detoxification addresses the acute physiological effects of stopping alcohol or drug use, it is considered a precursor to treatment; it is only the first step of what should be a comprehensive treatment strategy. Detoxification has levels of intensity and matching the patient to the appropriate setting is an important clinical decision. For some patients, the process can be carried out in a doctor's office. Others in an outpatient setting may need intensive monitoring by nursing staff, sometimes referred to as "social setting" detoxification. The most intensive (and expensive) level is provided in an acute care hospital with full medical management.

Medically supervised detoxification can involve pharmacotherapy, or treatment with drugs that minimize withdrawal symptoms. Other therapies available during detoxification may include individual assessment, brief interventions and family involvement, and discharge or transfer planning.

Stabilization refers to early treatment aimed at addressing the acute physical, psychological, or emotional emergencies related to excessive alcohol or drug use. The two key components are assessment and brief intervention. Both can help begin the recovery process by determining an individual's treatment needs and engaging the person in continued rehabilitative care.

Rehabilitation. Rehabilitation is the appropriate stage of treatment when an individual's substance abuse problem is stabilized and any related acute conditions (physical or emotional) have been addressed. Typically, rehabilitation is a formal program of an array of treatments that can include: medication to reduce cravings; various behavior therapies; substance abuse education; and various supplementary services. It can be provided in both residential and ambulatory settings.

In general, the most severe alcohol and drug abuse cases require residential rehabilitation treatment. Individuals whose lives are out of control or who lack strong supports in the community generally need 24-hour care and supervision. Some patients transition from residential settings through a series of less intensive care levels -- partial hospitalization, day treatment, intensive outpatient, and regular outpatient -- while others move directly from residential to regular outpatient services. Those starting with less severe substance abuse

problems, and who have supportive families and stable employment, usually can begin their rehabilitation process on an outpatient basis.

Aftercare/continued care. Once rehabilitation or primary treatment process is completed, an individual may continue to receive similar therapeutic services (e.g., individual/group/family therapy, relapse prevention education, and guidance on daily living skills) but usually on a less frequent basis. The best aftercare programs include supports to prevent relapse and maintain recovery such as assistance with housing, employment, or transportation. Mutual assistance groups like AA and NA often have an important role in aftercare.

Continuing care is intended to help recovering individuals adjust to their lives in a community setting by monitoring their status and providing needed supports. Research shows individuals are most vulnerable to relapse during the first three to six months following active treatment so providing effective aftercare in this period can contribute to successful recovery.

	Detoxification/ Stabilization	Rehabilitation (Active Treatment)	Aftercare
Settings	<ul style="list-style-type: none"> • Inpatient hospital • Residential facility • Outpatient 	<ul style="list-style-type: none"> • Residential (free-standing specialty facility or hospital-based program) • Outpatient 	<ul style="list-style-type: none"> • Community-based
Components	<ul style="list-style-type: none"> • Assessment • Medication to reduce severity of withdrawal • Medical care and monitoring as needed • Sometimes brief treatment, acute clinical intervention 	<ul style="list-style-type: none"> • Array of therapies and treatment programs to address health and social problems associated with substance abuse • Often includes supplementary services 	<ul style="list-style-type: none"> • Monitoring and support services to maintain long term recovery
Duration	<ul style="list-style-type: none"> • Generally 3-5 days 	<ul style="list-style-type: none"> • Residential generally ranges short-term (under 30 days), intermediate, or long term (90 days or more) • Outpatient services vary in intensity (e.g., from 2-8 hours per day, 2-5 days per week, over a period of several weeks or months) 	<ul style="list-style-type: none"> • Generally 6-12 months following completion of rehabilitation
Goal	<ul style="list-style-type: none"> • Remove drugs from patient's system; address acute physical, social, or psychological emergency caused by excessive alcohol or drug use; begin recovery process by engaging patient 	<ul style="list-style-type: none"> • Sustain elimination of alcohol and other drug use; improve health and social functioning; engage patient in continuing care 	<ul style="list-style-type: none"> • Help recovering individual: self-manage cravings/temptations; sustain elimination of alcohol and other drug use; maintain healthy lifestyle and develop fulfilling life

Source: Adapted from Chapter Four: Treatment in John Hoffman and Susan Froemke, eds., *Addiction: Why Can't They Just Stop* (New York: Rodale, 2007).

Treatment Effectiveness

With substance abuse now recognized as a chronic, recurring disease, it is also understood that repeated episodes of treatment may be required before the ultimate goal of sustained abstinence is reached. Avoiding relapse, which is often part of a person's recovery process, cannot be the sole measure of treatment effectiveness. As with other continuing care conditions, reasonable expectations for substance abuse treatment include what can be considered intermediate goals: reduced use; improved functioning; minimized medical complications; and fewer negative social consequences (e.g., criminal activity) related to alcohol and drug abuse.

A substantial body of scientific research, much of it federally funded, exists concerning the effectiveness of substance abuse treatment in terms of these goals. Longitudinal studies of various programs and clinical practices began in the 1970s and continue today, producing extensive evidence on successful approaches for treating drug and alcohol dependence. This research is the basis for much of the evidence-based practice found in high quality treatment programs.¹⁶ Key findings from several national evaluations of substance abuse treatment conducted over the past three decades are highlighted below

National evaluation results. To date, three major longitudinal studies of publicly funded substance abuse treatment have been carried out by the National Institute on Drug Abuse (NIDA). Each one has:

- evaluated treatment outcomes;
- analyzed treatment issues (e.g., service delivery, access, and client engagement and retention); and
- identified emerging trends in client populations, substance use, funding, and treatment approaches.

The first study, the *Drug Abuse Reporting Program (DARP)*, collected initial data between 1969 and 1972 on 44,000 clients served by 139 separate programs across the country and included a series of follow-up studies on outcomes up to 12 years after treatment. During this time, the country was experiencing a growing heroin epidemic and many of the clients in the DARP study were using opiates on a daily basis. Among the study's most significant findings:

- *Time spent in treatment was a major predictor of post treatment outcomes; stays of 90 days or longer were significantly associated with favorable outcomes.*
- *Community-based treatment for opiate addiction was found to be effective in terms of reduced drug use and reduced criminal behavior.*

¹⁶ According to SAMHSA, evidence-based practices generally refers to approaches to treatment that are validated by some form of documented scientific evidence. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practices stand in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

- The six-year follow up of opioid addicts showed the majority (61% of these clients) had quit daily opiate use for a full year or longer and had improvements in employment, use of other substances (alcohol or other nonopioid drugs), and criminal activity; *on-going treatment or returning for subsequent treatment was associated with better outcomes.*

NIDA expanded its research scope in its second national evaluation, the ***Treatment Outcomes Prospective Study (TOPS)***, to include specialized studies of co-occurring conditions, cost-effectiveness, and the impact of criminal justice involvement in addition to general treatment program effectiveness. The TOPS study, which gathered data on 11,750 clients admitted to 41 different treatment programs in 10 U.S. cities between 1979 and 1981, produced the following major findings:

- *Treatment was effective in reducing daily opiate use and other illicit drug use during and after the treatment period (a finding supporting earlier DARP study results).*
- *Clients with pressure from the criminal justice system to enter treatment were just as likely as those entering treatment voluntarily to benefit from substance abuse treatment*
- *Study results concerning methadone maintenance programs showed client retention rates, a factor critical to treatment success, were higher for programs with flexible dosing policies, specialized personnel, frequent urine monitoring, and comprehensive services.*

The third national evaluation of the effectiveness of public substance abuse treatment services, the ***Drug Abuse Treatment Outcomes Studies (DATOS)***, was initiated in 1990. Baseline data for the DATOS studies were collected for more than 10,000 adults entering 96 separate treatment programs located in 11 representative cities during 1991-1993. Follow-up data were gathered at several different points (from three months to five years after treatment) for certain samples of clients. Four research centers to conduct on-going, coordinated research in several key areas of study (e.g., service delivery and access, client engagement and retention, treatment for substance-abusing offenders, and trends in treatment effectiveness) were also created as part of DATOS.

To date, numerous reports on all aspects of treatment effectiveness have been, and continue to be, produced based on analysis of the DATOS data files. In the late 1990s, NIDA reviewed all results from the many studies based on DATOS research, as well as from the earlier national studies, to identify principles that should form the basis of any effective treatment program. The principles, described below, were published as a “research-based guide” in 1999. Overall, they underscore the complex nature of substance abuse and the need for a continuing care strategy for treatment of alcohol and drug dependency, like other chronic diseases.

NIDA Principles. The 13 principles discussed in the NIDA guide for addiction treatment are summarized in Table III-3. As the table indicates, what is central to effective treatment is a continuum of customized care that addresses all aspects of an individual’s life

(medical, emotional, psychological, behavioral, and social) and includes “follow up options” for supporting recovery (e.g., community- or family-based service systems).

According to these principles, other critical components of effective treatment are: ready availability of treatment; continuous monitoring of possible substance use during treatment; and adequate time in treatment. Contrary to some popular opinion, research shows treatment does not have to be voluntary to be effective. Finally, successful outcomes may require more than one treatment episode, and research shows, in many cases, multiple episodes of treatment have a cumulative impact.

Table III-3. NIDA Principles of Treatment

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.
5. Remaining in treatment an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves and others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Source: National Institute on Drug Abuse, National Institutes of Health, *Principles of Drug Addiction Treatment: A Research-Based Guide*, 1999.

NIDA published another research-based guide targeted to substance abuse treatment for those in the criminal justice system in July 2006.¹⁷ It contains many of the same principles as the 1999 guide but highlights the research finding that addiction is a brain disease and emphasizes that a comprehensive assessment is the first step in the treatment process.

¹⁷ National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, July 2006.

In addition, several principles in the criminal justice treatment guide focus on factors specific to treatment for drug-abusing offenders. They include the following guidelines: correctional supervision must balance rewards and sanctions to enhance treatment participation and prosocial behavior; continuity of care is essential for maintaining recovery of drug abusers treated in prison when they re-enter the community; and criminal justice supervision should incorporate treatment planning for drug abusing offenders to improve the success of community re-entry and substance abuse treatment provided during parole and probation periods.

In many ways, findings presented in the NIDA research-based guides can be viewed as best practices for treatment programs. For example, the research clearly demonstrates good outcomes are contingent upon adequate lengths of treatment. According to the guides, residential or outpatient treatment participation for less than 90 days is of limited or no effectiveness; for methadone maintenance, 12 months of treatment should be considered the minimum, and for some individuals addicted to opiates, several years of treatment is beneficial.

Regarding treatment program operations, NIDA found the following practices contribute to better outcomes:

- ensuring counselors are able to establish positive, therapeutic relationships with clients;
- establishing and following an individualized treatment plan;
- making an array of services (medical, psychiatric, social services) available to clients; and
- providing transition to continuing care (aftercare) after completion of formal treatment.

NTIES results. The *National Treatment Improvement Evaluation Study (NTIES)*, considered one of the largest and most rigorous substance abuse research projects carried out in the United States, was a five-year study mandated by Congress in 1992. NTIES examined service delivery issues (e.g., organization, budget, staffing, use of federal funds) for all programs in the country that received federal substance abuse treatment grants. It also evaluated, and continues to update, clinical outcomes for a representative sample of more than 4,400 clients served by these programs. The final report on the five-year study, issued in 1997, contained the following key findings:

- Clients served by the federally funded *treatment programs significantly reduced their alcohol and other drug use.*
- *Treatment had lasting benefits, with significant reductions in drug and alcohol use reported a full year after treatment.*
- One year after treatment, clients also reported *increases in employment and income; improvements in mental and physical health; and decreases in criminal activity, homelessness, and behaviors that put them at risk for infectious disease.*

Like earlier national studies, the NTIES evaluation of study showed the positive outcomes of treatment (reduced drug and alcohol use as well as decreased criminal activity and increased employment) were better among those clients who: completed their treatment plans; received more intensive treatment, and were treated longer. The final report noted it was not clear how these treatment factors and other patient characteristics (e.g., demographics, legal status, severity of problem) contribute to variation in clinical outcomes and suggested continuing research in this area.

Cost-effectiveness results. A number of the studies summarized above examined whether substance abuse treatment is cost-effective. NIDA, based on its examination of national research results, estimated in 1999 that every \$1 invested in addiction treatment returned \$4 to \$7 in reduced crime and criminal justice system costs. Including projected cost-savings related to health care boosted the benefit ratio to \$12 returned for every \$1 invested.

The NTIES study found substance abuse treatment appeared to be cost-effective, particularly when compared to one alternative common for many individuals, incarceration. Cost estimates developed by the study researchers in the mid 1990s for various types of treatment were compared to the American Correctional Association’s estimate of the annual cost of incarceration at the time (1994). As Table III-4 shows, the cost to imprison a person for one year was significantly higher than the costs of any of typical types of treatment for alcohol and drug dependency.

Table III-4. Comparative Cost of Treatment: 1997 NTIES Study Estimates		
Methadone maintenance	\$13/day	\$3,900/client (about 300 days)
Outpatient	\$15/day	\$1,800/client (about 120 days)
Short-term residential care	\$130/day	\$4,000/client (about 30 days)
Long-term residential care	\$49/day	\$6,800/client (about 140 days)
Substance abuse treatment in a correctional facility	\$24/day*	\$1,800/client (about 75 days)
One year of incarceration	-	\$18,330
*Cost over and above incarceration costs		
Source: NTIES Highlights		

A recent federally funded benefit-cost analysis of substance abuse treatment in California found similar results. Published in 2006, this study concluded each dollar spent on treatment produced a \$7 return on the investment. On average, substance abuse treatment in that state cost \$1,583 and resulted in monetary benefits valued at \$11,487. These benefits were primarily due

to increased employment earnings and reduced costs of crime. (Direct benefits to clients such as improved health and quality of life were not addressed in the analysis.)¹⁸

¹⁸ Ettner, et. al, *Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment “Pay for Itself?”*, Health Services Research v. 41(1), pp. 192-213, Feb. 2006.

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Section IV

CONNECTICUT SUBSTANCE ABUSE TREATMENT SYSTEM

Substance abuse treatment in Connecticut is defined by state law as a continuum of inpatient and outpatient services and care that includes "... diagnostic evaluation, medical, psychiatric, psychological and social services, vocational and social rehabilitation, and other appropriate services which may be extended to alcohol-dependent, drug-dependent, and intoxicated persons." The Department of Mental Health and Addiction Services, as the state's lead substance abuse agency, has primary responsibility for planning and coordinating the state's system of alcohol and drug abuse treatment services.

DMHAS also is a major provider of publicly funded treatment services; it operates three state inpatient facilities and funds a statewide network of more than 150 private providers of all levels of substance abuse treatment through grants and fees-for-service. However, other state agencies and the Judicial Branch fund, and in the case of the Department of Correction, even operate, substance abuse treatment services for the adult clients they serve.¹⁹

DMHAS and the other state entities that provide or fund substance abuse treatment serve two main populations of adults: persons with substance use disorders who lack the financial means to obtain care on their own; and individuals involved in the criminal justice system who have alcohol and drug dependency problems. For the most part, adults with private health insurance, or the ability to pay for care on their own, obtain services they need for alcohol or drug dependency outside of DMHAS and other state-operated facilities and programs. Many of the private providers contracted to care for state agency substance abuse treatment clients, however, also serve private-pay patients.

An overview of the network of facilities and programs that comprise Connecticut's publicly supported treatment system for adults with substance use disorders is presented below. In addition, this section describes the role and responsibilities of the Department of Mental Health and Addictions Services as the state's lead agency for prevention and treatment of alcohol and other substance abuse, including: its current mission; organization; planning and coordination functions; and resources related to adult substance abuse treatment.

The department's major treatment programs and services and key steps in the agency's treatment process for adults with substance use disorder also are summarized. The substance abuse treatment activities carried out for adults involved in the criminal justice system by the Court Support Services Division of the Judicial Branch and DOC are described separately in later sections of this report.

¹⁹ The Department of Children and Families, since it was established as the state's consolidated children's agency, is responsible for providing and funding behavioral health services (including substance abuse prevention and treatment) for children and adolescents (anyone under age 18). DMHAS works with DCF, as well as a number of other state agencies and the Judicial Branch, to plan and coordinate all state alcohol and drug abuse services. In recent years, the agencies have been collaborating to improve transition services (for youth moving to the adult system).

Treatment Programs and Providers

At present, the publicly supported substance treatment system for adults in Connecticut is comprised of:

- state-operated substance abuse treatment programs at DMHAS facilities;
- alcohol and drug treatment programs operated by DOC within state correctional facilities;
- detoxification, residential rehabilitation, and other treatment services provided at general hospitals and at specialized private residential facilities; and
- a wide array of outpatient programs operated by licensed, private providers agencies, primarily nonprofit agencies, and treatment services delivered in the community by private practice physicians and other licensed professionals.²⁰

In Connecticut, all private providers of behavioral health treatment services must be licensed by the state Department of Public Health (DPH). (Treatment programs and facilities operated by state or other government agencies are not subject to DPH licensing requirements.) As of November 2007, there were 181 private programs licensed by DPH to provide alcohol and drug dependency services in Connecticut.

The majority of Connecticut's private substance abuse treatment facilities (128) provide only outpatient services. Just under 30 percent (53) are licensed to provide various types of residential care for substance abuse. Most of these outpatient and residential programs are operated by private nonprofit provider (PNP) agencies. Many serve as substance abuse treatment contractors for state agencies and the Judicial Branch.

Program profile. The most comprehensive information on substance abuse treatment programs in Connecticut is collected through SAMHSA's annual survey of all alcohol and drug facilities in the country (N-SSATS).²¹ The most recent national survey data about Connecticut facilities, summarized in Table IV-1 below, are for 2006.

As Table IV-1 indicates, the vast majority (86 percent) the substance abuse treatment facilities in Connecticut are private non-profit organizations. They also serve 86 percent the more than 22,000 adult clients in treatment at the time of the survey. Government-operated facilities accounted for just under 10 percent of the total number of alcohol and drug treatment providers and a similar proportion of clients. (The client figures include all adults in treatment on the day of the survey, both public- and private-pay.) Only 12 of the 209 facilities operating in the state on March 31, 2006, were private for-profit entities.

²⁰ The government-operated alcohol and drug treatment programs at state and federal veterans' hospitals in Connecticut, which are targeted to a special adult population and relatively small scale, are not included in scope of this study.

²¹ The national survey attempts to identify all facilities, which are providers, public and private, for-profit and not-for-profit, that offer alcohol and drug abuse treatment services in each state. For the most part, what N-SSATS counts as a facility is comparable to what DPH and DMHAS count as programs. However, there are some inconsistencies in the ways the federal and state agencies count separate programs located within the same facility (e.g., a residential facility with one program for men and one for women) so total numbers can vary among sources.

	No. Facilities	Pct. of Total	No. Adult Clients in Treatment	Pct. of Total
Private Not-For-Profit	179	86%	19,030	86%
Private For-Profit	12	6%	1,121	5%
State Government	12	6%	1,170	5%
Other Government	6	3%	843	4%
Total	209		22,164	

Source of Data: N-SSATS Connecticut Profile 2006

The majority of Connecticut facilities (63 percent) included in N-SSATS data were providers that specialize in substance abuse treatment. A little more than one-quarter (28%) were combination (mental health and substance abuse) treatment facilities. The primary focus of the remainder was only mental health (7 percent), or other (2 percent).

Information on the types of care provided by the state's substance abuse facilities and the number of clients receiving each level is summarized in Table IV-2. A single facility can offer more than one type of care (e.g., regular and intensive outpatient, outpatient and inpatient, etc.) About three-quarters of Connecticut facilities provide one or more types of outpatient services while nearly one-third have some type of residential care. Just 17 facilities were providers of hospital inpatient services.

Type of Care	No. Facilities	No. Clients in Treatment*	Median No. Clients Per Facility
All Facilities	209	22,809	-
Outpatient	152	20,896	65
<i>Regular</i>	128	8,993	36
<i>Intensive</i>	79	1,468	12
<i>Day Treatment/Partial Hosp.</i>	39	474	7
<i>Detoxification</i>	32	352	6
<i>Methadone</i>	38	9,609	221
Residential	66	1,607	18
<i>Short-term</i>	21	338	16
<i>Long-term</i>	51	1,147	14
<i>Detoxification</i>	10	122	12
Hospital Inpatient	17	306	13
<i>Detoxification</i>	13	157	8
<i>Rehabilitation</i>	17	149	5

* Total number of clients in treatment on March 31, 2006 including clients under age 18 (645)

Source of Data: N-SSATS Connecticut Profile 2006

About 92 percent of the clients in treatment at the time of the survey were receiving outpatient care. Just 7 percent were in residential treatment facilities and only 1 percent were getting hospital inpatient care for their substance abuse problem. Slightly more than 40 percent of all those in treatment were receiving outpatient methadone services, which is about the same portion as those in regular outpatient care.

In general, the numbers of clients in treatment per facility in Connecticut are not large. The median number of clients treated in an outpatient facility, except for those providing methadone services, was 36 or fewer. For residential treatment facilities and inpatient hospitals the median number of clients in treatment was 18 and 13, respectively.

Treatment FUNDING

In Connecticut and nationally, substance abuse treatment, unlike other types of health care, is primarily government-funded. DMHAS estimates approximately 75 percent of the clients included in its substance abuse treatment reporting system (SATIS), which receives admission data from all licensed and all state-operated programs, are publicly supported. This means their service is paid for by a government program like Medicaid, or they have no insurance or ability to pay for substance abuse treatment.²² Nationally, it is estimated at least 80 percent of addiction specialty care is paid for by federal, state, or local government.²³

Under state law, most individual and group health insurance policies must provide benefits for diagnosis and treatment of substance use disorders on the same basis as any other medical condition. For example, lifetime and annual limits, deductibles, co-payments, and limits on inpatient and outpatient visits for treatment related to alcohol or drug dependency (and other mental illnesses) must equal those for physical illnesses. While a number of states have enacted mental health insurance parity laws in the past decade, only about a half dozen, including Connecticut, encompass treatment for substance use disorders.

State expenditures. In compliance with statutory requirements, DMHAS compiles information on all state agency substance abuse expenditures for its biennial report. The most recent available data on substance abuse spending by agency (for FY 05) is shown in Table IV-3. The total expenditure information includes funding from all sources (state, federal, and other) for all three main categories of substance abuse services: prevention, which encompasses education, non-clinical types of early intervention; deterrence or law enforcement activities; and treatment, which is limited to services with a clinical component for the purpose of the biennial report.

Table IV-3 shows the state's lead agency for alcohol and drug services, DMHAS, is responsible for the largest portion (57 percent) of state agency substance abuse spending. Overall, about three-quarters of total state substance abuse spending is for treatment services. Two agencies, DMHAS and DSS, account for the bulk of state expenditures for substance abuse treatment (82 percent).

