

Findings and
Recommendations

Substance Abuse Treatment for Adults

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State Substance Abuse Treatment for Adults

Each year, thousands of individuals with alcohol and drug problems are served by Connecticut's publicly funded substance abuse treatment system. In total, the state spends more than \$200 million a year providing clinical treatment services to adults with alcoholism and other drug addictions, most of whom are poor or medically indigent. In April 2008, the Legislative Program Review and Investigations Committee directed its staff to examine how the Department of Mental Health and Addiction Services (DMHAS) carries out its substance abuse treatment mission, including how it coordinates and determines the effectiveness of state services for adults.

Substance abuse treatment strategies have undergone dramatic changes over the past two decades. Research now shows alcohol and drug dependence is a chronic, relapsing brain disease that requires long-term, continuing care for successful outcomes. Recent studies also have found co-occurring mental health and medical conditions are common among those with substance use disorders, and can complicate planning and implementation of appropriate care.

This new understanding of the nature of substance abuse has forced major rethinking of service delivery systems and public policies regarding treatment, as well as prevention programs and law enforcement. It is recognized that recovery is possible with effective treatment, but repeated interventions usually are necessary. It also is known that clients have better outcomes when clinical services are combined with recovery supports (e.g., housing, transportation, and peer support groups) during and following formal treatment programs. Given this, the program review committee found sustained abstinence cannot be the only measure of effectiveness of alcohol and drug treatment; improved quality of life and harm reduction also are valid and important goals of substance abuse treatment services.

The Department of Mental Health and Addiction Services has been the state's lead agency for substance abuse since 1995, when responsibilities for the state-funded community-based alcohol and