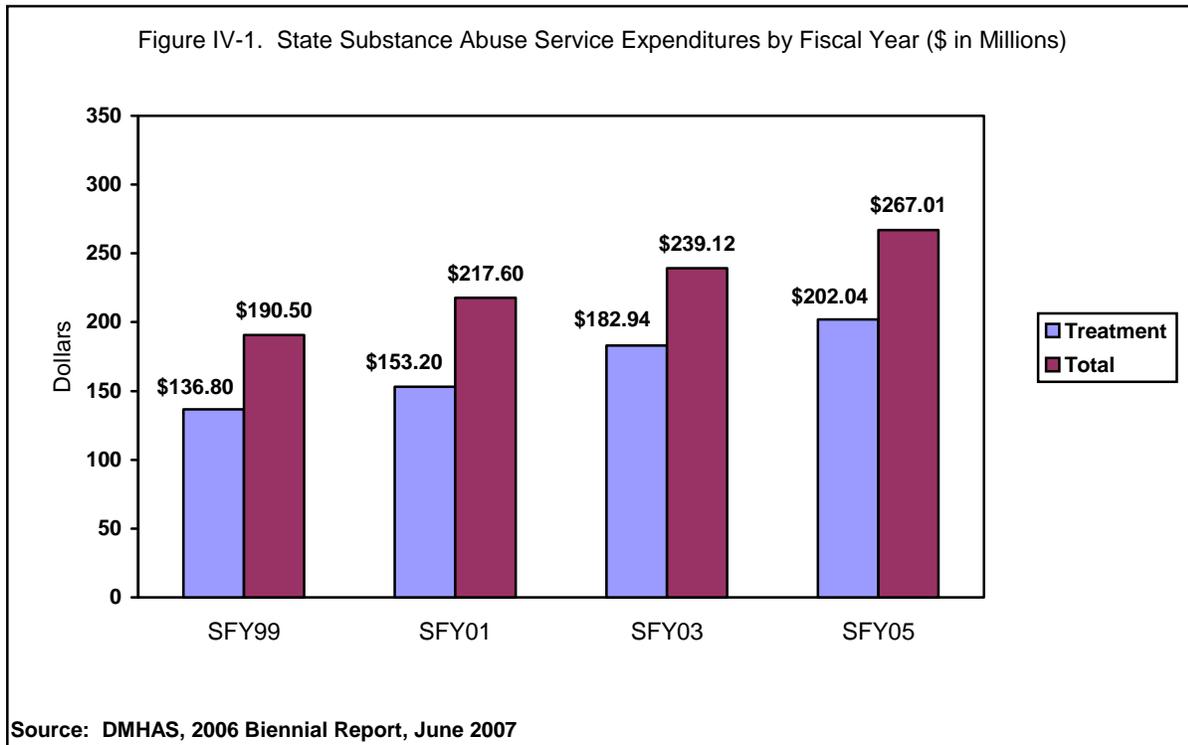
²² DMHAS 2006 Biennial Report, June 2007, p. 13.

²³ Dr. Thomas McLellan, Treatment Research Institute, PowerPoint presentation for Connecticut General Assembly Appropriations and Public Health Committees Informational Forum, January 23, 2008.

Table IV-3. Substance Abuse Expenditures by State Agency: FY 05.*				
	Total All Services	Treatment Services Only	Treatment as % Agency Total	Agency Treatment as % Treatment Total
Dept. of Mental Health & Addiction Services	\$151,358,130	\$128,862,295	85.1%	63.8%
Judicial-Court Support Services Division	\$27,140,267	\$10,856,107	40.0%	5.4%
Dept. of Children & Families	\$17,341,290	\$14,128,612	81.5%	7.0%
Dept. of Correction (includes Parole)	\$10,616,883	\$10,616,883	100%	5.3%
Dept. of Social Services	\$37,175,576	\$37,175,576	100%	18.4%
Dept. of Veterans Affairs	\$397,873	\$397,873	100%	0.2%
Other State Agencies**	\$22,979,675	\$0	0%	0%
Total	\$267,009,694	\$202,037,346	75.7%	100%
<p>* Refer to explanatory footnotes in source document for expenditure calculation methodology. ** Other state agencies include those that fund prevention and deterrence services but not treatment for alcohol and drug dependence (i.e., Departments of Education, Transportation, Public Health and Public Safety, and the Office of Policy and Management).</p> <p>Source of Data: DMHAS 2006 Biennial Report, June 2007, p. 27.</p>				

Among the agencies that fund treatment services, treatment accounts for all or most (almost 82 to 100 percent) of their substance abuse spending with one exception -- the Court Support Services Division of the Judicial Branch. Less than half of CSSD total expenditures for substance abuse services (40 percent) is identified as treatment spending. Many of the division's substance abuse services are prevention and non-clinical treatment interventions related to the statewide alternatives to incarceration network. For the purposes of the biennial report, non-clinical interventions are not considered to be treatment and, therefore, these CSSD services are categorized as prevention.

Statewide funding for treatment services and for substance abuse services in total over time is shown in Figure IV-1. The figure shows there has been steady growth in state expenditures for treatment services, and for substance abuse services in total, since DMHAS



began compiling funding information in 1999. However, according to the department, most of what appears to be a substantial increase over time is due to better expenditure reporting and the identification and inclusion of additional funding sources (e.g., Department of Social Services treatment expenditures have only been reported since FY 02). Improvements made in data collection will permit more reliable examination of spending trends in future biennial reports.*

Department of Mental Health and Addiction Services

By law, DMHAS must coordinate all activities in the state relating to substance abuse treatment for persons age 18 and older, including those of other state agencies and the Judicial Branch. It is mandated to develop and implement a state plan for prevention, treatment, and reduction of alcohol and drug abuse problems. Furthermore, the department must establish "...comprehensive and coordinated programs for the treatment of alcohol-dependent, drug-dependent, and intoxicated persons..." consistent with the state plan.

Responsibility for alcohol and drug abuse services has been within an integrated mental health and addiction services department since 1995, when all state substance abuse and mental health functions for adults were merged under the legislation that established DMHAS. Prior to the 1970s, authority and responsibility for substance abuse was within the former Department of Mental Health.

In 1977, the former Connecticut Alcohol and Drug Abuse Commission (CADAC) was created to plan, coordinate, and oversee publicly funded, primarily community-based, substance abuse prevention and treatment services throughout the state. In the late 1980s, CADAC assumed responsibility for state-operated inpatient care from the state mental health department. CADAC's functions were transferred to a newly established Department of Public Health and Addiction Services under a 1993 public act and moved again in 1995 when the legislature eliminated that agency and created DMHAS.

Other legislation enacted in 1995 required the newly combined department to operate, within available appropriations, a behavioral health managed care program for individuals eligible for medical services under State-Administered General Assistance, or SAGA. This program, the General Assistance Behavioral Health Program (GABHP), began as a pilot and was made permanent in 1997.

At present, DMHAS, as the state's lead agency for adult behavioral services, is responsible for mental health and substance abuse prevention programs for all Connecticut citizens across their lifespan. The treatment services the department directly provides, or funds and monitors, are targeted to adults who lack the financial means to obtain services on their own (i.e., the publicly insured population and individuals without insurance or ability to pay). DMHAS considers its treatment programs for substance abuse, as well as its mental health services, to be the "safety net" of the state's behavioral health system, targeting those without any other resources for obtaining care.

Agency Mission

The overarching mission of the Department of Mental Health and Addiction Services is to promote and administer: "... comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut." According to the department, its alcohol and drug treatment services are aimed at assisting recovery from substance use disorders while its prevention efforts promote factors that reduce the likelihood of substance abuse.

Current department leadership emphasizes the department's role as a healthcare agency focused on promoting wellness and improving the quality of life of individuals who receive DMHAS behavioral health services. Since the late 1990s, the agency has been working to integrate its mental health and addiction services and develop a recovery-oriented system of care.

The department defines recovery as: "... a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within, the limitation imposed by that condition." According to the agency, this concept of recovery is the guiding principle and operational framework for its entire system of care, both state-operated and state-funded.

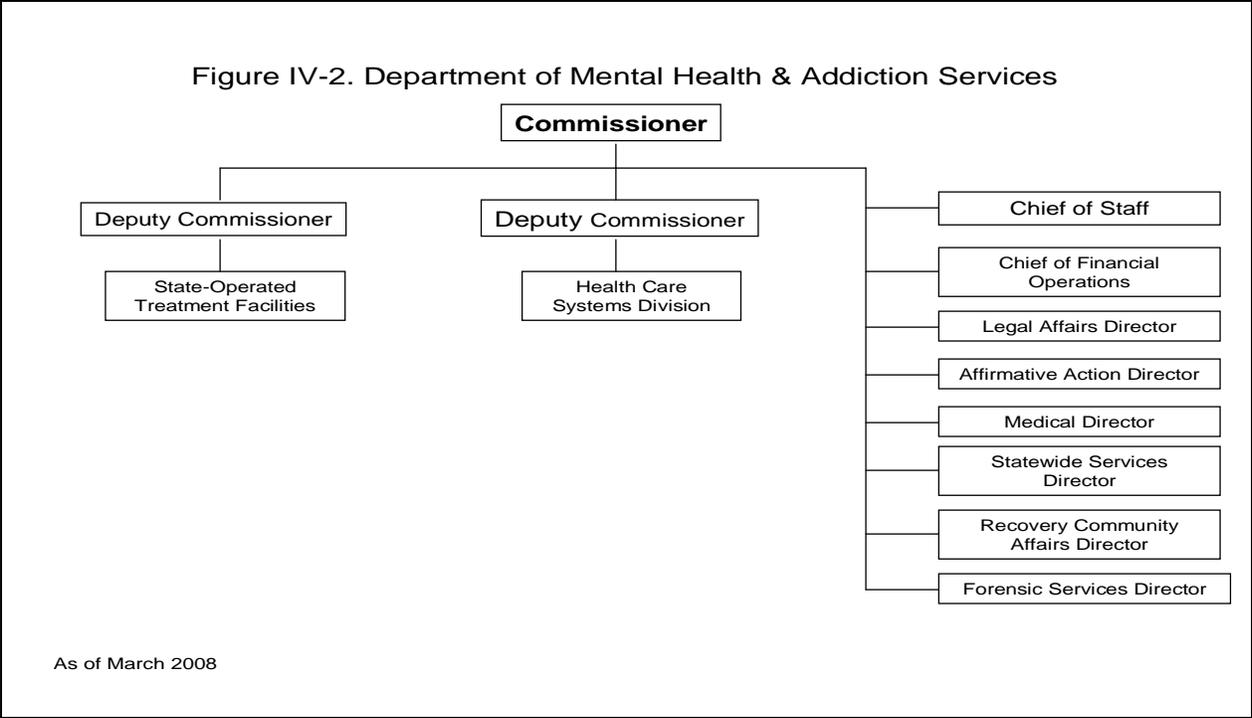
DMHAS began the process of transforming its system of care by asking client advocacy groups to help develop a set of core recovery values to guide future agency policy and operations. In 2002, the commissioner issued a written policy statement incorporating the 27 guiding principles resulting from this process; chief among them are the following :

- Services shall identify and build upon each recovering individual's strengths.
- The system shall encourage hope and emphasize individual dignity and respect.
- As recovery is a process rather than an event, services shall address needs over time and across different levels of disability.
- The system shall be notable for its quality, marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care, and sustained, rather than short-lived and crisis-oriented, effects.
- The system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact one's recovery.
- When possible, services shall be provided within the person's own community setting, using the person's natural supports.

Subsequent implementation strategies have included: additional formal policy statements to promote critical initiatives (e.g., co-occurring conditions); extensive provider training in recovery-oriented concepts and practices; and development and publication of recovery-oriented practice guidelines and standards. The department also has put in place recovery-oriented performance and outcome measures, a consumer feedback process, and a "technology transfer" program to promote use of recovery-oriented and evidence-based practices. Improvements in agency data systems are underway and the commissioner is committed to using new funding and realigning existing resources to promote recovery-oriented practice and programs.

DMHAS Organization

Responsibilities related to substance abuse are carried out within many areas of the Department of Mental Health and Addiction Services. The organization chart presented in Figure IV-2 highlights the department management positions with key roles for substance abuse treatment. The commissioner instituted a major reorganization of agency leadership and reporting authority in March 2008, which is reflected in the figure.



As Figure IV-2 indicates, there is no single division or unit within DMHAS dedicated to substance abuse treatment (or to mental health treatment). For the most part, agency managers responsible for key operations -- e.g., department treatment facilities, systems of care, community relations, medical issues, support services, fiscal, policy, research and planning, and forensic services (those related to the criminal justice system) -- carry out these functions for both mental health and substance abuse. In addition, the commissioner recently divided top level management responsibilities for the agency's behavioral health treatment system between the two deputy commissioners based on whether the services are state-operated or contracted.

At present, one deputy oversees all state-operated treatment facilities, and one oversees the agency's network of contracted treatment program providers, which is administered by the Health Care Services (HCS) Division. The latter deputy, who is considered to have primary responsibility for addiction services, also is in charge of ensuring the DMHAS is in compliance with all federal requirements related to its designation as the state methadone authority.²⁴

State-operated facilities. The four facilities DMHAS operates that include substance abuse treatment programs are listed in Table IV-4. Each one is headed by a chief executive officer who is responsible for day-to-day operations and overall management of programs and services. As the table shows, inpatient treatment for substance abuse is provided at three state behavioral health facilities, Connecticut Valley Hospital, Blue Hills Hospital, and Greater

²⁴ State statute requires there be two deputy commissioners for the department, both appointed by the commissioner, with one responsible for mental health and the other for addiction services.

Bridgeport Community Mental Health Center. One agency-operated facility, Connecticut Mental Health Center, provides outpatient services for alcohol and drug dependency.

Facility	Location	Substance Abuse Treatment Services
Connecticut Valley Hospital (CVH)	Middletown	<ul style="list-style-type: none"> • Inpatient detoxification • Residential rehabilitation
Cedarcrest Hospital -- Blue Hills Hospital Substance Abuse Division	Newington (Hartford)	<ul style="list-style-type: none"> • Inpatient detoxification • Residential rehabilitation
Greater Bridgeport Community Mental Health Center (Greater Bridgeport)	Bridgeport	<ul style="list-style-type: none"> • Inpatient detoxification
Connecticut Mental Health Center (CMHC)*	New Haven	<ul style="list-style-type: none"> • Outpatient program

* DMHAS operates CMHC in collaboration with the Yale University Department of Psychiatry

Source: PRI staff analysis

These department-operated programs represent only a small portion of the agency’s alcohol and drug abuse treatment system. The bulk of DMHAS substance abuse (and mental health) services are delivered by contracted private providers on a regional basis, as described below.

Regionalized service network. State statute requires the commissioner to establish regions with the purpose of creating a regionalized system of comprehensive, community mental health and addiction prevention and treatment services. Currently, there are five DMHAS regions, as shown in Figure IV-3. In accordance with state law, the department’s contracted network of behavioral health services is planned and delivered, for the most part, on a regional basis.

Also by law, each region must be advised by a board composed of consumers, who must be the majority of the membership, and service providers within the region. Although called regional mental health boards (RMHBs), they are required by law to include “adequate representation” of individuals concerned with alcohol and drug services.

The RMHBs are responsible for: studying regional needs and developing plans to improve and increase services; reviewing and making recommendations about agency funding of services in the region; and reporting findings and recommendations about services in the region to the commissioner each year. Each regional board receives funding (about \$105,500 in FY 08) from DMHAS that supports one or two staff positions to assist with these functions

Health Care Systems Division. The department’s Health Care Systems Division, staffed by 23 professional and two support personnel, has direct responsibility for overseeing all of the agency’s contracted services. The division’s two primary functions are: 1) managing the contracted private nonprofit providers that make up the agencies regional networks of behavioral health (mental health and substance abuse) services; and 2) overseeing the state’s managed care

system for behavioral health services for SAGA clients, the General Assistance Behavioral Health Services Program.

Regional teams. Small teams of two to three HCS staff are assigned to each of the DMHAS regions to manage and monitor contracted service providers. Each team is headed by a regional manager, all of whom report to the division director. At present, a total of 10 staff are assigned to four regional teams, with one overseeing two regions and the other three responsible for one region each.

The main activities of the regional teams include:

- contract compliance (through desk audits and on-site reviews);
- provider monitoring (review performance, regulatory compliance) and technical assistance;
- reviewing, negotiating, and making recommendations on provider funding applications;
- implementing new department services and initiatives; and
- identifying service gaps and developing new services (e.g., writing and reviewing requests for proposals for new or expanded programs)

- Figure IV-3.

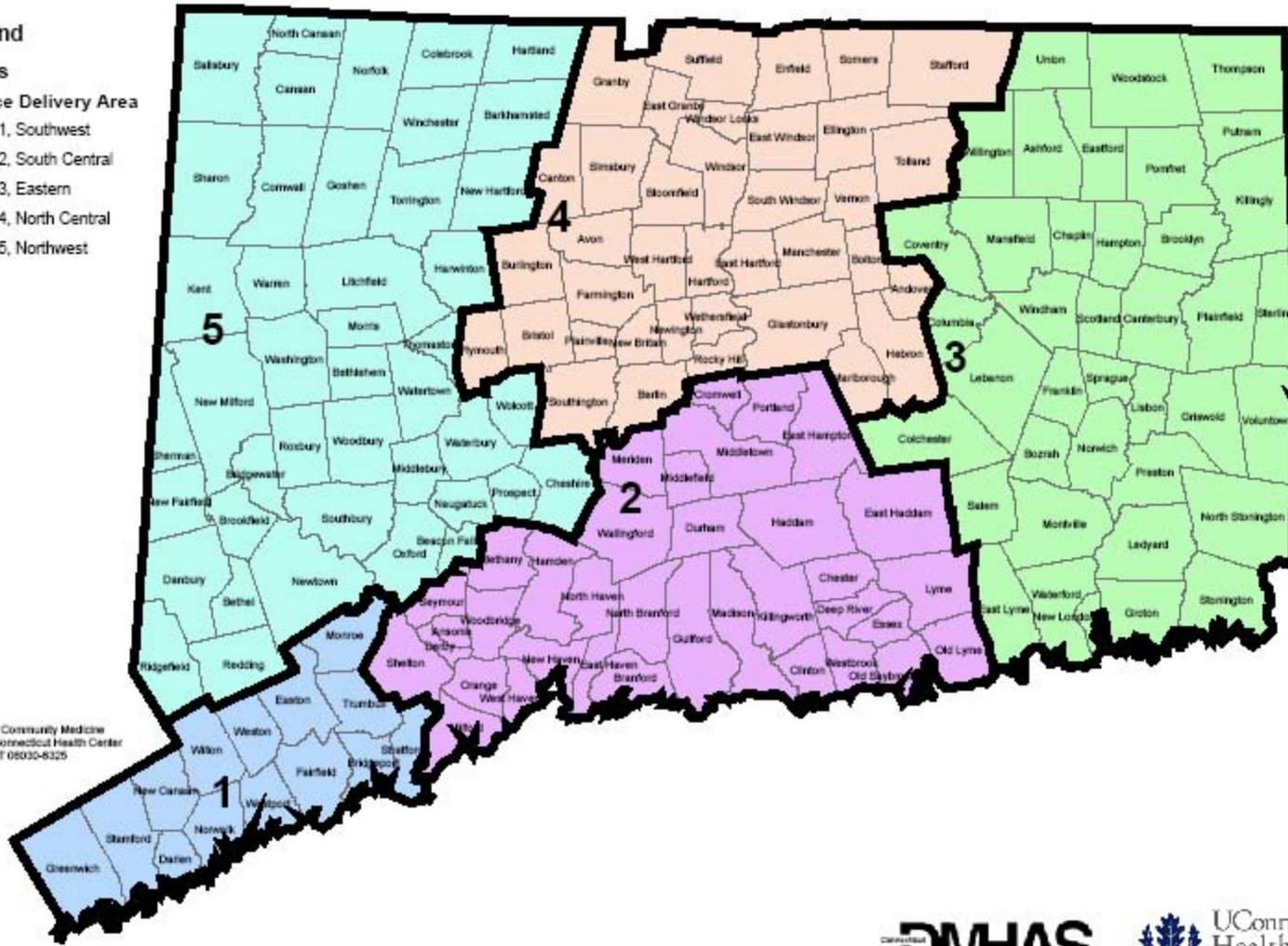
Connecticut Mental Health and Addiction Regional Service Delivery Areas

Legend

Towns

Service Delivery Area

- 1, Southwest
- 2, South Central
- 3, Eastern
- 4, North Central
- 5, Northwest



Prepared by:
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November 17, 2005



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Regional teams also are responsible for “troubleshooting” -- resolving consumer and contractor problems -- and ensuring contractor providers meet all the agency’s data reporting requirements.²⁵

The HCS regional teams have responsibility for contract management functions related to substance abuse services procured from private providers. They also perform this role for mental health service contracted services, although oversight responsibility is shared with DMHAS-operated local mental health authorities (LMHAs).

LMHAs. Before addiction services were merged with state mental health functions, the department had established local mental health authorities to manage systems of care for persons with serious and persistent psychiatric disabilities within specific geographic areas of each of the five regions. The LMHAs were designed to be the “clinical homes” for clients with chronic mental illness problems following deinstitutionalization of the department’s hospital population in the 1990s.

At present, there are 14 LMHAs throughout the state; six are state-operated entities and eight are private nonprofit agencies that perform this role under contract to the department. They continue to serve as the main agency contact for DMHAS mental health clients within specific geographic service (catchment) areas. They act as a “clearinghouse” for the array of behavioral health services a client may require and also follow their clients through different levels of care for as long as they are attached to the DMHAS care system, even when individuals are treated outside of their catchment area (e.g., admitted to a statewide treatment facility like CVH).

LMHAs have outreach workers who identify individuals in need of mental health services and help identified clients access services. Staff also may determine client eligibility and some LMHAs also provide case management and treatment, such as outpatient services. However, the majority of services are provided by the LMHA affiliates, which are their contracted private nonprofit care providers. LMHA staff, in conjunction with their DMHAS regional management team, oversee their affiliates by monitoring compliance with contract provisions, reviewing performance, and assessing the need for new or expanded services.

There are no similar “umbrella” organizations coordinating care for the agency’s substance abuse clients, except for the adults covered by the state behavioral health managed care program, GABHP (as discussed in more detail later in this section). In general, a program providing services to a DMHAS substance abuse client is responsible for coordinating his or her care throughout the treatment period. As a result, services can be more disjointed for adults receiving alcohol and drug abuse services than for mental health clients.

Managed care program oversight. Currently, five staff of the Health Care Systems Division are responsible for overseeing the agency’s behavioral health managed care program for the state’s General Assistance clients. Their main responsibility is contract compliance monitoring of the private company hired to as the program’s administrative services organization (ASO). The HCS staff duties also include procuring ASO services and developing and negotiating that contract, as well as developing and enforcing program regulations. In addition.

²⁵ In accordance with state and federal law as well as contract provisions, DMHAS providers must report admission and discharge data, client demographics, and information on services delivered.

all reports and information on program services the ASO is required to submit to DMHAS, such as monthly, quarterly, and annual utilization statistics and client demographics, are reviewed by division staff.

Forensic Services Division. Among the several divisions shown in Figure IV-1 that report directly to the DMHAS commissioner is Forensic Services. Staff within this division are responsible for:

- collaborating with the state's law enforcement, judicial, and correction systems to implement and coordinate services for adults with serious mental illness or substance use disorders who are involved in the criminal justice system;
- providing, per state statute, specialized consultation and evaluation services to the courts (e.g., assessing competency to stand trial) and the state Psychiatric Security Review Board; and
- providing forensic risk management consultation to state-operated and private nonprofit provider programs in the DMHAS service system.²⁶

The Forensic Services Division's collaborative activities involve a number of intervention programs, which have substance abuse treatment components, that are designed to meet two main goals:

- to divert people from the criminal justice system and into treatment for mental health and substance abuse problems; and
- to help people re-enter the community successfully after incarceration.

Many of the criminal justice diversion and re-entry programs, which are described briefly later in this section, are carried out in conjunction the Court Support Services Division of the Judicial Branch and the Department of Correction. At present, the division funds 96 full-time equivalent staff positions (52 state employees at community-based agencies and 44 staff within private nonprofit agencies) that provide direct client services related to 10 of its collaborative intervention programs for persons with behavioral health needs involved in the criminal justice system.

Planning and Coordination

DMHAS is responsible for statewide substance abuse planning activities in accordance with both state and federal requirements. Under state statute, it must produce a comprehensive state substance prevention and treatment plan that contains long-term goals and objectives in consultation with community-based, regional planning and action councils (RACs). The department also must meet regularly with its state advisory board to review planning efforts. The

²⁶ Staff within the division currently total 34.6 FTE positions (30.5 are state employees and 4.1 are forensic psychiatrists under contract from Yale Law and Psychiatry Department) and professional staff are also retained on a per diem basis for some court evaluations. The division's assistant director and six managers are responsible for the criminal justice collaborative activities.

state's regional substance abuse planning process and the state board's role in planning is described briefly below.

Among the federal planning requirements related to substance abuse DMHAS must comply with, is the Substance Abuse Prevention and Treatment Block Grant application process. The federal block grant process requires a comprehensive planning and needs assessment effort with public participation and evidence of interagency coordination and collaboration. State law also directs DMHAS to coordinate state substance abuse treatment activities and to collaborate with other agencies in planning and delivering services. To accomplish this task, the department participates in several groups aimed at improving communication and cooperation across state agencies and system. Descriptions of two that focus on substance abuse treatment matters, the Alcohol and Drug Policy Council (ADPC) and the Criminal Justice Policy Advisory Commission (CJPAC), are included below

In recent years, DMHAS has initiated a regional priority setting process as a foundation for comprehensive, unified planning for behavioral health services. This process draws upon the extensive, existing mental health and substance abuse planning, advisory, and advocacy structure in the state. The department relies on the RMHBs and RACs to facilitate the needs assessment process in each region to determine service gaps regarding both mental health and substance abuse treatment and prevention needs. The agency intends the process to be an ongoing method for obtaining regional input and broad stakeholder perspectives on behavioral health priorities.

State substance abuse planning. Under state law, regional and subregional organizations called planning and action councils (RACs) are responsible for planning and coordinating state substance abuse prevention and treatment activities. At present, there are 14 councils designated within the five DMHAS service regions. (See Appendix B, which presents an overview of the department's regional structure.) Separate statutorily required organizations, known as Catchment Area Councils (CACs), carry out similar planning functions regarding mental health services. Both types of groups work in conjunction with the Regional Mental Health Boards, discussed earlier, to advise the department in planning, evaluating, and implementing community-based behavioral health services.

The RACs are public-private volunteer organizations that, by statute, must represent: local community leaders (e.g., chief elected officials, school superintendents, business executives, and state legislators); major service providers and funders; and minority populations, religious organizations, and the media. The councils are prohibited by law from providing any direct services to clients. Their main duties related to substance abuse service planning and coordination are to:

- identify gaps in the continuum of care, which includes community awareness and education, prevention, intervention, treatment, and aftercare;
- develop and submit to DMHAS an annual action plan to address service gaps;
- conduct fund-raising activities to fill identified gaps; and
- carry out activities to implement plan initiatives and promote council visibility.

DMHAS provides funding to support their core administrative functions for substance abuse planning (about \$1.6 million total in FY 08) and for the councils' prevention coordination activities.

State Board. The Board of Mental Health and Addiction Services, by law, meets monthly with the DMHAS commissioner to review and advise the agency on its programs, policies, and plans. Its other statutory duties include:

- advising the governor on candidates for DMHAS commissioner;
- issuing periodic reports to the governor or commissioner;
- advising and assisting the commissioner on program development and community mental health or substance abuse center construction planning; and
- serving as the state advisory council to DMHAS in administering the state's mental health and substance abuse programs.

The state board is broadly representative of behavioral health services stakeholders. Its members must include: mental health and substance abuse treatment professionals; representatives of consumers, their families, and advocacy groups; and designees of various regional planning entities, including RACs. Board members may include others interested in the state mental health and substance abuse system but no more than half of the members can be service providers. The board selects its own chairperson and other officers, may establish rules for its internal procedures, and may appoint nonmembers to serve on ad hoc advisory committees as it deems necessary.

ADPC. The Connecticut Alcohol and Drug Policy Council has a primary role in coordinating substance abuse policies across state agencies and all three branches of government. First established by executive order in 1996 in response to recommendations of a gubernatorial task force on substance abuse, the council was made statutory in 1997. Its members are executive, judicial, and legislative branch officials or their designees; by law, the DMHAS and DCF commissioners serve as co-chairs of the council. OPM, within available appropriations, provides staff for the council.

Since its creation, ADPC has had responsibility for overseeing state substance abuse treatment and prevention policies and programs. It is required by law to review policies and practices of state agencies and the Judicial Department concerning: substance abuse treatment and prevention programs; referral to such programs and services; and criminal justice sanctions and programs. State statute further requires the council to "... develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions." Each year, by January 15, the council must submit a report to the governor and the legislature evaluating progress in implementing its plan and recommending proposed changes to substance abuse policies and programs.

The council's current plan, issued in January 2007, identifies four issues as top priorities at the national, regional, and statewide levels based on the council's research and input from stakeholders. They are: underage drinking; tobacco cessation; buprenorphine; and adolescent substance abuse treatment. The ADPC plan also outlines a series of recommendations for legislative action and state agency policy and procedures regarding each of the four areas of concern.

CJPAC. The Criminal Justice Policy Advisory Commission was created in 2006 as the successor to the state's Prison and Jail Overcrowding Commission. Its main purpose is to examine issues related to prison overcrowding and promote collaborative efforts to address the problem. The commission is comprised of 12 executive and judicial branch officials, including the DMHAS commissioner, and eight gubernatorial appointees who represent various interested parties, such as local police chiefs, providers of community services for offenders, and victims, and the general public.

CJPAC's primary duties are to:

- develop and recommend policies for preventing prison and jail overcrowding;
- examine the impact of current policies and research efforts to prevent prison and jail overcrowding, and make this information available to criminal justice agencies and the legislature; and
- advise OPM's Criminal Justice Policy and Planning Division on policies and procedures to promote an effective and cohesive criminal justice and juvenile justice system and the statutorily required offender reentry strategy.

CJPAC is required by statute to have a behavioral health subcommittee that includes, among others, representatives from the departments of correction and mental health and addiction services. The subcommittee is charged with making recommendation concerning the provisions of mental health and substance abuse treatment to inmates. DMHAS also has had a major role in the commission's work to promote successful community reentry by better linking newly released inmates to behavioral health treatment and support services.

Collaborative contracting. A collaborative contracting project initiated in 2005 at the direction of the Office of Policy and Management is another way DMHAS promotes coordination of substance abuse treatment across state agencies. Under the project, the department coordinates procurement of more than 250 residential beds for adult alcohol and drug abuse treatment from 12 different private providers that, in the past were purchased individually by DMHAS, CSSD, and DOC.

The two main goals of the collaborative process are: more efficient management of shared, private nonprofit treatment resources; and reduced administrative burden for the provider agencies that operate the contracted residential treatment services. The joint steering committee that operates the project is considering expanding the process to other services, beginning with certain types of outpatient treatment.

Substance Abuse Treatment Resources

The best available estimate of agency resources allocated to treatment for alcohol and drug abuse is the expenditure information DMHAS develops for the statutorily mandated biennial report on state substance abuse activities. The most recent report shows the department spent \$128.8 million on alcohol and drug abuse treatment for adults in FY 05. This amount represents about one-quarter of the agency's total budget for that fiscal year (\$520 million) and accounted for almost two-thirds of all state agency spending on substance abuse treatment in FY 05 (\$202 million).

Current staffing information indicates about 10 percent of the DMHAS workforce is assigned to the agency-operated substance abuse treatment programs. As of May 2008, 404.3 of the 4,048.4 total full-time equivalent positions employed by the department were clinical and support staff for the inpatient and outpatient substance abuse treatment programs at DMHAS facilities. The number of agency staff involved in planning, coordinating, procuring, and overseeing community-based alcohol and drug abuse treatment services funded by DMHAS is still being determined at this time.

Total spending for agency-operated and contracted substance abuse services also is still being calculated for the purposes of this study. At present, expenditure data are known for DMHAS inpatient substance abuse treatment programs, which totaled an estimated \$42 million for FY 08, and for the substance abuse service grants DMHAS provides to private nonprofit organizations for community-based treatment programs. These grant payments totaled roughly \$28 million for the same fiscal year.

PRI staff is working with the department to develop complete information on agency funding and staff positions allocated to its substance abuse treatment activities that can be used to analyze costs over time, and by type of service, client population, and provider. Findings from that analysis will be included in the next staff report.

DMHAS Treatment Programs and Services

The Department of Mental Health and Addictions Services maintains a regionalized, comprehensive substance abuse treatment system for its clients that is comprised of four main components: *community treatment*, which includes emergency services and outpatient programs; *residential treatment*, which encompasses a wide range of 24-hour care and supervision; *inpatient services* provided at department-operated facilities; and *recovery supports*. In addition, it carries out a number of special programs and initiatives targeted to particular client groups or substance abuse problems.

According to DMHAS, all of its treatment modalities and programs for alcohol and drug dependent clients are intended to focus on the following service priorities:

- medical management of withdrawal from alcohol or drugs;
- residential services that impact significant levels of dysfunction;

- ambulatory services that help individuals re-enter or remain in the community; and
- for opiate addicted persons, opioid replacement therapy along with supportive rehabilitative services.²⁷

Preliminary information about each component of the DMHAS substance abuse treatment system and several major initiatives is provided below. During the next phase of research, PRI staff will be accessing the agency's automated provider database to develop more complete information on treatment services provided, client profiles, and program capacity, utilization, and outcome data.

System overview. As noted earlier, DMHAS contracts for the majority of substance abuse treatment services its clients receive. With the exception of the detoxification and rehabilitation programs at the department's three inpatient facilities, and the outpatient services for alcohol and drug dependency available at one of the agency's community mental health centers, all clinical treatment and recovery support services are provided through contracted providers, who are primarily community-based, nonprofit agencies. Currently, the department funds about 180 different private programs that provide clinical services including detoxification, outpatient services, and residential treatment.

All contracted programs providing clinical services must be licensed as substance abuse treatment facilities by the Department of Public Health. The department facilities that provide substance abuse treatment, while not DPH licensed, are nationally accredited by the Joint Commission.²⁸

DMHAS also encourages, but does not require, its contracted service providers, as well as its own treatment programs, to use evidence-based treatment modalities and to follow preferred practices standards. The agency offers training on the foundations of evidence-based practices for private provider staff and its own employees and provides courses on several specific evidence-based practices (e.g., cognitive behavioral therapy and motivational interviewing). As noted earlier, the department provides training, and issued guidelines, on its recovery-based practice standards for staff of all agency-operated and contracted treatment programs.

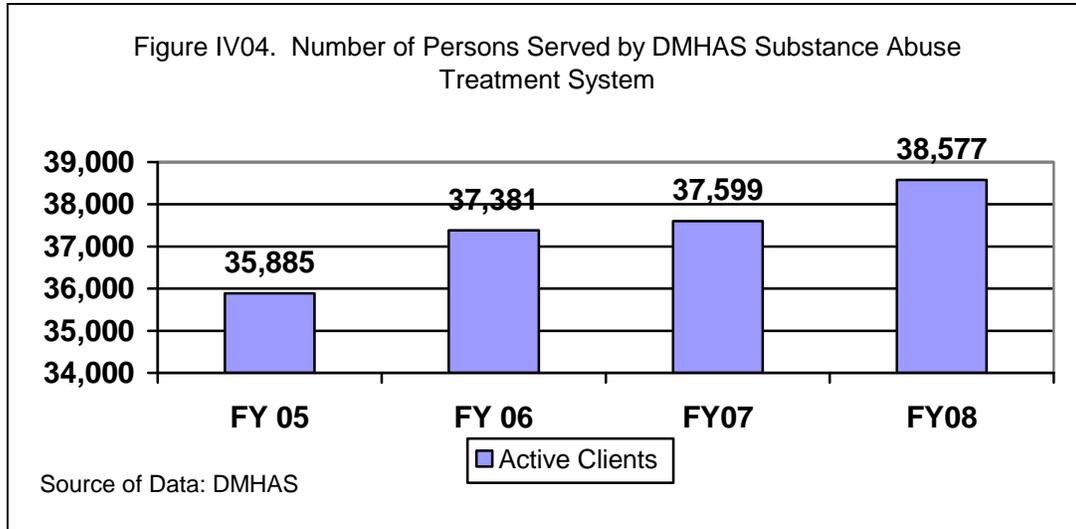
Clients served. Over the past four years, the department's substance abuse treatment system has served over 35,000 adults annually. As Figure IV-4, shows, the total number of clients receiving services has grown each year and increased about 8 percent from FY 04 to FY 08. (Numbers for FY 08 are still estimates at this time.)

The numbers presented in the figure include all persons admitted to treatment in the reported year, or admitted in a prior year but still receiving clinical services for substance abuse (e.g., detoxification, residential treatment, and outpatient services including methadone

²⁷ DMHAS federal Substance Abuse Prevention and Treatment (SAPT) block grant application, 2007.

²⁸ The Joint Commission, formerly the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) is a national, nonprofit organization that accredits a variety of types of health care facilities throughout the U.S.

maintenance). It does not include persons only receiving evaluations or support services (e.g., case management, vocational, employment, and educational services, and housing assistance).



DMHAS does not maintain formal wait lists for any of its services, as they proved to be unreliable and difficult to manage in the past. Instead, it relies on its regional planning process to identify unmet treatment needs, gaps in services, and underserved populations. In addition, the agency is working on building utilization management capability through ongoing improvements to its automated information systems.

Community treatment services. Within the department's service system, both emergency or crisis services and all outpatient programs, including methadone maintenance, are considered community treatment services. Emergency/crisis services assess and treat adults with acute psychiatric or substance use disorders, or both, to stabilize their conditions, prevent hospitalization when possible, and arrange for further treatment when necessary.

These services are available 24-hours a day, seven days a week at general hospital emergency departments and walk-in clinics supported by mobile crisis teams of emergency workers operated or funded by the agency. At present, 15 mobile crisis teams provide services to alcohol and drug dependent persons in need of emergency care.

As noted earlier, DMHAS provides some outpatient substance abuse treatment at its Connecticut Mental Health Center facility located in New Haven. However, most of the wide array of outpatient services for the agency's clients with alcohol and drug dependence problems are provided by contracted private nonprofit providers. Health professionals employed by the outpatient program providers evaluate, diagnose, and, in regularly scheduled visits, treat clients through medication and behavioral therapies.

At present, outpatient services funded by the department include: intake and evaluation; regular and intensive outpatient therapies; partial hospitalization; and ambulatory detoxification

and methadone maintenance and other opiate replacement therapies. Preliminary data on the number of clinical outpatient treatment programs and their capacity is shown in Table IV-5.

Table IV-5. DMHAS Outpatient Clinical Treatment Services, September 2008.		
	Number Programs	Capacity
Regular Outpatient (OP)	76	4,634
Intensive Outpatient (IOP)	28	301
Partial Hospitalization (PH)	7	115
Ambulatory Detoxification	9	193
Methadone Maintenance (MM)	20	8,533
Source of Data: DMHAS		

As the table shows, most of the department's outpatient service capacity is concentrated in regular outpatient treatment and methadone maintenance programs. DMHAS estimates in FY 08, the number of substance abuse clients receiving traditional outpatient treatment totaled 18,719; another 12,523 participated in methadone maintenance treatment.

Residential treatment. The department contracts for a full array of residential treatment services for clients with substance use disorders ranging from the most intensive type of residential treatment, medically managed detoxification, to the least intensive level of residential care, which is provided in halfway house settings. Halfway houses provide 24-hour supervision, along with some clinical treatment (e.g., counseling) and recovery supports, to help clients prepare to transition to independent living arrangements.

Residential treatment programs funded by DMHAS, in addition to intensive detoxification and halfway houses, include a continuum of rehabilitative care of varying duration (e.g., short-term, intermediate, and long-term) and intensity. For example, some programs offer treatment through a very structured, therapeutic community environment, while others provide daily therapy in a relatively independent living setting. Preliminary data on the different types of residential treatment programs for alcohol and drug abuse that are funded by DMHAS are shown in Table IV-6. As described below, the department also directly provides some of the most intensive residential treatment services available in the state (medically managed detoxification and rehabilitation) at its inpatient facilities.

Table IV-6. DMHAS-Funded Residential Treatment Services, September 2008.		
	Number Programs	Capacity
Medically Managed Residential Detoxification	4	64
Residential Detoxification	7	121
Long-Term Care and Rehabilitation	1	50
Intensive Residential Treatment	20	375
Intermediate/Long-Term Residential Treatment	17	738
Halfway Houses	8	93
Source of Data: DMHAS		

State-operated inpatient services. Information about the department's three inpatient facilities is summarized in Table IV-7. As the table indicates, all three facilities provide medically managed detoxification services and two (CVH and Blue Hills) also operate residential rehabilitation programs.

Table IV-7. DMHAS-Operated Inpatient Substance Abuse Treatment Programs, FY 08.			
	Connecticut Valley Hospital Addiction Services Division	Blue Hills Hospital Substance Abuse Services	Greater Bridgeport Addiction Services Division
	<i>Detox and Rehab</i>	<i>Detox and Rehab</i>	<i>Detox (only)</i>
Number Beds	110	42	20
Patient Days*	40,398	14,149	6,421
Unduplicated Clients*	1,616	1,205	510
Operating Budget	\$25.981 million	\$8.412 million	\$5.057 million
* Statistics for FY 07			
Source of Data: DMHAS and Governor's Budget, 07-09 Biennium			

Recovery supports. There is substantial research showing successful recovery from substance use disorders is promoted when effective treatment is combined with client supports such as housing, transportation, and employment assistance, and social and other supplemental services. (See treatment effectiveness discussion in Section II). To promote recovery, DMHAS make a wider range of community-based support services available to clients suffering from substance use disorders, or mental illness, or both.

At present, the department's continuum of recovery support services include:

- case management, which helps clients maintain their recovery by identifying their needs, developing plans for meeting them, linking them with community-based services, and monitoring their progress;
- rehabilitation services that promote employment and skills necessary for independent living (e.g., vocational, educational, daily living, interpersonal, life management skills);
- short-term housing assistance (including sober housing);
- transportation services;
- vouchers for basic needs (i.e., food, clothing, toiletries); and
- peer- and faith-based supports.

The main sources of recovery supports for the department's clients with substance use disorders are two special programs described in more detail below: the federally funded Access to Recovery (ATR) and the Recovery Supports component of the General Assistance Behavioral Health Program.

Special programs and initiatives. DMHAS carries out special substance abuse treatment programs targeted to certain populations (e.g., individuals involved in the criminal justice system) or particular treatment needs (e.g., co-occurring disorders). These initiatives, which often are funded through federal grants and conducted in collaboration with other state agencies and organizations, are highlighted below.

Criminal justice collaborative projects. For a number of years, DMHAS has been working with law enforcement agencies, the Judicial Branch, and the Department of Corrections to help ensure individuals with severe mental illness, substance use disorders, or both, receive appropriate behavioral health services when they are involved with criminal justice system. The purpose of many of the department's joint efforts with criminal justice agencies is: to reduce recidivism by diverting persons with substance use disorders from the courts and correctional facilities into treatment and recovery; and to promote successful reentry into the community by providing substance abuse treatment and recovery supports to individuals with alcohol and drug abuse problems when they are released from prison.

At present, the agency's Forensic Services Division is participating with CSSD in three pre-trial diversion programs that specifically serve adults with substance abuse problems involved in the criminal justice system. The target population for 10 other collaborative criminal justice intervention programs is adults with serious psychiatric and co-occurring disorders. All of the division's collaborative programs are described in more detail in Appendix C.

As the appendix indicates, the majority of the programs operate in a limited number of sites and some serve relatively small numbers of clients. Many of programs are supported with federal grant funds. As a result, they often involve evidence-based practices and were or are subject to an independent evaluation of their effectiveness. PRI staff will be examining outcome

information concerning substance abuse treatment services provided through the collaborative criminal justice programs during the next phase of the study.

Access to Recovery. The department's Access to Recovery program began in 2004 under a three-year, \$22.8 million federal grant. The federal grant was aimed at: expanding treatment and recovery supports for the clients with substance use disorders; creating relationships between clinical and nonclinical service providers; and promoting collaboration among agencies and systems involved with substance abuse clients. Funding could be used for a variety of services and supports, including: housing, transportation, vocational/educational services; case management; faith- and peer-based support services; basic needs; and certain types of substance abuse treatment (e.g., intensive outpatient, methadone maintenance, and brief treatment). DMHAS received another multi-year grant award (\$14.5 million) in June 2007 to continue a second phase of the program.

Under the first phase of ATR, DMHAS worked with four other agencies (DOC, CSSD, DSS and the Department of Children and Families) to provide alcohol and drug dependent clients access to a portfolio of recovery-oriented services, both clinical and nonclinical. Many of the recovery supports were evidence-based practices and program outcomes were monitored and evaluated by Yale University.

Over the three-year grant period, the program served over 18,000 unduplicated clients, with about half coming from CSSD and DOC. Through ATR, DMHAS also established five regional recovery support networks representing 34 clinical treatment providers and 88 recovery support services agencies. The Yale evaluation showed, overall, the combination of clinical and recovery supports services had better outcomes (decreases in substance abuse and jail time/arrests, increases in stable housing, and employment) than clinical treatment alone.

Co-Occurring Disorders Projects. Since the 1990s, DMHAS has been involved in a number of initiatives intended to improve services for adults with co-occurring disorders. These include its dual diagnosis task force in 1997 and a series of academic research partnerships (e.g., with Yale, Dartmouth, and the University of Connecticut) aimed at determining prevalence, developing diagnostic tools, and assessing treatment practices for dual disorders/co-occurring conditions. In 2005, the department received a 5-year, \$4 million federal grant (Co-Occurring State Improvement Grant) to help implement integrated services for people with co-occurring mental health and substance abuse disorders statewide.

DMHAS is using the grant funding to accomplish three main goals: implementation of standardized screening measures (see intake process discussion, below); information sharing and network building for integrated service delivery; and data-based decision making (e.g., development of reliable estimates of the prevalence of co-occurring disorders to inform planning efforts). In conjunction with the grant project, the Dartmouth medical school is providing training and technical assistance to treatment providers who are trying to integrate their services for clients with co-occurring conditions. Yale University is monitoring and evaluating the outcomes of the agency's activities.

General Assistance Behavioral Health Program (GABHP). The General Assistance Behavioral Health Program provides mental health and substance abuse treatment for people

who receive medical benefits through the State-Administered General Assistance Program. Under the program, some clients also can receive case management services and basic needs assistance to support their treatment and recovery process.

Responsibility for SAGA behavioral health services was transferred from the Department of Social Services (DSS) to DMHAS in 1998. (DSS is still responsible for SAGA medical benefits *other* than mental health and substance abuse treatment services.) DMHAS designed the program as a public-private partnership, fee-for-service system. It contracts with an administrative services organization to perform operating functions including: credentialing of providers; claims management, processing, and payment; and utilization management. Authority for all policy decisions related to the program rests with DMHAS. As noted earlier, staff of the department’s Health Care Systems Unit oversee administration of the program and monitor Advanced Behavioral Health, the program’s ASO.

Under the program, clients can receive a full array of behavioral health treatment and recovery supports, subject to utilization management and prior authorization. Appendix D outlines the program’s levels of care and model for utilization management. The model is based on the department’s standardized client placement criteria discussed later in this section.

Basic information on treatment services provided to GABHP clients over the past two fiscal years is provided in Table IV-8. As the table indicates, the majority of the SAGA clients eligible for behavioral health services received treatment for substance use disorders. Just over 70 percent in FY 07, and about 67 percent in FY 08 of the more than 23,000 individuals served annually under the program were provided treatment for alcohol and drug abuse problems.

	FY 07	FY 08
Total Individuals Served	23,762	23,820
<i>Number Receiving Mental Health Treatment Services</i>	9,978	10,957
<i>Number Receiving Substance Abuse Treatment Services</i>	16,863	16,053
Source of Data: DMHAS		

Under a part of the program called Recovery Supports, GABHP clients can receive temporary assistance for housing (independent apartment, congregate sober housing, security deposit, utilities) and transportation (bus pass, livery, gas card) as well as vouchers for basic needs such as food, clothing, and personal care items. These support services are intended to help people remain in treatment while promoting recovery, independence, employment, self-sufficiency, and stability. Recovery Supports, like the GABHP clinical treatment services, are managed by the program’s ASO.

Eligibility is limited to individuals who do not receive SAGA cash benefits (or other income) and who are receiving or attempting to enter treatment at a mental health or substance abuse facility. Clients can apply for the program through their treatment provider or a recovery

specialist; if approved, they receive assistance on a monthly basis for up to three months. vouchers for basic needs items.

Case management services also are available for some GABHP clients through a program called Intensive Recovery Supports. It provides additional support for clients having great difficulty maintaining their recovery and meeting their treatment goals as evidenced by frequent readmissions to inpatient treatment (e.g., detoxification or psychiatric hospitalization).

The department has used the GABHP intensive case management program to address the needs of opiate addicted clients with numerous, repeat admissions for certain detoxification services. Through an initiative called the Opiate Agonist Treatment Program (OATP), the department's ASO staff identify "high utilizers" of expensive, residential detoxification (e.g., those with three detoxification episodes in six months) for opiate abuse and educate them about treatment alternatives, such as methadone maintenance, long-term methadone detoxification or abstinence in conjunction with long-term residential treatment. Individuals who decide to enter OATP are given priority admission to the alternative service they select and intensive case management is provided to arrange "wraparound" services such as housing, vocational, and educational opportunities to support their recovery.

The OATP program began as a pilot in state-operated facilities and following a positive assessment of program outcomes, was expanded to other detoxification service providers. Research showed participation in the program significantly reduced use of detoxification and inpatient care and favorably increased a client's connection with less intensive and expensive care following discharge from detoxification. Overall, OATP has been credited with a marked decrease in use of residential detoxification services throughout the state and more efficient and effective management of that costly level of care. The department is considering a similar program for individuals with repeated admissions for alcohol detoxification.

Intake, Assessment, and Referral Process

Clients come into the DMHAS substance abuse treatment system in several ways: through screening and referral by a physician or other health care professional in the community; because of involvement with the criminal justice system; or on their own initiative due to concerns about their alcohol or drug use problem. State statute also provides for an involuntary commitment process for individuals with behavioral health problems that is overseen by the probate courts.

Under the involuntary commitment process, alcohol or drug dependent persons who meets certain criteria (e.g., dangerous to self or others, at risk of potentially life-threatening withdrawal symptoms) can be admitted for emergency treatment without their consent under what is called a physician's emergency certificate (PEC). According to DMHAS, a PEC for an adult needing substance abuse treatment is rare. In general, involuntary commitments to agency services are infrequent and most cases involve individuals with serious psychiatric problems rather than alcohol or drug dependency.

Intake. Individuals seeking DMHAS substance abuse treatment services, from either a state-operated or contracted program, are subject to the same intake process. Intake involves two

main steps: screening and assessment. Screening identifies the person’s risk of having a substance use disorder. It determines whether or not a person has a particular substance abuse problem that warrants further attention at the current time; it does not result in a diagnosis.

The assessment step is carried out for individuals who are found to be at risk (“screen positive”) for alcohol or drug dependency. It identifies the specific problem and its severity. Assessment involves a professional evaluation to develop a diagnosis and recommendations for appropriate care and placement. As described below, DMHAS has established standardized screening tools and placement criteria that all substance abuse treatment programs it funds or operates must use.

Screening. Standardized screening of potential clients is a widely recognized best practice encouraged by SAMHSA. Since July 1, 2007, all DMHAS programs, whether agency funded or operated, are required to use standard screening measures for substance use and mental health problems for all treatment program admissions.

Under department policy, treatment providers can choose from two types of mental health screening instruments and two substance use screening instruments, which are listed in Table IV-9. The screening measures were selected by a workgroup of treatment providers and agency staff responsible for a DMHAS initiative on co-occurring disorders. All four are validated instruments widely used in other states and endorsed by SAMHSA and a national center for excellence on co-occurring conditions.

Mental Health	Substance Use
Mental Health Screening Form-III (MHSF-III)	Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
Modified Mini International Neuropsychiatric Interview (Modified Mini)	CAGE-Adapted to Include Drugs (CAGE-AID)

Source of Data: DMHAS, <http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802> , Screening Measures website, accessed 9-26-2008

Providers must use one of each type, unless it would be medically or clinically inappropriate, or for an specific exception listed in DMHAS policy (e.g., for pretrial intervention or jail diversion programs). Each of the screens involve a series of yes-no questions, which the department recommends be asked in a face-to-face interview. Self-administration is allowed but not preferred. It is estimated the screens take about 10 minutes to administer.

According to department policy, all programs should establish written protocols for their screening procedures that include but are not limited to: how the screens will be administered and by whom; next steps to take based on screening results (e.g., arranging an assessment, referrals to make if a person answers yes to questions on suicidal thoughts); and what additional screening information should be collected (e.g., toxicology).

Any staff member trained on the measures can administer them, but department guidelines recommend clinical personnel oversee any screening done by nonclinical staff. Clients who receive a positive score on any of the screens should receive a comprehensive assessment by appropriate staff. Clients, however, can choose not to have an assessment done.

Screening data must be reported to DMHAS and can be submitted electronically. The agency's automated information systems for department-funded providers (DPAS) and for department-operated facilities (BHIS) both allow treatment program staff to enter directly an individual's score from each screen administered, along with other clinical and demographic information.

Assessment. For the most part, clients are assessed where they present for treatment services. DMHAS requires that clients receive a comprehensive biopsychosocial assessment by appropriate staff to develop a treatment plan and a recommendation for appropriate level of care (a placement decision). A biopsychosocial assessment evaluates a person's physical and psychological status, social and emotional resources, including support systems, and any other contributing factors needed to make a diagnosis and placement decision.

Appropriate staff means treatment professionals who are authorized under state public health department regulations to make a diagnosis, such as doctors, nurses with advance practice credentials (APRNs), licensed clinical social workers, and certain other licensed or certified therapists and treatment professionals. Such individuals have been trained in applying the diagnostic criteria for substance use disorders contained in the Diagnostic and Statistical Manual of Mental Health Disorders (the DSM), which is the medical profession's clinical guide to psychiatric care. Under DMHAS contracts and DPH licensing standards, as well as national accreditation standards, substance treatment providers must have appropriate staff available to carry out assessment and diagnosis functions, either within their program or on a referral basis.

The department does not require its own treatment programs or its contracted providers to use a particular assessment tool, although there are a number of validated instruments available. In contrast, several of the more commonly used standardized assessment instruments for substance use disorders (e.g., the ASI and ASUS) are mandatory components of the intake process for substance abuse treatment in other state agencies, as the following sections describing CSSD and DOC describe.

Placement criteria. DMHAS requires all placement decisions for substance abuse treatment it provides or funds be made in accordance with the department's standardized Connecticut Client Placement Criteria (CCPC). Standardized placement criteria are recognized as one of the essential elements for better quality, and more efficient, treatment services. A workgroup of agency staff and representatives of private providers developed the CCPC after reviewing criteria used in other states and the patient placement criteria developed by the American Society of Addiction Medicine (ASAM). The agency's final criteria, which were adopted in 1997, are a combination of the ASAM criteria and a Connecticut-specific supplement.

As Table IV-10 shows, the Connecticut Client Placement Criteria encompass four levels of treatment of increasing intensity; within each level, there also is a range of care.²⁹ The CCPC provides detailed guidelines for placing clients that correspond to DSM diagnostic criteria and take into account the following considerations: acute intoxication/withdrawal; biomedical conditions; emotional and behavioral conditions; acceptance of treatment; relapse potential; and recovery environment.

Table IV-10. CCPC Levels of Care for Substance Use Disorders			
Level 1 Outpatient	Level 2 Intensive Outpatient	Level 3 Residential/Inpatient	Level 4 Hospital-Based
<ul style="list-style-type: none"> • Outpatient - Drug free • Methadone Detox. • Methadone Maintenance 	<ul style="list-style-type: none"> • Ambulatory Detox. • Intensive Outpatient • Opioid Maintenance Therapy • Partial Hospitalization 	<ul style="list-style-type: none"> • Clinically Managed Low Intensity Residential • Clinically Managed Medium Intensity Residential • Clinically Managed Medium/High Intensity Residential • Medically Monitored Inpatient Detox. • Medically Monitored Intensive Inpatient • Medically Managed/ Monitored Inpatient Services 	<ul style="list-style-type: none"> • Observation Bed • Medically Managed Inpatient Detox.
Source of Data: DMHAS Connecticut Client Placement Resource Packet , Jan. 1, 1997			

DMHAS providers are required to base their admission, continued stay, and discharge decisions for all clients treated on these criteria. According to the department, in applying the criteria, individuals presenting for treatment are matched to the least intensive level of care that is appropriate, and then “stepped up” to more intensive treatment settings if they do not respond. If the provider performing the assessment and applying the CCPC does not have the appropriate level of care available, then placement must be coordinated with a provider that does. Overall, the department’s four main objectives of its CCPC clinical protocols are:

- improve access by coordinating entry to services;

²⁹ The full CCPC includes one additional care level, Level .5 Prevention, which include clinical prevention services.

- assist decisions for placement in the least restrictive and most appropriate setting;
- provide statewide consistency; and
- identify service gaps for future service development.

Treatment planning. In addition to determining appropriate care level, the information gathered through the assessment process helps treatment staff develop treatment plans with clients, following their admission. State statute, as well as federal policy and national accreditation standards, require that persons with psychiatric disorders receive treatment based on an individualized plan of care. DMHAS policy issued in October 2004 contains further treatment planning requirements that apply to all persons receiving agency services for mental health or substance use disorders.

Under this policy, all services must be provided in accordance with an individualized, multidisciplinary recovery plan developed in collaboration with the person receiving the services. All changes to a plan, and the rationale for the changes, must be documented in a person's treatment record. Under DMHAS policy, the plan must be based on an individual's strengths and a culturally sensitive assessment of the person's needs and resources. According to the department, the primary focus of a recovery plan is the services, structures, and/or supports a person needs to live successfully in the least restrictive environment possible.³⁰

³⁰ Commissioner's Policy Statement No. 33: Individualized Recovery Planning, October 2004.

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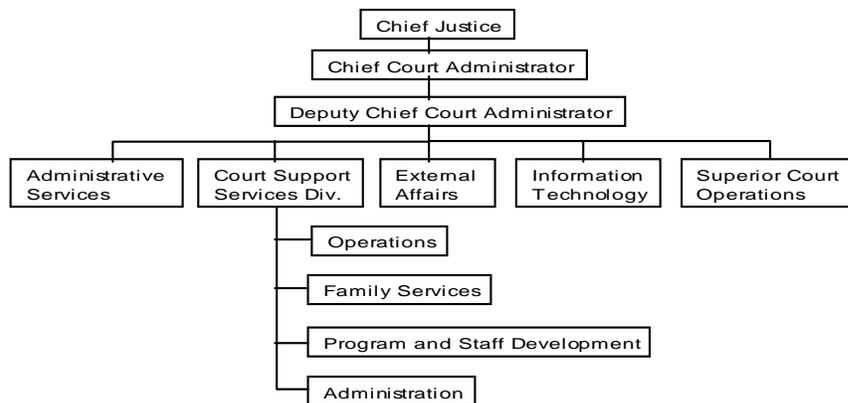
COURT SUPPORT SERVICES DIVISION

While criminal activity is generated from a variety of factors, a number of research studies have noted a relationship between drug use and crime. It is a crime to use, possess, manufacture, or distribute drugs classified as illegal and the various effects of drug-related behavior are felt daily, from violence that can result from drug use to robberies to get money to buy drugs. Generally, drug users are more likely than nonusers to commit crimes, arrestees frequently are under the influence of a drug at the time they committed their offense, and trafficking in drugs generates violence.

In Connecticut, the Judicial Branch through its Court Support Service Division is responsible for supervising individuals convicted of crimes whose sentences include probation in lieu of or after a prison term. In addition, for persons who are pre-trial, CSSD or a judge can order that person to fulfill certain requirements as a condition of bail, or otherwise divert the defendant. Addressing substance abuse behaviors on the part of these individuals while under the auspices of CSSD is described in this section.

As shown in Figure V-1, the Court Support Services Division (CSSD) is one of the five administrative sub-units of the Judicial Branch that report to the chief court administrator, who is the administrative head of Connecticut’s court system.

Figure V-1. Administrative Organization of the Judicial Department



The division was established in 1999 as result of a consolidation of six offices.³¹ It oversees a range of functions including bail and other pre-trial services, family services, and various probation options for adults and juveniles.

As noted, persons involved with CSSD may be pre-trial (defendants) or sentenced (offenders) and may be referred to programs as ordered by a judge or in some circumstances by probation officers. Its stated mission is “to provide the Judges of the Superior Court and the judicial system with timely and accurate information, quality assessments, and effective services that ensure compliance with court orders and instill positive changes in individuals and families.” On average, CSSD supervises nearly 57,000 sentenced offenders on probation and 17,000 pre-trial/diverted defendants on a daily basis for a total of 74,000 persons.

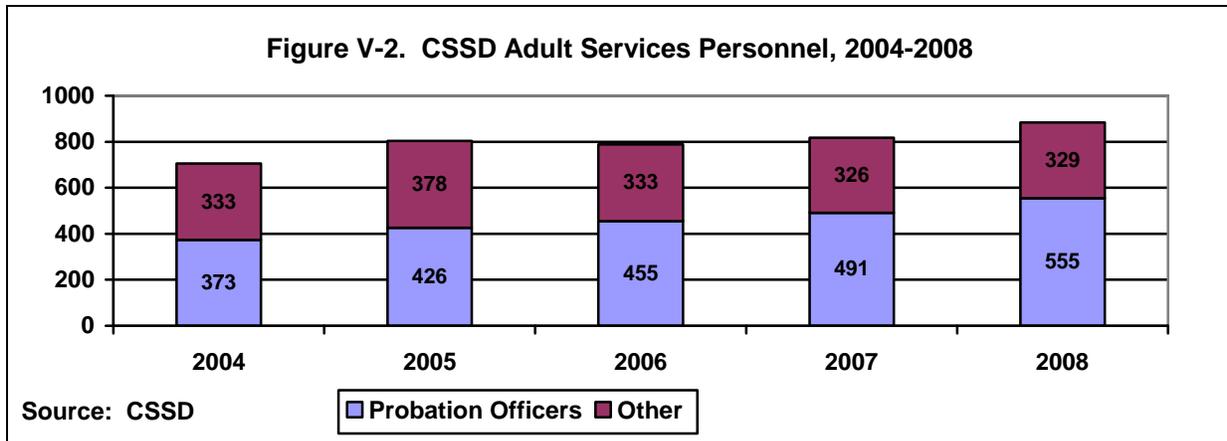
Profile of CSSD. The Court Support Services Division is headed by an executive director who oversees a central office and four divisions. The operation of CSSD is also broken down into regional service delivery areas (two regions for juvenile probation and family services, and five for adult services/probation). The four major divisions of CSSD and their sub-units include:

- *Operations* – adult services/probation, juvenile probation, and juvenile detention;
- *Family Services* – family services, center for best practices, and center for research, program analysis, and quality improvement;
- *Program and Staff Development* – training academy and statewide community service; and
- *Administration* – materials management, grants and contracts, human resources, fiscal and administration, and information technology.

The adult services sub-unit within the operation division is further divided into two units: intake, assessment, and referral (IAR) and supervision. The IAR bail staff (called IAR specialists) perform a host of pretrial activities including collecting criminal and demographic information about defendants, recommending bail, conditions of release, and determining eligibility and submitting status reports for some pretrial diversionary programs. The IAR probation staff (called probation officers) are responsible for offender assessments, pre-sentence investigations, determining eligibility and submitting status reports for some pretrial diversionary programs, and referral to treatment as well as monitoring of clients to ensure public safety. Probation supervision staff provide supervision to offenders released into the community, promote community protection, victim safety, condition compliance and referrals to treatment.

The family services unit provides pretrial assessment, case management and supervision to domestic violence defendants and offenders involved in the criminal court. In civil court, unit staff assist the court personnel and clients in the resolution of family and interpersonal conflicts through a program of negotiation, mediation, evaluation, and education.

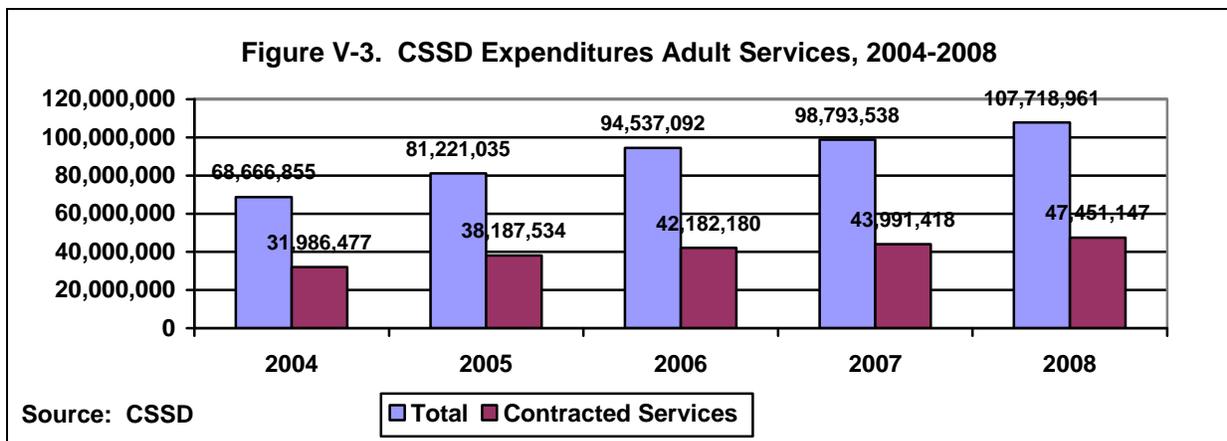
³¹ Office of the Bail Commissioner, Family Services division, Juvenile Detention Services, Office of Juvenile Probation, Office of Adult Probation, and Office of Alternative Sanctions.



Employees and caseload. As of June 30, 2008, the division had 1,364 (31 percent) of the judicial branch’s 4,392 employees. Of the 1,364 employees in CSSD, 64 percent were dedicated to adult services.

As shown in Figure V-2, the total number of adult service employees has increased by about 25 percent since 2004. Probation officers are the largest classification of CSSD employees. The number of adult probation officers has increased over the last five years by 49 percent. Consequently, the Judicial Branch has been able to significantly reduce average adult probation officer caseloads from 160 in 2004 to 91 in 2008. The two criminal justice reform bills passed over the last year authorize a total of 55 additional probation officers to be hired by the end of 2009 (not including the 50 probation officers to be hired this year as a result of the changes to the classification of 16 and 17 year olds). Lower caseloads, validated assessment tools, and evidence-based interventions are correlated with reductions in recidivism.

The division’s total estimated expenditures in FY 2008 were \$194 million, which is approximately 43 percent of the entire Judicial Department’s expenditures. As shown in Figure V-3, about \$108 million of total CSSD expenditures (56 percent) was spent on adult services in FY 2008, an increase of 57 percent since 2004.



CSSD contracts with a private, non-profit network to provide most of its client services, except for certain assessments that its staff perform, described below.³² There are a total of 23 different program models, of which 18 have a substance abuse component for adults. In FY 2008, the division managed a total of 114 adult services contracts in 149 locations throughout the state. The division spent about \$47.5 million through those contracts for adult services. Since 2004, spending on adult services has increased by about 65 percent.

Substance abuse treatment expenditures. The latest estimate for substance abuse expenditures by CSSD was made in 2005 and includes both adults and those under age 18. The amount spent on substance abuse treatment and non-clinical interventions was \$27.1 million or 19 percent of total CSSD expenditures.

Substance abuse risk factors. The precise number of defendants and offenders who are involved in this phase of the criminal justice process that have a substance abuse problem is difficult to determine because not all clients are assessed, as discussed further below. CSSD bail staff ask defendants questions about substance use during the pre-trial intake process. About one-half of the 55,000 pre-trial clients self-identify as having an alcohol or drug problem. In addition, most probation clients are thoroughly assessed as described below. In 2006, 17,522 of CSSD's probation clients were assessed for criminogenic and other risk factors.³³ Of those clients, 9,355 (53 percent) had indicated substance abuse as one of their top problems. Most of these clients with a substance abuse problem were male (82 percent), between the ages of 16-29 (49 percent), and White (58 percent).

Intake, Assessment, and Referral

The division uses validated assessment tools from the onset of court intake through the completion of the sentenced period of supervision. The validated assessments used are the Bail Decision Aid, the Domestic Violence Screening Inventory-Revised (DVSI-R), Level of Service Inventory-Revised (LSI-R), and the Adult Substance Use Survey (ASUS-R). These tools are used by CSSD to assist staff in making certain recommendations to the court, such as bail, and for making service referrals after sentencing. This section, however, is limited to those assessment tools related to substance abuse and determining treatment needs.

Assessment instruments. The division uses two validated assessment instruments to determine a defendant's or offender's risk of recidivating and the need(s) of the clients that lead to or cause crime. They are the Level of Service Inventory-Revised and the Adult Substance Use Survey – Revised. A shorter screening version of the LSI-R (LSI-R-SV) is generally used to determine if a full LSI-R is required. A full LSI-R assessment is mandated for offenders convicted of certain offenses, such as sex crimes, domestic violence cases, and other serious crimes.

The LSI-R is a validated, objective, quantifiable assessment tool that predicts client risk and service needs. It is a 54-item questionnaire and contains 10 "subscales" about different

³² These include certain LSI-R, ASUS-R, and DVSI-R assessments that probation officers administer. The DVSI-R is administered by Family Relations Counselors. These assessments are described below.

³³ Criminogenic factors are those areas identified by research as predictors of crime and/or related to recidivism.

personal characteristics that are both dynamic (i.e., changeable, such as companions) and static (non-changeable, such as criminal history). The dynamic factors are what probation and program personnel hope to influence to change an individual's behavior. The subscales are:

- criminal history
- education/employment
- finances
- family/marital
- accommodation
- leisure/recreation
- companions
- alcohol/drug problems
- emotional/personal
- attitude/orientation

Independent studies have shown that the LSI-R has a high level of predictive validity when looking at outcomes of various correctional populations. Its factors have been found to be highly correlated with recidivism and have produced consistent results with subgroups of offenders. The short version (LSI-R-SV) is also a validated assessment tool, and contains eight questions based on a subset of the longer version.

While the LSI-R is a general risk tool, the other instrument, the Adult Substance Use Survey-Revised is a complementary assessment that provides CSSD staff with detailed information regarding client involvement in and disruption caused by alcohol and drugs. The ASUS-R is a 96-question, self-reported survey with 15 subscales that indicates an offender's mood, degree of psychological stress, and emotional well-being. It is completed by the offender under the supervision of CSSD staff. The outcome is used as a guide to help staff discern the level of substance use severity and make treatment determinations.

The Bail Decision Aid is used by CSSD staff in cases where pre-trial release conditions may be appropriate. This assessment was developed in 2004 to guide pretrial personnel in determining if a bail condition is needed and in matching the client's needs with conditions. The decision aid classifies client needs into three primary areas: personal needs (e.g., substance abuse, unemployment); compliance needs (e.g., living alone); and safety risks (e.g., violent offender). The menu of available conditions (such as drug treatment, call-ins, and electronic monitoring) is similarly organized according to these need areas.

The Domestic Violence Screening Inventory-Revised is administered to all individuals who are arrested for domestic violence. The DVSI-R includes 11 separate items regarding previous incidents of both non-family and family violence, the presence of weapons, substance abuse, and children during the incidents, the defendant's prior participation in family violence intervention, violations of court orders, the defendant's employment status, the presence of verbal or emotional abuse in the relationship and the frequency and escalation of violence. The DVSI-R also includes a summary risk rating that is completed by the Family Relations

Counselors by using their professional judgment to assess the imminent risk of violence towards the victim and others. The DVSI-R is informed by five sources: the defendant, victim, police report, criminal history review, and the protective order registry (on which all protective orders by judges and police are required to be maintained).

Who is assessed? While all offenders sentenced to probation are assessed, including those with “split sentences” (meaning they are discharged to probation from the Department of Correction after a period of incarceration), there are some offenders or defendants who, based on their charges or diversionary program eligibility, are not assessed. However, an intake form is completed for all CSSD clients and includes four questions related to substance abuse. While the intake form is not an assessment tool, the answers to the intake questions may trigger a full assessment for a low level defendant or offender.³⁴ The division processes about 25,000 to 30,000 offenders placed on probation on an annual basis and it administers about 15,000 to 20,000 LSI-Rs and ASUS-Rs. In addition, 55,000 pre-trial defendants and 30,000 domestic violence defendants/offenders are interviewed with an intake form annually.

Policy requires that assessments are performed by CSSD staff within 14 days of sentencing, or 90 days prior to discharge from the Department of Correction for split sentence offenders through the Probation Transition Program.³⁵ Pre-trial defendants may be assessed by contract staff upon entrance to certain programs. It takes about 2.5 hours to administer and score both assessments (LSI-R and ASUS-R).

Case plan. The results of the ASUS-R and LSI-R and any specific court ordered conditions together with collateral information (such as police reports, family feedback, and known criminal history) are used to develop an offender’s or defendant’s supervision level and case plan to address identified needs.

The results of the two assessments are converted into numerical scores. The LSI-R has 10 subscales or need areas, as listed above. The three areas of highest need are prioritized to develop a case plan and matched with services to address those needs. Similarly, the ASUS-R results in a score that indicates the severity of need. There are four levels of substance abuse services that are provided by CSSD depending on the scores:

1. a zero score indicates substance abuse services may not be needed;
2. low scores (1-2) result in referral to urinalysis monitoring and alcohol or drug education;
3. mid-level scores (3-6) result in a referral to a weekly outpatient program; and
4. high scores (7-10) will be referred to an intensive outpatient clinic or a residential treatment facility.

While the CSSD-administered assessments are meant to provide guidance to staff in making referrals, all treatment providers are required to conduct independent evaluations to confirm the appropriateness of the referral. Because mental health issues often accompany the

³⁴ These include questions such as: “Are you currently using drugs or alcohol?” and “Were you under the influence of drugs or alcohol at the time of your arrest.” An affirmative answer to any three of the four substance use questions leads to additional questions and possible formal assessment.

³⁵ The Probation Transition Program is described in Section VI

abuse of drugs and alcohol, both versions of the LIS-R and the ASUS-R have indicators of mental health needs. Scoring certain items on the ASUS-R mood scale will trigger a formal mental health evaluation.

The staff also develop a probation supervision level based on the LSI-R, which has to be considered when placing a client into services. A probationer at a higher risk level requires more contact with staff and more intensive and extensive services.

Recently, the division has placed more emphasis on collaboration between the offender and staff in developing the case plan. After feedback is given on the assessments, the offender fills out a questionnaire that identifies the issues most important to the offender. CSSD staff will assess and reinforce the offender's motivation and readiness to change. Staff will take into account the offender's degree of motivation in developing the case plan, and which needs to address first. In any event, depending on the classification of the offender, the top two to three highest needs should be addressed during the term of supervision. Re-assessments can be completed throughout the supervision period.

It is important to note that matching the offenders' level of service to the right criminogenic need at the appropriate risk level is crucial to reducing recidivism. Offenders with high needs should be placed in high intensity programs. What is paradoxical is that if low need offenders receive high intensity services, their recidivism rates actually increase.

Motivational interviewing. CSSD staff are trained in motivational interviewing techniques to complete the LSI-R based on self-reported information from the offender. Motivational interviewing techniques include strategies such as asking open-ended questions not easily answered with a single word or phrase, listening reflectively to an offender and repeat what was said back to them, affirming the offender's recognition of a problem and intention to change, and eliciting self motivational statements from the offender that recognize his or her problems and express an intent to change.

Treatment Programs

Treatment programs may be accessed by defendants and offenders at various points in the criminal justice process according to specific eligibility requirements established by law and based on the results of assessments described above. Some programs are only available at a pre-trial stage, while others are available after an offender is convicted as part of an alternative sanction program or probation. Under most circumstances, pre-trial defendants are also eligible to participate in the programs available to those on probation. In addition, there are specialized community courts and court dockets to which some defendants/offenders may be diverted that focus on specific types of crimes. The programs discussed below are not a comprehensive listing of all CSSD programs, as the focus in this study is on those CSSD programs with a substance abuse treatment component.

Pre-trial programs. Appendix C shows the programs that are usually considered pre-trial diversion programs, with a substance abuse treatment connection. CSSD conducts eligibility determinations, community service oversight, and status reporting; the treatment components are administered in collaboration with DMHAS. For those participating in these

programs on a pre-trial basis (where prosecution has been suspended), charges are nolle and/or dismissed after successful completion.

The drug education program and the community service labor program (CLSP) are intended for people who are charged with possession of drugs and drug paraphernalia. Eligible applicants to the drug education program are referred to DMHAS for placement in a drug education program. Charges are dismissed for those who successfully complete the drug program. (Prior participants in the drug education program or the CSLP are ineligible for the drug education program. Those who have participated in the CLSP twice and those with prior drug possession and sale convictions are ineligible for the CLSP program.)

The pre-trial alcohol education program is intended for people charged with driving while under the influence. Defendants are ineligible if they have been convicted of certain serious motor vehicle crimes. Defendants are referred to DMHAS for evaluation and placement in an educational program or a treatment program.

The fourth “program” is a sentencing option (drug and alcohol treatment in lieu of prosecution or incarceration). Courts may also order defendants who are drug and alcohol dependent into treatment in lieu of prosecution or incarceration. The pretrial part of this option includes all drug sale and possession crimes. Certain serious motor vehicle crimes or class A, B, and C felonies are not eligible. The court, however, may waive these eligibility rules at its discretion.

Some first-time defendants/offenders may be allowed to use private services and do not use a CSSD network program. These individuals have insurance coverage, and choose to pursue treatment in a more private clinical or doctor-level setting. CSSD receives status letters of compliance from the treatment providers.

There are other programs administered at the pre-trial phase that do not focus solely on substance abuse issues, but do have a component that addresses these issues (e.g. Family Violence Education Program). These programs are described in Appendix E.

Post-conviction programs. Many types of programs with a substance abuse treatment component are available to offenders who have been sentenced and are on probation in lieu of incarceration, or are on probation after a period of incarceration (i.e., split sentence), or not incarcerated because of time served awaiting trial. Several types of services provided by CSSD’s network of providers are intended to assist offenders in identifying and changing problem behavior so they may successfully integrate into the community. Many of the programs offer substance abuse education and treatment as well as other types of interventions, including life skills training, individual and group counseling, vocational counseling, and referral services. A key distinction among the various services is the setting (e.g., more intensive services for a longer duration or less intensive for a shorter duration) and the client profile (e.g., risk level, gender, and ethnicity). Appendix E (Tables 1-3) shows the 18 programs with a substance abuse treatment element divided into three categories: residential programs, non-residential programs, and special programs. CSSD also collaborates with the DMHAS forensic services division in implementing the two pretrial education programs (alcohol and drugs), six diversion programs, and two reentry programs, as noted earlier.

Residential. The residential programs include a continuum of inpatient drug treatment services intended to provide offenders with emergency as well as short-, intermediate- and long-term placement. Appendix E describes the various residential programs, target population, and treatment timeframes. Residential programs include halfway houses, transitional housing, medical detoxification, intermediate and long-term intensive treatment (up to 18 months), and facilities for the dually diagnosed with mental illness and drug dependency. The total residential bed network available to CSSD in FY 08 is over 500 beds.

Like the rest of its services, CSSD purchases many of its beds through a bidding process, except for those purchased through a collaborative contracting process with DMHAS and DOC. Currently, the division purchases 287 beds from DMHAS and 18 beds with DOC.

As of July 2008, there were over 480 CSSD clients waiting for residential placement. In 2007, there were over 4,000 referrals to residential services, although only about 1,800 people received them. This means that about 2,200 people who needed them did not receive residential services. If a bed is not available, the client is placed on a wait list and a triage process is used by staff to address client needs, which may include non-contracted substance abuse treatment or transitional housing with Adult Incarceration Center services (see description of AIC below).

Non-residential. Most defendants/offenders involved with the criminal justice system have multiple service needs and the adult service programs (Appendix E) provide a range of community-based non-residential services. The non-residential programs are among the most heavily used. The average wait time for outpatient services is about two to six weeks across the state. The wait times are significant because the large majority of those waiting are housed at the Department of Correction, incurring costs of about \$121 per day.³⁶ The daily cost for a CSSD bed ranges from \$65-\$104.

The Adult Behavioral Health Services provide substance abuse evaluations, weekly substance abuse outpatient treatment, intensive outpatient treatment, group anger management, and mental health evaluation and treatment. These services may be accessed at 37 locations throughout the state, and in FY 08 about 10,400 clients were served. The average wait time for outpatient services is 2 two to six weeks across the state.

Alternative Incarceration Centers (AICs) provide monitoring, supervision, and programming during the day and evening in a structured center-based setting. They offer case management services, substance use assessments, group interventions (including substance abuse treatment), and also focus on employment skills and job development. Some AICs have transitional housing associated with them, but services are delivered at the AIC. There are 17 centers statewide that served about 8,700 clients in FY 08.³⁷

The Adult Risk Reduction Centers (ARRC) are intended for high risk and high need probation clients. Offenders report regularly for treatment and typically have multiple needs.

³⁶ Based on the Office of Fiscal Analysis estimate - the annual cost to incarcerate an inmate in Connecticut in FY 06 was \$44,165. See also February 13, 2008, OLR Memo, *Cost of Incarceration and Cost of a Career Criminal*- 2008-R-0099.

³⁷ The table in Appendix E shows 20 AICs. There are 17 AICs but three other locations are AIC transitional housing programs.

The ARRC is intended to provide targeted interventions that focus on anger management, substance abuse treatment, motivational enhancement training, cognitive restructuring, and reasoning and rehabilitation. About 134 offenders were served in FY 08.

The Drug Intervention Program (DIP) replaced Connecticut's drug courts. There were five drug courts in Connecticut that were terminated in 2001 because of high costs. This program is available in New Haven, Bridgeport, and Danielson. Eligibility requirements for the DIP include that the offender be drug dependent and have a non-violent criminal history. Persons eligible for DIP may be identified at any point in the court process. Referrals may be made by judges, defense counsel, state's attorneys, or CSSD staff. Defendants are required to plead guilty to any charges and sentencing is deferred pending completion of the program.

The court uses a more intensive team approach within the DIP (including attorneys, treatment personnel, and court personnel), and the offenders are required to report to the court on at least on a monthly basis. A course of treatment is developed with private nonprofit treatment agencies and CSSD providers, which may include an inpatient stay. The program lasts 12 to 15 months depending on progress in treatment. In FY 08, 167 people participated in this program.

Special services. As shown in Appendix E, there are a number of CSSD programs that target offenders with special service needs or who have been traditionally underserved. This includes programs aimed at domestic violence offenders as well as female and Latino offenders. Males involved in family violence offenses may participate in two programs offered statewide. The 26-week EXPLORE and more intensive 52-week EVOLVE domestic violence programs focus on education and behavior change to encourage positive interpersonal relationships and to aid in conflict resolution. Six of the sessions in the EXPLORE program and 12 sessions of EVOLVE focus on the role of substance abuse in violent behavior. Two other domestic violence programs, the Bridgeport Domestic Violence Intervention Services and the Family Violence Education Program, have either a substance abuse evaluation and treatment or education component.

Female offenders often have dependent children, a history of substance abuse, or have been victims of abuse or sexual assault. CSSD has two programs geared to the unique service needs of female offenders. Gender Specific Programming for Females is a non-residential program for women that provides gender responsive assessment and clinical services, while the Women and Children program is a residential (4-12 months) treatment and rehabilitation program for women that allows women to be housed with their children.

There is also a program tailored to Hispanic clients located in New Haven, called Latino Youth Offender Services. The bilingual/bi-cultural program provides intensive case management, counseling, education services, and substance abuse treatment for Latino male offenders between 16 and 23 years of age.

Evidence-based programming. Most of the programs offered by CSSD can be classified as research-based programming, with a few exceptions. The domestic violence programs meet the higher standard of being evidence-based (i.e., Evolve and Explore), while the Halfway House model is neither; this program address basic client needs of housing and supervision. Research-based programming means that there is research to support the

effectiveness of the practices, though it may not be specific to the treatment organization's population, age group, or gender; their primary substances of abuse; and even the geographic location.

DEPARTMENT OF CORRECTION

In the 2004 Survey of Inmates in State and Federal Correctional Facilities by the Bureau of Justice Statistics, 32 percent of state prisoners and 26 percent of federal prisoners said they had committed their current offense while under the influence of drugs. Among state prisoners, drug offenders (44 percent) and property offenders (39 percent) reported the highest incidence of drug use at the time of the offense. In Connecticut, the sale of hallucinogen/narcotic substances and the possession of narcotics are among the top three offenses of the incarcerated population.

Many studies have also noted that addressing substance use and addiction is viewed as an essential component of successful reentry into society. Such treatment increases the likelihood that former inmates will find and keep jobs, secure housing, and forge positive intimate and familial relationships after their release. In addition, research has shown that in-prison drug treatment, when linked with post-release continuity of treatment, can reduce post-release drug use and enhance positive outcomes.

Overview. The Department of Correction (DOC) is responsible for confining pre-trial defendants not released on bail and offenders sentenced to incarceration. The department provides medical and rehabilitative services to incarcerated offenders, and supervises and provides services to certain offenders who have been released into the community. The department's mission is to "protect the public, protect staff, and ensure a secure, safe, and humane supervision of offenders with opportunities that support successful community reintegration."

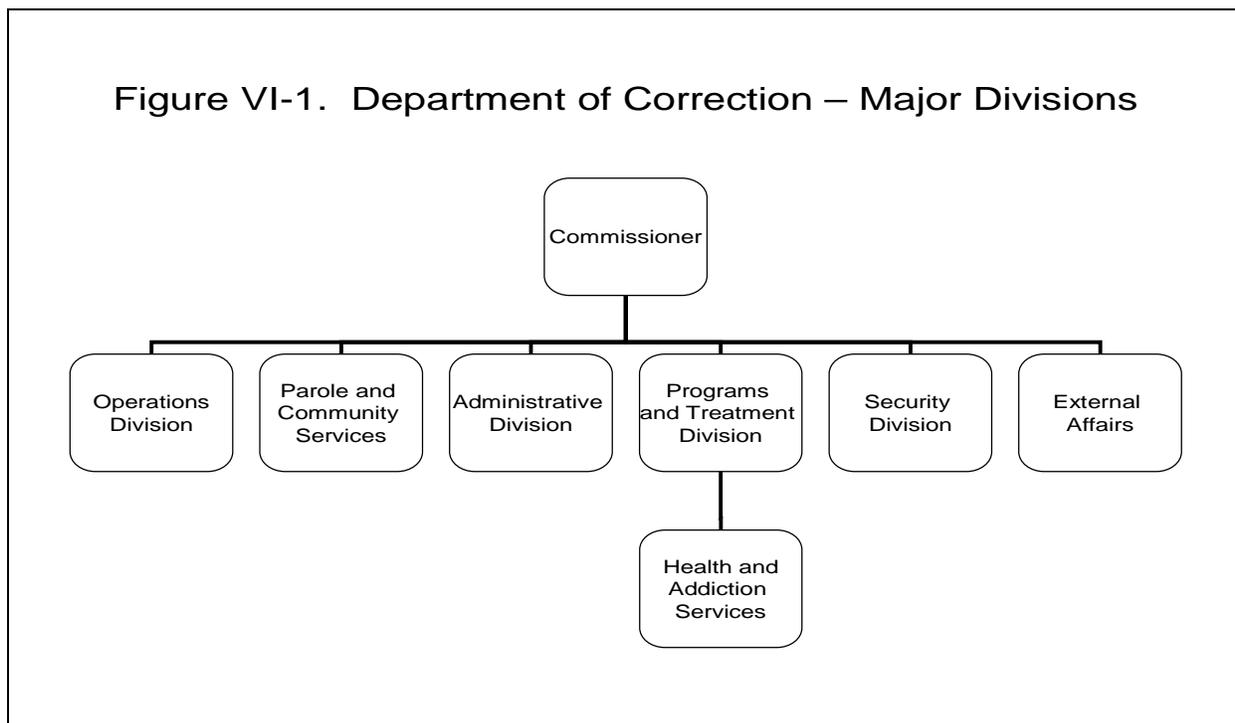
On average, the department annually confines about 19,500 individuals in 18 correctional facilities (about 20 percent of which are pre-trial), and supervises another 4,300 inmates in various community programs for a total supervised population of approximately 24,000 offenders. A total of 34,800 people were admitted to DOC in the last year and 20,300 were released from DOC custody (12,100 at the end of their sentences) or to DOC community supervision (8,200).³⁸ Another 14,500 are released for various reasons, including release on bail, the case is not pursued, transfer to probation, or the person is sentenced to time served.

Obtaining appropriate medical care, treatment, and skills-based training are important elements of an inmate's successful reintegration into the community. As DOC notes, about 95 percent of all inmates are eventually released from custody. Given that fact, the department has increasingly emphasized and strengthened its focus on each inmate's need to be prepared to return and integrate back into the community. Re-entry planning begins at the beginning of incarceration at a DOC facility. As each inmate nears the end of his or her incarceration, DOC provides various transitional and support services to prepare for discharge into the community. Substance abuse programs are a critical component of this preparation for many offenders.

³⁸ Current Correctional Population Indicators Monthly Report, Office of Policy and Management, August 2008. Average refers to the period of August 1, 2007 through July 31, 2008.

The department maintains a formal substance abuse screening and assessment process and provides a continuum of substance abuse treatment services. About 12,000 incarcerated pre-trial and sentenced inmates (65 percent) are in need of addiction treatment services. About 5,500 offenders were admitted to one of the department’s formal “Tier” programs (46 percent of those in need) and about 2,700 inmates completed one of the programs. Over 2,400 inmates were on a wait list for one of the department’s treatment programs at the end of FY 07.³⁹ Within the incarcerated population, nearly \$7.1 million was spent on treatment in FY 07.

For offenders in the community on parole, the department spent \$6.8 million on substance abuse treatment in 2007. About 8,200 offenders were released into the community on parole in the last year and approximately 5,600 (68 percent) offenders were in need of addiction treatment. Information on the number of parolees that did not receive treatment because they completed their sentence before the end of treatment is not readily available, though the department reports that there are no wait lists for substance abuse services under the parole division. About 12,000 offenders reach the end of their sentence at DOC (without transfer to parole), and it is not known how many do not receive any treatment.



Organization. As shown in Figure VI-1, the Department of Correction is composed of six major divisions. Two of the divisions have a role in providing or overseeing substance abuse treatment for offenders. The Programs and Treatment Division provides substance abuse treatment through the Health and Addiction Services Unit to incarcerated offenders and those released through transitional supervision and for certain offenders on parole. (Transitional Supervision is a statutorily authorized form of early release that is under the discretion of the warden of each correctional facility).

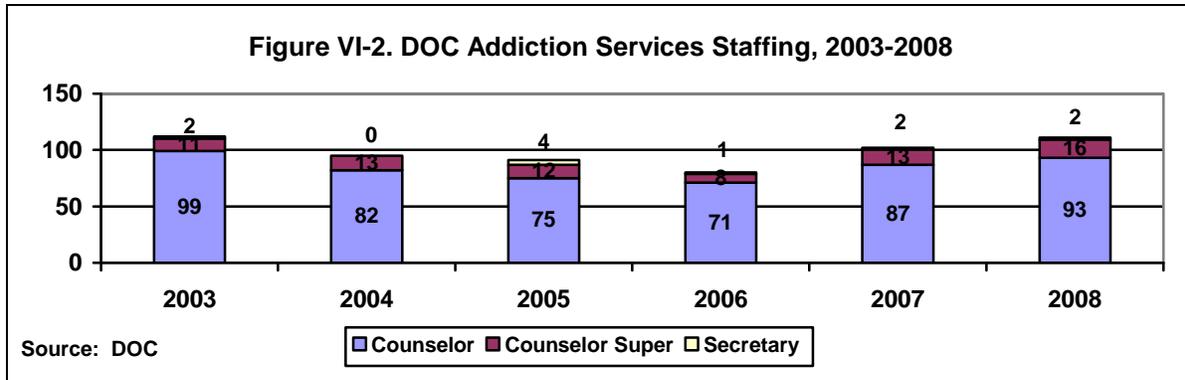
³⁹ Not everyone who is eligible for addiction treatment signs up for treatment. It is not a requirement.

In addition, the Parole and Community Services Division is responsible for supervising offenders who have been released into the community prior to the end of their sentence, including those released on parole under the discretionary authority of the Board of Pardons and Parole and those released by the DOC under Transitional Supervision. Each unit will be discussed separately below.

Profile of the Health and Addiction Services Unit

The Health and Addiction Services Unit is headed by a director who reports to the director of the Programs and Treatment division and is responsible for overseeing the provision of a comprehensive health care system for the offender population that includes medical, mental health, dental, substance abuse, and ancillary services. Except for substance abuse treatment, all other medical care is carried out through a partnership with the University of Connecticut Health Center.

Staffing. The department’s Addiction Services Unit (ASU) within the Health and Addiction Services Unit is headed by a deputy warden. As shown in Figure VI-2, the unit is currently staffed by 93 substance abuse counselors, 16 counselor supervisors (not including the deputy warden), and two secretaries, for a total of 111 staff. This is one less staff position than six years ago, but a 39 percent increase since 2006 when the ASU was reduced to 80 staff. All substance abuse counseling staff maintain professional certification or licensure as Alcohol and Drug Counselors through the Department of Public Health. The DOC is the only state agency that is required to maintain certification per P.A. 02-75.



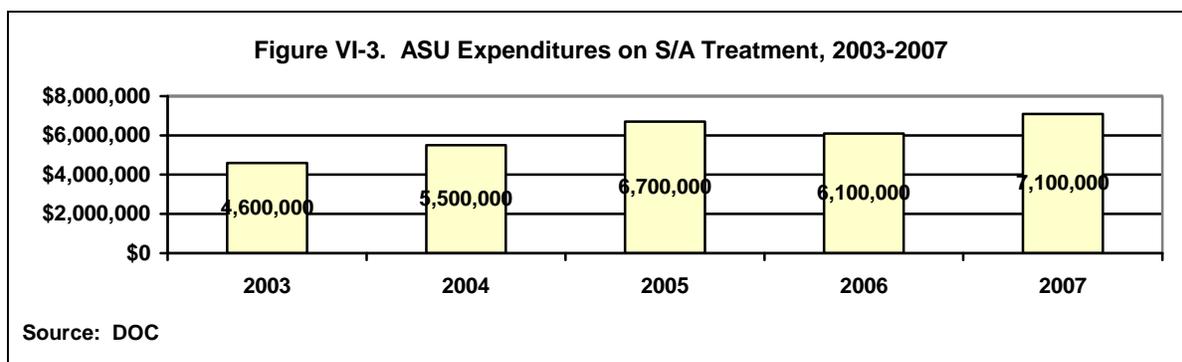
The stated mission of ASU is to “provide treatment for inmates with substance abuse problems, provide for continuity of care, and support the Department of Correction mission of public safety through substance abuse treatment, staff training, and program evaluation consistent with established best practices.”

The ASU central office contains the deputy warden and three counselor supervisors who perform various operational, administrative, and clinical duties. As Appendix F shows, the Addiction Services Unit operates programs in 17 of the 18 correctional facilities, though some high security sections within multi-security level facilities may not have ASU programming. Due to the long-term nature of the confinements at the Northern Correctional Institution in

Somers, that facility has no addiction services programming-- if any Northern inmates are to be released into the community, they are generally transferred to other facilities with programming.

Thirteen of the sixteen counselor supervisors oversee counselors in the various facilities or in regional parole offices. Three of the 13 counselor supervisors are assigned to supervise multiple sites. Each facility with programming has between two and 11 counselors. Addiction services are also provided to inmates who are released into the community before the end of their sentences through parole or Transitional Supervision. These services are provided at four of the department's five Parole and Community Services Offices.

Expenditures. As shown in Figure VI-3, expenditures for substance abuse treatment provided through ASU have increased by about 54 percent since 2003 from \$4.6 million to \$7.1 million. This increase is greater than the 19 percent increase for total DOC expenditures over the same time period (\$535 million increasing to \$636 million). Substance abuse treatment provided through ASU represents just over one percent (1.12 percent) of the entire DOC budget.



Institutional Intake, Assessment, and Treatment – Addiction Service Unit

The intake and assessment process for DOC inmates begins at pre-sentencing and during direct admission to facilities. The Department of Correction houses accused (awaiting trial/disposition), unsentenced, and sentenced populations. Incarcerated pre-trial defendants may participate in many of the services available to the sentenced population but formal release planning is not performed due to the transitory nature of this population.

Health services personnel meet with inmates and perform initial screens for acute mental and medical health needs when admitted to DOC. Offenders with special needs are placed in facilities designed to address specific issues (e.g., serious medical and mental health issues).

Generally, newly admitted inmates receive an initial need and risk assessment to determine their security classification. Offenders serving sentences greater than two years are transferred to the MacDougall Walker and York Correctional Institutions for orientation and assessment (York is the sole women's facility in the state). Within 10 days, a series of assessments are performed that includes an extensive medical and mental health examination, a substance abuse evaluation, educational and vocational assessments, a sex offender treatment needs review, and a security risk management review.

Offender Accountability Plan. The results of the assessments form the basis of each inmate's Offender Accountability Plan (OAP), which outlines the treatment and programming needs for the duration of an inmate's incarceration. The OAP requirements were implemented in January 2006 for each newly admitted inmate. The OAP is developed in collaboration with the inmate. Those offenders who are serving two years or less are classified and assessed at pre-trial facilities (Hartford, New Haven, Bridgeport, and Corrigan) and transferred to another facility where the OAP is developed and implemented.

The purpose of the OAP is to address the specific areas that need to be modified so that the inmate may successfully reintegrate into the community. The plan also includes behavioral expectations as well as spiritual, family, and community support components. It is through the OAP that the department begins planning for and assisting the inmate's ultimate discharge back into the community. After development of the OAP, the inmate is transferred to an institution commensurate with his/her assigned security level. The OAP is reviewed and modified on a regular basis through the term of incarceration to assess progress and reinforce achievement of stated goals.

During the orientation phase of incarceration, a parole officer from the Board of Pardons and Parole meets with each offender to outline the eligibility criteria and expectations for earliest possible discretionary release. While treatment and other activities needed to gain skills for reintegration cannot be legally required of inmates, the parole board emphasizes the benefits of doing so.

Substance abuse assessment. The Addiction Services Unit uses two substance use assessment tools for adults. They are the Texas Christian University Drug Screen II (TCUDS) and the Addiction Severity Index (ASI).⁴⁰

The TCUDS is a screening tool that allows correction staff to quickly identify individuals who report heavy drug use or dependency and might be eligible for treatment. It is a standardized, evidence-based 15-item assessment. The measures in the tool represent diagnostic criteria for substance abuse and dependence as specified in the Diagnostic and Statistics Manual (DSM-IV-TR). There are two parts to the TCUDS – one part of the scale includes questions related to drug and alcohol use problems and the second part addresses the frequency of use and readiness for treatment. Several studies have demonstrated its reliability and validity in criminal justice settings.

The TCUDS is used in the four DOC pre-trial facilities. The TCUDS is quicker to administer on a larger number of individuals.

The TCUDS takes about 15 to 25 minutes to complete and is administered to incoming pre-trial defendants and offenders in a group setting. The self-reported responses are scored by addiction services staff. In 2007, ASU staff have performed 13,494 TCUDS on adults.

For the sentenced population (entering through two DOC facilities), ASU staff use the Addiction Services Index. The ASI is a semi-structured interview instrument that addresses both

⁴⁰ A teen version of the ASI is used for those under 18 called the Teen Addiction Severity Index.

alcohol and drug use in the preceding 30 days and over one’s lifetime. It is designed as a comprehensive assessment tool with over 200 questions that cover seven potential problem areas. The department, though, only uses the 35 questions related to substance abuse. The ASI is administered by an ASU staff person. The average time to administer the ASI has not been calculated. Program administrators note that the questionnaire with its open-ended questions allows the clinician to have a more in-depth conversation with the offender as the interview progresses. In part, the interview process begins the therapeutic process of engaging the offender about his or her substance use and dependency and identifies what can be done to address the offender’s needs.

Table VI-1. DOC Substance Abuse Treatment Need Scores and Response*

Score	Assessment	Response
T-1	These individuals do not appear to have a substance abuse problem.	These individuals do not require any substance abuse intervention.
T-2	These individuals have a slight substance abuse history and would benefit from brief substance abuse intervention.	The appropriate level of intervention is voluntary participation in recovery support services.
T-3	Individuals receiving this rating have a moderate substance abuse problem.	The appropriate level of intervention is Tier III where available, or Tier II programming and community-based aftercare services. If the inmate has not completed Tier II or Tier III during this period of incarceration, community-based outpatient substance abuse treatment is recommended.
T-4	Individuals receiving this rating indicate a serious substance abuse problem and require residential or intensive outpatient treatment.	The appropriate level of intervention is completion of a Tier IV (Therapeutic Community) program where available, community residential substance abuse treatment and community based-aftercare services. If the inmate has completed Tier III or Tier II during this period of incarceration, community-based outpatient services are recommended.
T-5	These individuals have an extremely serious substance abuse problem and require a high-level of intensive treatment of extended duration, such as DOC residential treatment. These individuals have a very high probability of relapse into active substance abuse.	The appropriate level of intervention is completion of a Tier IV (Therapeutic Community) program where available, or long-term community residential substance abuse treatment. If the inmate has completed Tier III or Tier II during this period of incarceration, reevaluation by Addiction Services is recommended for community-based outpatient services.
* There is a less-intense Tier I program designed for inmates with a T-Score of 3 or above who are within 90 days of their release. Source: DOC		

While the ASI is widely used on prison populations throughout the U.S., systematic tests of the reliability and validity of the ASI in populations of substance abusers within the criminal justice system have not been done. DOC asserts that research does support the use of the ASI across a spectrum of substance abuse treatment environments and populations.

In 2007, ASU staff performed 6,033 ASIs on adults, which, when combined with the TCUDs noted above, means addiction services staff performed about 20,000 substance abuse evaluations on adults.

Treatment. The ASI scores are calculated and converted into a severity scale ranging from one to five called the substance abuse treatment need scores or T-scores. Table VI-1 above shows how the T-scores relate to the level of treatment required. Substance abuse treatment is available at four levels depending on the amount and intensity of treatment required based on individual needs and the point in time at which intervention is determined to be the most effective. The Tier programs are described below.

Figure VI-4 shows the distribution of T-Scores for the DOC incarcerated population at the end of 2006. While nearly 80 percent of DOC inmates come into the system having some level of substance abuse history (T-Score of 2 or more), about 65 percent (T-score of 3 or more) have a score that requires an intervention with formal treatment programming. For FY 06, this equated to about 12,000 inmates in need of addiction services.

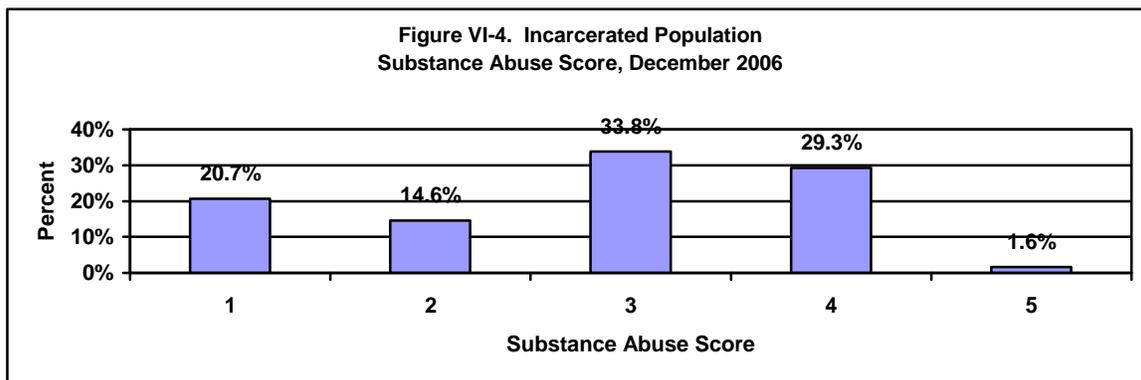


Table VI-2 describes each of the tiers, the number of facilities where they are offered, and the number of inmates who completed the programs, and compares them to the number discharged from the program before completion. The far right column also shows the number of inmates on the wait list at the end of FY 2007. (See Appendix F for substance abuse treatment offerings by facility.)

In FY 2007, a total of 2,700 inmates completed one of the Tier programs, while another 2,400 were on the wait list for a program. Over the same time period, more than 26,000 inmates requested to be in a program.

The less intense programs (Tiers 1 and 2) are offered at more facilities, while the more intense programs are only offered at six facilities. Except for the Tier 1 program and as noted above, the Tier programs generally require a T-Score of T-3 or higher. Generally, eligible inmates must have a certain mental health rating to participate – they cannot have a severe mental health disorder (see co-occurring below). Finally, inmates must not have any disciplinary issues and have enough time on their sentences to complete the indicated program. Priority is given to those inmates with less than 3 years to serve on their sentences.

Table VI-2. DOC Addiction Services Tier Programs

Programs	Description of Program	Number of Facilities Offered*	Number Discharged /Completing Program - % Complete (2007)*	Number on Waitlist (End of FY 2007)*
Tier 1	Pre-release substance abuse education program. Nine sessions based on the evidence-based “Beat the Streets” curriculum. Program is intended for inmates who are within 90 days of release to the community. DOC notes that that model is not evidence-based but has “longitudinal reliability within the correctional environment.”	8	n/a/1,355	397
Tier 2	Intensive outpatient substance abuse treatment. Uses an evidence-based curriculum (“Living in the Balance”) provided three times per week for 10 weeks in a non-residential setting. The model is evidence-based and validated in correctional facilities.	10	1,385 / 1,037 (75%)	1,846
Tier 3	A four month residential substance abuse treatment is designed to provide recovery and relapse prevention skills in preparation for reentry in the community. The program is based on a modified therapeutic community model. Participants are housed separately from the general population. This is an evidence-based model validated in correctional facilities.	2	126 / 61 (48%)	128
Tier 4	Longer term residential treatment (6 months) based on a Therapeutic Community Model with full-time programming. Participants are all housed together, separate from the general population and are expected to attend school or hold a job while in the program. This is an evidence-based model validated in correctional facilities.	4	702 / 247 (35%)	51
* Includes Manson Youth Institution, a facility for young offenders between the ages of 14 and 21. It offers Tiers 1, 2 and 4. Source: DOC				

The Tier 1 program had the highest number of participants, but it is also has the shortest number of sessions and is limited in its objectives. Tier 1 admits all offenders with a treatment need (T-Score of 3 or higher) and participants are kept in the program until they complete or leave the facility.

The Tier 2 program had the highest percentage completion rate (75 percent), while the residential programs, Tier 3 and Tier 4, had the lowest completion rates at 48 percent and 35 percent respectively. This is in part due to the length and rigor of the program requirements in the residential programs.

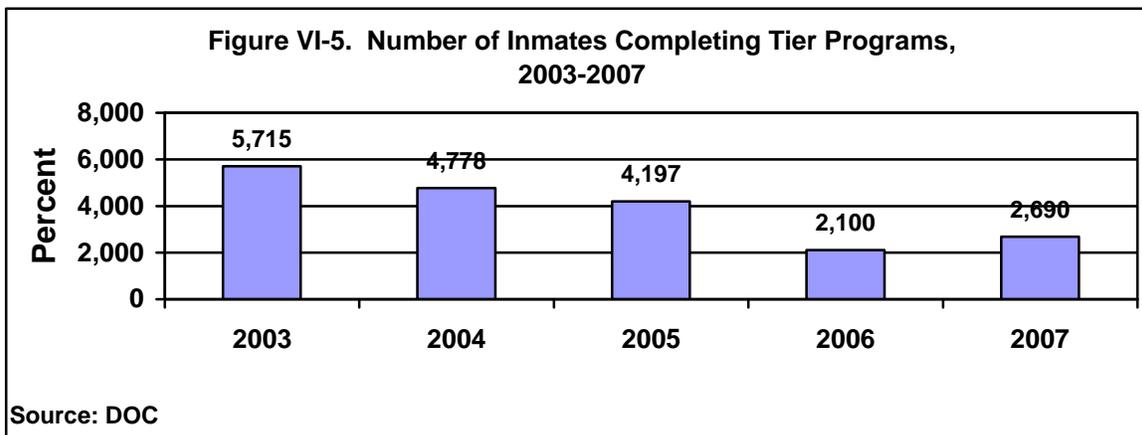


Figure VI-5 shows the number of participants completing the Tier programs has declined by about 53 percent over the last five years. The biggest reductions were in the Tier 3 (down 69 percent) and Tier 1 programs (down 68 percent). DOC administrators have cited a number of reasons for this decline including changes made in the eligibility requirements for Tier 1 (pre-2004, anyone could attend) and changes to the Tier 3 program design and in the number of sites offered (seven sites down to and now two).

In addition, the overall completion rate (program discharges compared to program completions) over the last five years for Tiers 2 through 4 has declined from 65 percent to 61 percent. DOC administrators cite several reasons for this decline including a reduction in counselor staffing through 2006, a focus on providing more services to offenders closer to discharge (resulting in more discharges prior to completion), and a decrease in the amount of space available for non-residential programming.

Client ratios and caseloads. Each program has optimal client to staff ratios that range from 25 to one for Tier 1 to 10 to one for Tier 4. The size of caseloads among counselors varies depending on the Tier level of treatment and other programming for which they are responsible. A clinician who is responsible for performing assessments and running Tier 1 programs may have a caseload of 75 clients. A clinician running a Tier 2 program with the responsibility of overseeing an aftercare program may have a caseload of 40 clients. Tier 3 and Tier 4 programs have a 10 to 1 caseload ratio, but within each of these therapeutic programs the counselors are responsible for each resident, which could be as high as 75 clients.

Co-occurring. As of July 1, 2008, about 19 percent of the offenders incarcerated in a DOC facility had a mental health issue that required treatment. About 13 percent of inmates have both a mental health issue and a substance abuse issue. Those with the most serious mental health issues are housed and treated at Garner Correctional Institution. Historically, those offenders with more severe mental health disorders would not be eligible for addiction services

unit programs. In FY 08, DOC implemented a co-occurring disorders program at Garner. The department is expanding the program to two more facilities in this fiscal year.

Facility aftercare. Aftercare is an important part of the recovery process. Aftercare refers to continuing care services offered after discharge from a treatment program. It is intended to prevent relapse by encouraging the development of social networks and activities to address emotional needs of recovering alcoholics and substance abusers. Aftercare is available in 12 DOC facilities and is offered to anyone who has completed Tier 2 or higher programs.

Aftercare sessions are co-facilitated by addiction services staff and inmate participants, consisting of three open group sessions per week for a total of 30 sessions over 10 weeks. In addition, 11 DOC facilities offer Alcoholics Anonymous (AA) and five offer Narcotics Anonymous (NA). Both programs help to support treatment efforts by reinforcing recovery attitudes and practices. In 2007, there were about 1,400 AA meetings and 1,100 NA meetings conducted in DOC facilities.

Other institutional programs. The ASU is also involved in other substance abuse treatment and treatment-related programs offered within DOC facilities aside from the main Tier programs. These include the following:

- *DUI Awareness* – This is a program for offenders who were convicted of driving while under the influence (DUI) of alcohol or drugs and other related offenses. The program consists of a 14-session psycho-educational group using the Hazelton Institute’s “Who’s Driving” curriculum.
- *Jail Re-interview Project* - The Jail Re-interview Project enables CSSD’s intake, assessment, and referral staff to reassess pre-trial defendants held on bond for the development of a supervised, community-based treatment program instead of incarceration prior to trial. The ASU staff are a referral source for this project.
- *Technical Violations Program* – The program provides substance abuse treatment to offenders remanded into custody for non-compliance with the stipulations and/or conditions of their release to the community. The program uses the evidenced-based “Matrix Program” (15 sessions) and “The Relapse Prevention Workbook for Criminal Offenders” (10 sessions) to meet the needs of the defined offender population. The program is designed to return the offender to the community within 60 days of being remanded.
- *Drug court recommendations* - ASU staff refer possible candidates to the CSSD’s Drug Intervention Program, as described in the previous section.
- *Bridging the Gap* – A service provided by ASU staff that allows staff to get information about the nearest Alcoholics Anonymous meeting location along with the name of a contact person for inmates about to be released. The AA

member will contact the inmate upon release and provide transportation to the meeting.

- *Peer Mentors* – Peer mentors are graduates of the Tier programs who assist ASU staff in the presentation of Tier programs to new groups along with 12-step Fellowship groups. The primary purpose of peer mentors is to model a recovery lifestyle for other program participants. ASU staff provide weekly training to peer mentors.
- *Non-Tier substance abuse related groups* – ASU staff conducted 352 non-Tier substance abuse related group counseling sessions in FY 07. This included groups on anger management, fatherhood, and relationships. These groups are intended for offenders who are eligible for DOC services who have completed and/or are waiting to be added to a program list.

Community Addiction Services Programs. The Community Addiction Services Programs (CAS) provide substance abuse treatment for offenders placed on Transitional Supervision, the community release program under the jurisdiction of DOC for inmates with a sentence of two years or less. (This is distinct from parole, discussed below). Other eligibility requirements include a substance abuse treatment need score of T-2 or higher, a certain mental health status, and a minimum of 10 weeks remaining on his or her sentence.

These programs are staffed by five ASU counselors and overseen by a counselor supervisor. The staff is located in four of the Parole and Community Services offices: Bridgeport, Hartford, New Haven, and Waterbury.

The goal of this unit is to provide continuity of care in the areas of substance abuse treatment and reintegration into the community. The programs emphasize a balance of substance abuse treatment, required attendance in 12-step fellowship support meeting in the community, and maintaining a focus on recovery and reintegration. Generally, the treatment services include psycho-educational recovery groups, individual counseling, and community resource referrals. The optimal client to counselor ratio in these programs is 15-20 to one.

Table VI-3 provides a description of the programs offered by CAS, the number of offenders completing the programs compared to the number of discharges, and the number of counseling sessions for individuals and groups provided by CAS staff. The completion rate for the CAS programs runs from 45 percent for the Women's Recovery Group to 15 percent for the Relapse Prevention Program. The Matrix Program, The Relapse Prevention Workbook for Criminal Offenders, and The Helping Women Recover Program are evidence-based programs recommended by the federal Center for Substance Abuse Treatment (CSAT) for the correctional population.

Table VI-3. DOC Community Addiction Services Programs Primarily for Prospective Transitional Supervision Offenders

Programs	Description of Program	Number Discharges/ Completing Program and %Complete (2007)
Primary Substance Abuse Treatment Program – Early and Continuing Recovery Skills	The <i>Early Recovery Skills Group</i> is an eight-session intensive outpatient treatment module designed to meet the needs of those newly released to community supervision, who have 60 to 90 days remaining on their sentences. May also be used as an introduction to continuing recovery skills group. The <i>Continuing Recovery Skills Group</i> is a 16-session intensive evidence-based outpatient treatment module for those released from incarceration either on parole or Transitional Supervision status and have at least 120 days remaining on their assigned release program. Both programs are modeled on the Matrix Model developed by the Hazelton Institute.	838 / 355 (42%)
Relapse Prevention Program	A 10-session evidence-based program designed to help the addicted inmate to: 1) identify relapse triggers; and 2) develop a situation specific plan to avoid a relapse or reenter a recovery-focused lifestyle. Based on a Hazelton Institute relapse prevention program. This program was designed to be the initial intervention for offenders who relapsed into active substance use while on transitional supervision or parole.	149 / 23 (15%)
Women’s Recovery Group	A 10-session gender-specific program designed to integrate the theory of addiction, the theory of women’s psychological development, and theory of trauma into a client interactive program. This program is based on Stephanie Covington’s “Helping Women Recover” program.	87 / 39 (45%)
		Number of Sessions
Individual Counseling for Males	Individual counseling sessions are used for male offenders who do not have enough time prior to discharge to complete a structured treatment program. Individual counseling sessions are required for offenders admitted to DOC structured programming.	430
Individual Counseling for Females	Similar to the above, individual counseling sessions are used for female offenders who do not have enough time to complete a structured treatment program prior to discharge. Individual counseling sessions are required for offenders admitted to DOC structured programming.	235
Total Group Counseling Sessions	Total number of group sessions for CAS programs described above.	1,425

Source: DOC

Discharge planning. Inmates discharge from DOC facilities either directly to the community with no further supervision (because they reached the end of their sentences), through parole, transitional supervision, or to probation.⁴¹ The process for inmates who are discharged to parole or transitional supervision is described below. All inmates discharged from DOC facilities at the end of their sentences develop a discharge plan at a minimum of 45 days prior to release. Transition counselors assist the inmate with making arrangements for the transition by addressing matters such as housing, clothing, transportation, medical and mental health treatment, identification, and after care programs.

While this planning is not mandatory, inmates are strongly encouraged to participate. The program consists of a workbook and a video presentation. The video is a series of presentations from private and public service agencies that highlight what each agency does and how an inmate can access its services. Job centers and information kiosks listing various statewide resources are also available at certain institutions to allow inmates to obtain information. The “Bridging the Gap” program, described above, is also available to inmates at time of discharge. Planning for a comprehensive statewide re-entry strategy is underway through the Office of Policy and Management, as described earlier.

Profile of the Parole and Community Services Division

The DOC Parole and Community Services Division (parole division) is responsible for supervising and providing support services to all offenders released on parole, by the Board of Pardons and Paroles, or to transitional supervision by the Department of Correction. The mission of this division is to “enhance public safety by providing offenders opportunities to successfully reintegrate into the community and be productive, accountable members of society.” Ultimately, the goal of the division is to reduce recidivism by providing services and supervision that increase the probability of each offender’s successful reintegration.

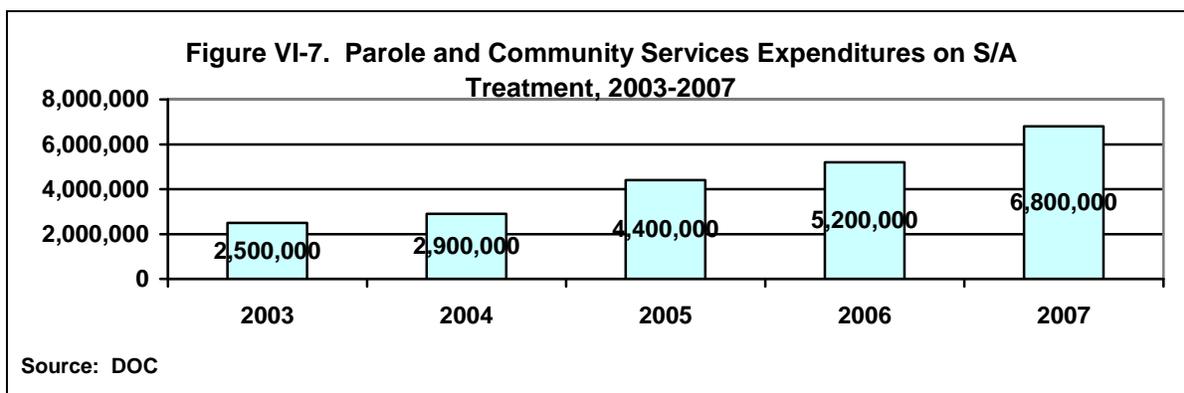
Organization. This division is the result of a consolidation of the community supervision and enforcement functions of the Department of Correction and the former Board of Parole, which occurred in the fall of 2004 at the direction of the General Assembly. As noted above in Figure VI-1, the Director of Parole and Community Services reports directly to the commissioner of correction and is responsible for the division’s administration, operations, and planning.

The parole division has a central office in Hartford and five district offices in Bridgeport, Hartford, New Haven, Norwich, and Waterbury. Parole managers and officers in each district oversee the progress of offenders and monitor their adherence to release conditions. The level of offender supervision ranges from very intensive (twice weekly reporting plus electronic monitoring) to minimal supervision (once monthly reporting). Current staffing for the division totals 157 and includes 124 parole officers and managers, 26 field support staff, and seven members of the director’s office.

⁴¹ Parole is a form of early release available to certain offenders serving sentences of greater than two years. By statute, offenders convicted of non-violent crimes are eligible for parole after serving 50 percent of their sentence. In most cases, those offenders convicted of certain violent crimes must serve 85 percent of their sentences.

The central office also contains a number of specialized units, including: standards and compliance, central intake, residential services, special management (for sex offenders), mental health, fugitive investigations, and strategic planning and research. These specialized units work with the district offices to enhance offender accountability and public safety. For example, the mental health unit, established in 2007, contains five officers and a parole manager who have smaller specialized caseloads that consist of offenders who have histories or current diagnoses of significant mental health disorders. The officers in this unit receive 40 hours of specialized training provided by DMHAS and DOC mental health treatment specialists.

Expenditures for treatment. As shown in Figure VI-7, expenditures for substance abuse treatment provided through the parole division have increased by about 172 percent since 2003 from \$2.5 million to \$6.8 million. This increase is greater than the 19 percent increase for total DOC expenditures over the same time period (\$535 million to \$636 million). Substance abuse treatment provided through parole represents just over one percent (1.1 percent) of the entire DOC budget. The combined expenditures for the addiction services unit and the parole division for substance abuse treatment in FY 2007 was nearly \$14 million or about 2.2 percent of the total DOC expenditures.

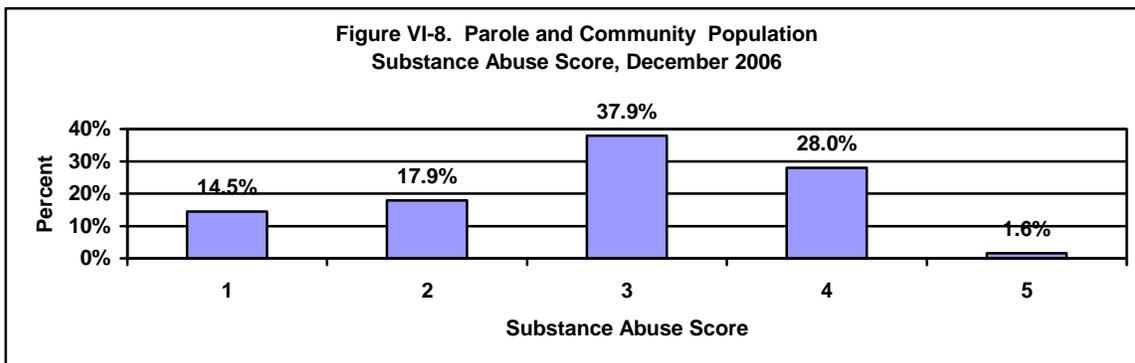


Caseloads and admissions. As noted above, on average about 8,200 offenders were released in the last year to the parole division, and about 4,300 offenders are under the supervision of this division on a daily basis. The Parole and Community Services staff supervises an average combined parole/transitional supervision caseload of 49 persons per officer. Specialized caseloads, such as sex offenders, are usually smaller at 25-30 cases per officer. There were 1,455 admissions to discretionary parole in FY 08 and 896 remands to custody. There were 692 admissions to special parole and 498 remands to custody and for TS there were 3,075 admissions and 1,117 returns to custody in FY 08.⁴²

Substance abuse score. Figure VI-8 shows the distribution of T-Scores for the DOC parole and transitional supervision population at the end of 2006. While nearly 85 percent of inmates coming onto parole or TS have some level of substance abuse history (i.e., a T-Score of 2 or more), about 68 percent have a score that requires an intervention with formal treatment programming (i.e., T-score of 3 or more). This means that about 5,600 offenders entering parole

⁴² Special parole is a form of parole that is mandated by the court in place of probation. It is generally reserved for high risk offenders.

would be in need of substance abuse treatment. It is not know how many offenders do not receive all the treatment needed because their sentence ends before treatment is completed.



Intake, Assessment, and Referral to Treatment – Parole Division

For each inmate who has been “voted to parole” by the Board of Pardons and Parole, the Parole and Community Services Division receives a packet of information from the parole board that contains the standard conditions of parole and any other conditions that the board may impose for the individual along with a parole summary. The packet also contains historical information about the offender including, pre-sentence investigations, sentencing transcripts, police reports, and information on any DOC activities that the offender may have engaged in.

The information the division receives from DOC correctional facilities for pending transitional supervision offenders is similar except it does not include a parole summary and related documents that would be generated by the parole board. Parole and community services officers (who are called parole officers) also have access to DOC electronic case management information and records.

For parolees, the parole board uses DOC- generated assessment information as a basis to stipulate any special conditions on offenders, like substance abuse treatment, when making release decisions. The parole board does not perform any independent assessments of offender needs. The parole board does administer the Salient Factor Score (SFS), which is an assessment instrument used to examine an offender’s likelihood of recidivating following release from prison. The board uses the information generated by the SFS to guide release decisions. The SFS, though, is a static prediction instrument (measuring only information at the time the offender was sentenced) and consists of only five risk factors. Thus, the SFS examines only the risk of recidivating and not the needs of the offender. Those needs are indicators of where criminal justice agencies should intervene and work to modify to reduce recidivism. Thus, the needs of paroled offenders are assessed by the DOC parole division, as described below, after the parole board has acted. The DOC parole division has the authority to add requirements to an offender’s release conditions.

Assessments. Parolees are required to meet with a DOC parole officer within three days of release of a DOC facility. The parole officer will review the parole agreement with the parolee and other conditions of his or her release. As a DOC requirement, all parolees receive a

substance abuse assessment by a community provider generally within 10 days of release from a DOC facility. While there is no standard instrument, the parole division requires its providers to use evidence-based assessment tools. The division reports that most providers use the Addiction Severity Index or the Adult Substance Use Survey (ASUS) assessment tool.

The level of need is determined by the assessor, and it is assumed the assessor is factoring in any treatment obtained while the offender was incarcerated. While there are no standard treatment protocols required by the parole division, the division does require an individualized treatment plan be created. The assessor also, in most instances, is the provider of substance abuse services. The parole division does not independently check on how an offender's needs match with the intensity of services delivered.

The parole officer receives information back from the provider regarding parolee noncompliance and program completion. Monthly reports are also received by the division indicating the aggregate amounts of activity (e.g, number of evaluations, admissions, toxicology screens, and individual and group sessions) by provider.

The parole division is in the process of changing its approach to assessing offender risk and needs by incorporating the administration of the Adult Substance Use Survey and the Level of Service Inventory – Revised by its own parole officers. The division is beginning to use these tools as a more sophisticated and evidence-based approach to determining the level of supervision an offender requires and in identifying the needs that should be addressed. As of September 2008, parole officers are undergoing intensive training to administer the two instruments. The changes should be implemented during the fall of 2008. The Judicial Branch's Court Support Services Division is assisting the parole division with this training.

The results of these assessments performed by parole officers will be incorporated into a case management plan created in collaboration with the offender. The case management plan is intended to address the offender's needs that most directly contribute to the risk of recidivating consistent with the results of the LSI-R sub-scales.⁴³ Similar to CSSD, it is expected that the offender will address the top three criminogenic needs during the term of supervision. Once the new process is fully implemented, the providers will no longer be required to do assessments.

A number of other requirements must be satisfied in order for an offender to be released into the community. For example, depending on the risk level of the offender, a sponsor usually must be identified by the offender in order to live in the community as opposed to alternative housing (e.g. halfway house).

Treatment programs. The parole division maintains a wide network of contracts with private non-profit community providers for residential and nonresidential supervision and treatment of offenders. Treatment is not the only consideration in determining offender placement in the community -- the offender's risk of noncompliance and to recidivate is also a consideration. Offenders on transitional supervision are generally afforded greater freedom than parolees, while offenders placed in residential programs have a more structured environment.

⁴³ The LSI-R scales were discussed in Section V.

There are currently 49 residential providers and 36 nonresidential providers that work in collaboration with parole officers to provide an array of residential and treatment services. All levels of substance abuse treatment are available through this non-profit network.

All substance abuse programs under contract with DOC are required to use evidence-based practices. These practices may or may not be validated for criminal justice populations. The providers that act as a referral service for offenders may send offenders to DOC programs or other programs that do not have evidence-based requirements, though the treatment programs are mostly likely DMHAS- funded.

Residential programs. The parole division maintains two broad types of housing: halfway houses and alternative or supportive housing. Halfway houses provide 24-hour supervision and offer a range of different services as described below. Supportive housing provides supervision to male and female offenders who lack appropriate living arrangements, while assisting them obtain services in the community and preparing them to function independently.

Taken together the number of contracted residential program beds is about 1,290, which are offered through 49 providers. All the housing options offer substance abuse education, counseling, or referral to treatment providers or aftercare services. Table VI-4 describes each of the programs, the treatment timeframes, and the number of beds available for each.

Of the 1,290 beds on line, 909 beds were for male offenders, 120 for female offenders, and 263 were mixed gender. The average cost per bed is \$23,700. In addition to receiving counseling, employment assistance, and substance abuse and mental health treatment, offenders in community residential programs work in the community and are thus required to pay taxes and rent, and, if applicable, victims' compensation and child support. Daily occupancy rates averaged nearly 100 percent, though there are no waiting lists for residential services. DOC has 77 beds co-contracted with CSSD through the collaborative contracting arrangement discussed above.

Table VI-4. Parole & Community Services Division Residential Programs				
Program	Program Description	Treatment Timeframe	Number of beds	Number Served FY08
<i>Halfway House Programs</i>				
Work Release	Work Release programs assist male and female offenders obtain gainful employment while providing secure on-site supervision. Individual treatment plans are developed for each offender with a focus on: meaningful employment, substance abuse education, life skills, and discharge planning. Some programs offer cognitive behavioral education programs	4 to 6 months	766 beds	2,366

Table VI-4. Parole & Community Services Division Residential Programs				
Program	Program Description	Treatment Timeframe	Number of beds	Number Served FY08
	and abuse and mental health services on-site ,and in others referrals are made to DOC nonresidential programs.			
Inpatient Substance Abuse Programs	Inpatient programs use a comprehensive evidence-based screening assessment tool that identifies problem areas to be addressed in an individualized treatment plan. Substance Abuse programs are highly structured environments, based on a cognitive behavioral treatment approach, offering relapse prevention, N/A & A/A, group therapy, and family counseling. Discharge plans include community aftercare referral for continuity of care.	30 days to 8 months	207 beds	641
Mental Health Program	Mental Health programs are highly structured environments offering mental health treatment, group therapy, family counseling, substance abuse treatment, and discharge planning. The mental health programs work with the local LMHA and DMHAS to enhance continuity of care while transitioning offenders on parole, Transitional Supervision, or end of sentence.	6 to 8 months	23 beds	63
Women & Children Program	Women & Children programs offer female offenders residential social reunification programming, in addition to substance abuse counseling. In conjunction with DCF, offenders are reunited with their children prior to parole, Transitional Supervision, or end of sentence.	4 to 6 months	31 beds	77
<i>Alternative Housing</i>				
Supportive Housing	Supportive housing designed for offenders on Transitional Supervision or parole that are in need of transitional housing. Supportive housing is provided in both scattered-site and congregate settings. The goal is to assist offenders in reestablishing themselves in society.	4 to 6 months	270 beds	118 congregate 655 Scattered

Table VI-4. Parole & Community Services Division Residential Programs				
Program	Program Description	Treatment Timeframe	Number of beds	Number Served FY08
	<p>Congregate houses are supervised houses that have house managers available 40 hours per week and initiate referral to community resources, including substance abuse treatment, based on client need. Congregate houses are chemical-free environments.</p> <p>Scattered site housing refers to individual apartments where offenders are placed to have the offender function independently. Staff provides extensive case management services that include the development of an Individual Case Service Plan, employment supports, securing entitlements, linking and referring to mental health, substance abuse, and other community-based social services.</p>			
CSSD co-contracted	<p>Beds are filled with accused (pre-trial) and sentenced individuals age sixteen (16) years and older. Parole officers may refer to these programs when an offender needs a higher level of support than can be offered at an Alternative Incarceration Center. Other DOC offenders who need residential housing may utilize these beds. Program services include: intake assessment for risk and need, case management, substance abuse assessment, group intervention (employment, cognitive skills, substance abuse), and community service restitution</p>		77	85
Source: DOC				

Non-residential programs. Thirty-six nonresidential programs provide a variety of services to offenders including outpatient substance abuse counseling, mental health evaluation and treatment, anger management, domestic violence education, employment assistance, individual, couples and family counseling, family training, child care education, transportation and other social services.

Only two types of services provide direct substance abuse treatment. There are no waiting lists for nonresidential programs. Table VI-5 provides a description of those non-

residential programs that have some substance abuse treatment component with the treatment timeframes and number of clients served in FY 08 (duplicates are possible).

Table VI-5. Parole and Community Services – Non-Residential Providers			
Program	Program Description	Treatment Timeframe	Number Served FY08
Multi-Service Centers	<p>Multi-Service Nonresidential Programs provide a wide variety of social service assistance directly or through referrals. These programs are able to provide “one stop shopping”. All programs provide care management and aftercare services. Offender needs addressed include:</p> <ul style="list-style-type: none"> • employment and vocational training, • housing, • substance abuse treatment, • mental health and psychiatric services, • social reunification services and educational advancement, • legal identification, and • vouchers for food and clothing. <p>Programs provide an individualized service and community integration plan that is sensitive to cross-cultural and gender specific issues. Programs are expected to demonstrate linkages to the community at large.</p>	Typically 90 days	3,920
Substance Abuse	<p>Substance abuse nonresidential programs provide intensive outpatient substance abuse treatment services. The programs utilize a risk reduction treatment approach that is based on an in-depth assessment of the needs of the offender utilizing evidence-based instruments.</p> <p>Treatment services utilize an intensive outpatient treatment model stressing the importance of the development of a supportive family network.</p> <p>Substance abuse programs offer the offender the opportunity to attend group therapy (2-6 groups per week) that may include couples therapy and family therapy.</p> <p>Most programs have the capacity to treat co-occurring disorders (mental health and substance abuse). Through a</p>	60-120 days	3,460

Table VI-5. Parole and Community Services – Non-Residential Providers			
Program	Program Description	Treatment Timeframe	Number Served FY08
	cognitive behavioral approach, the programs address offender needs regarding problem solving, coping strategies, lifestyle changes, and alternative positive approaches to manage addictive behavioral patterns. Most of the nonresidential substance abuse programs are licensed by the Department of Public Health.		

Source: DOC

Discharge plans and aftercare. Each residential and nonresidential provider is required to develop a discharge plan for each offender within 15 days of discharge. While the nonresidential plans are less formal, the residential provider discharge plans must include a brief summary of the offender’s participation in the program, future housing arrangements, substance abuse treatment recommendations, employment and vocational objectives, and utilization of support systems.

Split sentence. It should also be noted that many previously incarcerated offenders are transferred to the custody of the Judicial Branch because they have a split sentence. A split sentence requires the inmate to serve a period of probation after incarceration. This is in contrast to an offender being paroled by the parole board after a period of incarceration and under the custody of the Department of Correction. The Judicial Branch and DOC maintain a memorandum of understanding that facilitates the transition of these offenders.

Because research has shown that the first days of release are critical in successful completion of probation, CSSD created the Probation Transition Program (PTP) which targets inmates 90 days prior to release who have a term of probation following their discharge from correction custody.

Probation officers from CSSD conduct a needs and risk assessment within 45 days prior to placement on probation for the split sentence offenders. The DOC parole officer is required to furnish the CSSD probation officer with a status report that includes a list of programs in which the offender is currently enrolled or has already completed. If an offender is participating in a treatment program while transitioning to the outside, the two departments are supposed to take steps “when possible” to allow the offender to complete the program while under probation supervision.

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APPENDICES

Appendix A

Federal and State Substance Abuse Treatment Information Systems

TEDS: Since 1996, the federal government has required states to report to SAMHSA each year standardized demographic and substance abuse characteristic data for substance abuse treatment admissions and discharges. The resulting Treatment Episode Data Set (TEDS) provides admission-based information about services and clients treated at licensed, certified or state-operated treatment facilities on a national and state-by-state basis over time.*

TEDS does not contain all admissions to substance abuse treatment but, in general, all facilities in the country that receive any state alcohol or drug agency funds (including federal grant funds) report to the system through their state substance abuse agency. (DMHAS submits data for Connecticut and provides on all state-operated programs and all licensed programs regardless of their funding status.) The most recent system data on admissions are for 2006 and cover all states; corresponding discharge data are available for 2005 and only represent 34 states at this time.

N-SSATS: On an annual basis, SAMHSA conducts the National Survey of Substance Abuse Treatment Services (N-SSATS), which collects data on the location, characteristics, and use of alcohol and drug treatment facilities and programs in each state and other U.S. jurisdictions. The survey covers all known public and private facilities and asks for information on services offered and clients in treatment as of a specific point in time (i.e., the last business day in March).

The most recent nationally compiled survey data are from 2003 but some information for 2006 is available for individual states, including Connecticut. The N-SSATS profile information for Connecticut substance abuse treatment facilities is presented in the following section on the state's treatment system.

SATIS: DMHAS has established uniform procedures and policies for collecting, managing, and evaluating data related to substance abuse treatment programs operated or funded by the state and developed an interagency computerized database known as Substance Abuse Treatment Information System (SATIS). Currently, the department is working in collaboration with eight other state agencies, the Office of Policy and Management, and the Judicial Branch to link data systems, comply with all client confidentiality requirements, and compile standardized information on substance use, abuse and program effectiveness.

SATIS includes admission and discharge information from all substance abuse treatment programs licensed by the state Department of Public Health and from the state treatment programs operated by the DMHAS and the Department of Correction. The system does not include information on persons served by: general hospitals, unless the treatment is funded by DMHAS; private practitioners (e.g., physicians, psychologists, licensed counselors, etc.); or the Veterans' Administration.

* Admissions do not represent individuals so, for example, a person admitted to treatment twice within a calendar year would be counted as two admissions.

Source: PRI staff analysis

Appendix B. DMHAS Regional Structure

DMHAS Regions	Regional Mental Health Boards (RMHBs - 5)	Local Mental Health Authorities (LMHAs -- 14 statewide; 6 State, 8 PNP)	Catchment Area Councils (Mental Health CACs -23 total)	Regional Planning and Action Councils (Substance Abuse RACs -- 14 statewide)
I: Southwest (14 towns)	Office location: Norwalk	<ul style="list-style-type: none"> • Southwest CT Mental Health System (State), which includes 2 area programs: <ul style="list-style-type: none"> ○ F.S. DuBois Center ○ Greater Bridgeport Community Mental Health Center 	<ul style="list-style-type: none"> • 1, 2 • 3, 4 	<ul style="list-style-type: none"> • Lower Fairfield County Communities in Action • Mid Fairfield Substance Abuse Coalition • Regional Youth/Adult Substance Abuse Project
II: South Central (36 towns)	Office location: Middletown	<ul style="list-style-type: none"> • Bridges (PNP) • Connecticut Mental Health Center (State) • Harbor Health Services (PNP) • River Valley Services (State) • Rushford Center (PNP) • Valley Mental Health Center/Birmingham Group Health Services (PNP) 	<ul style="list-style-type: none"> • 6 • 7 • 8 • 10 • 9 • 5 	<ul style="list-style-type: none"> • Meriden and Wallingford Substance Abuse Council, Inc. • Middlesex County Substance Abuse Action Council • South Central CT RAC • Valley Substance Abuse Action Council
III: Eastern (39 towns)	Office location: Norwich	<ul style="list-style-type: none"> • Southeastern Mental Health Authority (State) • United Services (PNP) 	<ul style="list-style-type: none"> • 11, 12 • 13, 14 	<ul style="list-style-type: none"> • Citizen's Task Force on Addictions • Northeast Communities Against Substance Abuse
IV: North Central (38 towns)	Office location: Newington	<ul style="list-style-type: none"> • Capitol Region Mental Health Center (State) • Community Health Resources (PNP), which includes 2 area programs: <ul style="list-style-type: none"> ○ Genesis Center ○ North Central Counseling Service • Intercommunity Mental Health Group (PNP) • Community Mental Health Affiliates (PNP) 	<ul style="list-style-type: none"> • 18, 23 • 15 • 17 • 16 • 19 	<ul style="list-style-type: none"> • Capitol Area Substance Abuse Council • East of the River Action for Substance Abuse Elimination • Substance Abuse Action Council of Central CT, Inc.
V: Northwest (42 towns)	Office location: Waterbury	<ul style="list-style-type: none"> • Western CT Mental Health Network (State), which includes 3 area programs: <ul style="list-style-type: none"> ○ Danbury Mental Health Authority ○ Greater Waterbury Mental Health Authority ○ Northwest Mental Health Authority 	<ul style="list-style-type: none"> • 21 • 20 • 22 	<ul style="list-style-type: none"> • Central Naugatuck Valley Regional Action Council • Housatonic Valley Coalition Against Substance Abuse

APPENDIX C. FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS

Program Focus/ Collaboration	Program Description	Target Population	Program Locations	Program Capacity/ Individuals Served
DIVERSION/WITH LAW ENFORCEMENT				
<i>Crisis Intervention Teams (CIT)</i>	<ul style="list-style-type: none"> • Trained clinicians work with trained police officers to provide joint response or follow-up to crisis calls involving persons with apparent behavioral health disorders • Clinicians evaluate and make recommendations • Refer to appropriate treatment rather than arrest 	Persons in psychiatric crisis encountered by police	<p>DMHAS CIT clinicians serve 8 areas (Bridgeport, Groton, Hartford, New Haven, Norwich/New London, Waterbury, West Haven, Stamford)</p> <p>21 police departments have CIT policy and sufficient number of CIT-trained officers to provide effective response</p>	<p>In FY 07, 4 DMHAS CIT clinicians assisted with 1,700 police cases</p> <p>(Expanding to 7 DMHAS CIT clinicians in FY 09)</p>
DIVERSION/WITH CSSD				
<i>Pretrial Alcohol Education System (PAES)</i>	<ul style="list-style-type: none"> • Contracted program overseen by DMHAS to divert from trial certain persons arrested for Operating under the Influence (OUI) & referred by courts • Clinical evaluation to determine recommended service level • Four levels of service: <ol style="list-style-type: none"> 1) Evaluation 2) Level 1 Groups (intervention): 3) Level 2 Groups (intensive intervention) 4) Treatment (minimum of 12 therapy sessions) 	First time offenders arrested for OUI (or offenders with prior arrest >10 years ago with no intervening arrests or convictions)	Statewide; 11 providers in 23 communities (Level 1&2 groups)	<p>Total Served FY 07:</p> <ul style="list-style-type: none"> • Evaluation: 8,260 • Level 1: 3,780 • Level 2: 3,213 • Treatment: 200
<i>Pretrial Drug Education Program (PDEP)</i>	<ul style="list-style-type: none"> • Contracted program overseen by DMHAS to divert certain persons arrested for drug possession from trial referred by courts • Evaluation by substance abuse professional and 12 hours of intervention programming (Drug Education Program - DEP -- group) 	First time offenders arrested for possession of drugs and/or paraphernalia	Statewide ; 11 providers, 23 communities	<p>Total Served FY07:</p> <ul style="list-style-type: none"> • Evaluation: 4,302 • DEP Groups: 4,112

APPENDIX C. FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS

Program Focus/ Collaboration	Program Description	Target Population	Program Locations	Program Capacity/ Individuals Served
<i>Community Service Labor Program (CSLP)</i>	<ul style="list-style-type: none"> • Certain persons arrested for drug possession found eligible by CSSD for diversion program of 14 to 30 days of community service also required to complete drug education program • DMHAS, under MOU with Judicial Branch, allows CSLP participants to use PDEP program services to meet drug education requirement 	Persons charged with possession of illegal drugs and/or paraphernalia	(same as PDEP)	(included in PDEP statistics)
DIVERSION/ & EARLIER RELEASE/ WITH CSSD & DOC				
<i>Community Recovery, Engagement Support, and Treatment Center (CREST)</i>	<ul style="list-style-type: none"> • Intensive day reporting program for persons diverted or released from incarceration, or on parole/probation and at risk of incarceration • Provides daily monitoring, structured skill building, recovery supports • Outpatient treatment services provided by DMHAS-operated CMHC 	Persons with serious mental illness or co-occurring disorders, at pretrial stage or on probation or parole	New Haven	Began accepting client in December 2007 Center capacity: up to 30 individuals
<i>Jail Diversion</i>	<ul style="list-style-type: none"> • Facilitate access to appropriate treatment as alternative to incarceration • Provide court-based assessment, referral, and linkage to community treatment services • Inform courts of treatment compliance • Provide clinical information to jails for defendants detained on bond 	Persons with serious mental illness or co-occurring disorders arrested on minor offenses	Statewide	screen approximately 4500 clients per year and of these about 1500 are diverted by the court; consultation on approx 10,000 cases per year
<i>Jail Diversion- Women (JDW)</i>	<ul style="list-style-type: none"> • Trauma-informed diversion efforts for female offenders to reduce incarceration and future arrests • Pre-release assessment and immediate access to comprehensive, trauma-informed care • Treatment for trauma, mental illness, substance abuse plus community supports 	Women with history of trauma, at risk of incarceration, referred by courts, probation, or parole	New Britain/Bristol New Haven (With new federal grant, see JDI, below, Hartford location expanded to serve men as well as women)	New Haven began accepting clients in January 2008 Capacity is 50 women for each program annually

APPENDIX C. FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS

Program Focus/ Collaboration	Program Description	Target Population	Program Locations	Program Capacity/ Individuals Served
<i>Jail Diversion - Trauma (JDT)</i>	<ul style="list-style-type: none"> Trauma-informed diversion efforts for male and female offenders to reduce incarceration and future arrests Services similar to JDW, see above 	Women and men with history of trauma, at risk of incarceration, referred by courts, probation, or parole	Hartford area	Annular Capacity: is 50 clients per year
<i>Alternative Drug Intervention (ADI)</i>	<ul style="list-style-type: none"> 3-6-month treatment program provided as alternative to incarceration Intensive outpatient substance abuse treatment provided Also intensive case management, basic needs, employment & education supports, linkage to 12-Step groups 	Persons with substance use disorders, at pretrial stage	New Haven	Program annual capacity: approx. 150 - 200 Total Served FY 08: 157
<i>Advanced Supervision and Intervention Support Team (ASIST)</i>	<ul style="list-style-type: none"> Coordinate behavioral health services with supervision and skills training provided by DMHAS clinician at Alternative to Incarceration Centers to make AICs accessible to persons with moderate to serious psychiatric/co-occurring disorders DMHAS clinician provides case management Mental health and substance abuse recovery services provided by LMHAs for persons with serious mental illness and by CSSD contractors for others 	Persons with moderate to serious psychiatric disorders who may or may not have substance use disorders at risk of incarceration; referred by court, DOC facility, probation, or parole	Bridgeport Hartford Middletown New Britain New Haven New London Waterbury	Began accepting clients in some locations in November 2007; Projected annual capacity: 315- 420
REENTRY/ WITH DOC & CSSD				
<i>Connecticut Offender Reentry Program (CORP)</i>	<ul style="list-style-type: none"> Prior to discharge, DMHAS staff provide comprehensive assessment and skills building group twice per week in the DOC facility for 6-12 months prior to release, and develop comprehensive discharge plan After discharge, appropriate LMHA provides continuing treatment and support services 	Sentenced inmates with serious mental illness or co-occurring disorders returning to community after extended period of incarceration	In 3 DOC facilities (Garner CI, Osborn CI, and York CI) For inmates returning to Bridgeport; Hartford, and New Haven (expanding to Waterbury and Norwich/New London in FY 09)	Total served annually: approx. 60

APPENDIX C. FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS

Program Focus/ Collaboration	Program Description	Target Population	Program Locations	Program Capacity/ Individuals Served
<i>Transitional Case Management (TCM)</i>	<ul style="list-style-type: none"> • Case management by DMHAS staff (i.e., “transitions manager”) to support recovery-oriented reentry to community • Works with inmates in DOC institutions for 3-4 months prior to release for engagement and to develop a comprehensive discharge plan. • For 3-5 months after release provide substance abuse treatment and case management, and collaborate with parole, and CSSD to plan and provide care services • Community service providers given early notice of inmate’s potential discharge 	Inmates with significant histories of substance abuse transitioning to community	<p>Inmates returning to Hartford and Waterbury</p> <p>Expanding to serve persons returning to Norwich/New London and New Britain/Bristol in SFY09</p>	<u>SFY07 - TCM served 110 individuals,</u> transitioned 80 to the community
<i>Criminal Justice Interagency Referral Program</i>	<ul style="list-style-type: none"> • Comprehensive DOC-DMHAS referral program • 3-6 month prior to release from DOC, appropriate LHMA meets with inmate to plan/arrange needed community services • On-going interagency communication to coordinate care, resolve any system issues 	Persons with severe psychiatric disabilities transitioning from correctional facility to community. For those individuals who are not served by the CORP program.	Statewide	Served annually: 220-270

Sources of Data: DMHAS and CSSD

Appendix D.

GABHP Utilization Mangement Model: Levels of Care for Substance Abuse Treatment

LEVEL OF CARE	Code	Initial Length of Stay	Continued Length of Stay
Ambulatory			
Outpatient	SA I.1	13 visits	Up to 16 visits
Outpatient - Methadone Detox.	SA I.2	Up to 21 days	Up to 21 days
Methadone Maintenance	SA I.3	Up to 26 wks	Up to 26 wks
Intensive Outpatient	SA II.1	Up to 10 visits	Up to 7 visits
Day/Evening Treatment	SA II-5	Up to 5 visits	Up to 5 visits
Observation (23-hour bed)	SA II.7	Up to 23 hours	None
Residential			
Transitional Care/Halfway House	SA III-1	Up to 15 days	Up to 45 days
Long-Term Care	SA III-3	Up to 30 days	Up to 60 days
Residential Treatment - Intermediate/Long-Term	SA III-5	Up to 20 days	Up to 45 days
Intensive Residential Treatment	SA III.7R SA III.8	Up to 10 days	Up to 10 days
Detoxification			
Detox. - Ambulatory	SA I.D	Up to 7 days	Up to 7 days
Detox.- Ambulatory with on-site monitoring	SA II.D	Up to 7 days	Up to 7 days
Detox - Residential Medically Monitored	SA III.7D	Up to 3 days*	Up to 2 days
Detox - Inpatient Medically Managed	SA IV.2D	Up to 3 days*	Up to 2 days

* Up to 3 days for alcohol or alcohol & cocaine detoxification: all other substances up to 5 days

Source of data: DMHAS Utilization Management Model for GABHP

APPENDIX E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
Adult Behavioral Health Services (ABHS)	<ul style="list-style-type: none"> • Substance abuse assessment • Group and intensive outpatient substance abuse treatment • Group anger management • Mental health evaluation and treatment (Each location may provide all or any of the services listed) Fees = Sliding scale fee	Clients referred by Adult Intake, Assessment and Referral or Supervision offices. Referrals are based on outputs of LSI-R and ASUS-R, court ordered conditions, and presenting issues/problems at time of supervision.	Varies by service. Services are based on individual need generally: <u>Sub Abuse Eval.</u> ~ 1 to 2 sessions. <u>Sub Abuse Group</u> ~ 12 sessions 1x wk. <u>Intensive Out Patient tmt.</u> 3 to 4 times per week for 4 to 6 weeks. <u>Anger Management.</u> ~ 12 sessions. <u>Mental Health Eval.</u> 1 to 2 sessions. <u>Mental Health Treatment:</u> individualized based on presenting issues.	Yes	Eastern	12	No specific slot number	1,654
					North Central	5	No specific slot number	2,348
					Northwest	10	No specific slot number	2,815
					Southwest	5	No specific slot number	1,549
					South Central	5	No specific slot number	2,002
Alternative Incarceration Centers (AIC)	<ul style="list-style-type: none"> • Intake, assessment, for risk and need • Substance abuse assessment • Case management • Group interventions (including 	Accused and sentences offenders age 16 years and older Referrals are based on outputs of LSI-R and ASUS-R, court ordered conditions, and presenting problems at time of supervision.	Average length of stay in program is 3 to 4 months. Case management frequency is based on risk level of client ~ minimally 2 times per month. Sub. Abuse group is 12 sessions run 2	Yes	Eastern	4	No specific slot number	1,272
					North Central	6	Hartford - 30 beds - (the only AIC in region with beds). Other AICs no specific slot number.	2,207

APPENDIX E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
	substance abuse) • Community service restitution • Pre-trial urinalysis testing • Referral to community and job development Note: Some transitional housing may be available. This housing component of the AICs generally do not have any services on-site. Services are conducted at the AIC.	Pre-trial referrals receive supervision and services to ensure their appearance in court and is used as a tool in reducing prison overcrowding for pre-trial population.	times per week. Cog. Skills group is 14 sessions run 2 times per week. Urines are random, minimally 2 times per month when ordered by referral source. Employment group ~ skills component is 4 sessions, graduated clients stay in group until job is obtained.		Northwest	4	Torrington and Waterbury – 60 beds – Other AICs no specific slot number	1,960
					Southwest	3	No specific slot numbers	1,577
					South Central	3	New Haven – 22 beds – Other AICs no specific slot number	1,651
Adult Risk Reduction Centers (ARRC)	• Anger management • Substance abuse treatment • Cognitive self change • Motivational	High risk and need sentenced offenders	Typically 6 to 9 months	Yes	Eastern	0	0	
					North Central	1	75 slots	134
					Northwest	0	0	
					Southwest	0	0	

APPENDIX E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
	enhancement training <ul style="list-style-type: none"> • Cognitive restructuring • Reasoning and rehabilitation • Seeking safety ~trauma • Moving on 				South Central	0	0	
Drug Intervention Program (DIP)	Program conducts clinical evaluations, prepares treatment plans, and delivers a full continuum of substance abuse treatment, case management, residential (long and short term) and support services	Criteria include: <ul style="list-style-type: none"> • Non violent criminal history • Referral by court • Drug dependent <p>Clients may be identified at arraignment, prior to sentencing and not incarcerated, or arrested and in jail awaiting trial, or on probation and non compliant with treatment</p>	Varies depending on court order, assessed level of care and accomplishments made in treatment.	Yes	Eastern	2	30 slots	35
					North Central	0	0	0
					Northwest	0	0	0
					Southwest	4	Bridgeport 45 slots and 7 beds Stamford 3 beds	89

APPENDIX E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
		stipulations or for committing new crimes connected to substance abuse problems or arrested for a violation of probation			South Central	1	60 slots	43

APPENDIX E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08
Residential Services – Halfway House (Union House)	Provides pretrial supervision services for accused individuals and work release supervision for sentenced (probation and parole) offenders. Other services include interim treatment for those awaiting availability of inpatient treatment	Male and female offenders age 16 and above in need of residential supervision in lieu of incarceration	Varies	No	Statewide	1	36 beds	140
Residential Services - Medical Detoxification	Community – based, residential program. Services include medically managed or medically supervised intensive substance abuse detoxification	Pre-trial, court sentences, alternative to violation of probation and parole males and females aged 18 and above	3 to 28 days. Detox is 3 -4 days.	Yes	Statewide	1	5 beds	n/a

APPENDIX E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
Residential Services – Project Green	Community –based residential program. Services include but are not limited to community services, substance abuse education and treatment, employment readiness, case management, resources management, and life skills training	Pre-trial and sentenced males and females are age 16 and above who are addicted/dependent on drugs and/or alcohol and are capable of performing intensive community service labor. (Male only in New Haven)	4 to 6 months	Yes	Statewide	2	49 beds	188

APPENDIX E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
Residential Services – Substance Abuse Short Term and Intermediate	<p>Community-based residential program. The following services are provided:</p> <ul style="list-style-type: none"> • Substance abuse treatment • Individual and group counseling • Educational/ vocational skills development • Crisis intervention • Health intervention • Independent living skills • Family counseling • Access to recreational opportunities • Pre-release counseling • Aftercare/discharge planning <p>Includes CVH and Blue Hills which are state run facilities. (195 clients)</p>	Male and female (age 18 and above) pretrial and sentenced offenders and alternative to probation/parole violation cases. Individuals must be drug and/or alcohol dependent. (Sixteen and 17 year olds may be accepted at some locations)	3 to 6 months	Yes	Statewide	0	327 beds	1,169

APPENDIX E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served FY 08
Residential Services – Substance Abuse Long Term	Community-based residential program. The services include all the service provided under intermediate above but for a longer duration.	Admission is based on multiple previous episodes for one facility. All other programs conduct an evaluation to determine level of care. Client’s progression through treatment is individualized.	6 to 12 months One program is 6-12 months; three programs are 6-9 months.	Yes	Statewide		74 beds	220
Residential Services – Youthful Offender	Community-based residential program. Services include: <ul style="list-style-type: none"> • Academic/ vocational education, • Life skills training • Substance abuse education and treatment • Case management • Community service participation • Recreation and physical fitness • Family counseling and support • Community reintegration 	Sentenced male offenders 18-21	4 to 6 months	Yes	Statewide	1	24	72

APPENDIX E

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served Annually FY 08
Domestic Violence – Evolve (52 weeks)	A cognitive/ behavioral intensive program designed for high risk offenders. Focus is on the effects of violence on victims and children, behavior change, interrelation and communication skill building, responsible parenting and substance abuse. (12 sessions related to substance abuse).	Male offenders involved in a family violence offense as referred by the criminal court, following a guilty plea	52 weeks	Yes	Eastern	0	0	FY 06-07 412
					North Central	0	0	
					Northwest	1	288 units	
					Southwest	1	576 units	
					South Central	1	480 units	
Domestic Violence – Explore (26 weeks)	A cognitive/ behavioral intervention focused on educating repeat offenders about the impact and harmful effects for violence on victims and children; emphasis on establishing inter personal skills to develop violence-free relationship. Six sessions focus on the role of substance abuse in violent behavior. (8 sessions related to substance abuse).	Male offenders involved in a family violence offense as referred by the criminal court, following a guilty plea.	26 weeks	Yes	Eastern	3	352 units	FY 06-07 641
					North Central	2	506 units	
					Northwest	1	46 units	
					Southwest	3	230 units	

APPENDIX E

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served Annually FY 08
					South Central	2	138 units	
Bridgeport Domestic Violence Intervention Services	Services include: <ul style="list-style-type: none"> • Individual and group counseling for men and women not eligible for Family Violence Education Program • Conflict management groups • Adolescent group counseling • Substance abuse evaluation and treatment cognitive based treatment (10 sessions) • Psychological testing • Parenting skills 	Persons involved in court proceedings after an arrest for a domestic violence offense.		Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	
					Southwest			138
					South Central	0	0	
Family Violence Education Program	Cognitive intervention focused on educating offenders on the impact of violence on relationships, developing an understanding of its harmful effects and providing offenders with the building blocks of	Persons charged with family violence crimes.	9 weeks	Yes	Eastern	4	26 units	FY 06-07 3,885
					North Central	3	54 units	

APPENDIX E

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served Annually FY 08
	interpersonal skills to develop violence-free relationships. Consists of 10 weekly classes at 1.5 hours per class. Two sessions focus on substance abuse.				Northwest	3	25 units	
					Southwest	4	38 units	
					South Central	3	40 units	
Gender Specific Programming for Females	Community-based program provides services for women that address the risks and needs of women offenders. Services include: <ul style="list-style-type: none"> • Trauma services related to sexual/ physical/ and mental abuse • Substance abuse treatment • Parenting • Cognitive skill building • Education and employment services 	Accused and sentenced female offenders age 16 years and older	Varies	Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	
					Southwest	1	75 Slots	236
					South Central	0	0	
Women and	Comprehensive community	Pretrial or sentenced,	4-12 months	Yes	Eastern	0	0	

APPENDIX E

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region, Locations, Capacity			Number Served Annually FY 08
Children Services	based substance abuse, dual diagnosis, and rehabilitation treatment facility	substance abusing female offenders, age 16 and above			North Central	1	21 beds	60
					Northwest	1	12 beds	30
					Southwest	0	0	
					South Central	1	15 beds	35
Latino Youth Offender Services	Cognitive-based approach which services include the development of educational, economic, social, and community resources through intensive case management, substance abuse treatment services, and community service.	Latino offenders age 16-23	Up to 6 months	Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	
					Southwest	0	0	
					South Central	1	30 slots	68

Source: CSSD

Appendix F. Department of Correction Institutional Substance Abuse Programs by Facility

Facility Name	Location	Level	Population (2007)	Assessment & Orientation	Tier 1	Tier 2	Tier 3	Tier 4	Aftercare	Peer Mentor Program	Alcohol Anon	Narc. Anon
Bergin	Storrs	Low	1,084		x		x		x		x	x
Bridgeport	Bridgeport	High	941	x	x	x						x
Brooklyn	Brooklyn	Med	455			x			x	x	x	x
Cheshire	Cheshire	High	1,336						x	x		x
Corrigan-Radgowski	Uncasville	Med & High	1,481	x	x	x				x	x	
Enfield	Enfield	Med	725			x			x	x	x	
Garner	Newtown	High	554								x	
Gates	Niantic	Low	1,021			x	x		x	x	x	
Hartford	Hartford	High	957	x	x						x	
MacDougall-Walker	Suffield	High & Max	2,131	x	x	x			x	x	x	
Manson ⁴⁴	Cheshire	High	680	x	x	x		x	x	x		
New Haven	New Haven	High	834	x	x							
Northern	Somers	Max	453									
Osborn	Somers	Med	1,929			x		x	x	x		
Robinson	Enfield	Med	1,218					x	x	x	x	
Webster	Cheshire	Low	583						x	x		
Willard-Cybulski	Enfield	Med	1,099			x			x	x	x	x
York ⁴⁵	Niantic	Low to Max	1,408	x	x	x		x	x	x	x	
Total			18,889	7	8	10	2	4	12	12	11	5

Source: DOC

⁴⁴ Manson Youth Institution is a facility for young offenders between the ages of 14 and 21.

⁴⁵ York Correctional Institution is the only women's prison in Connecticut.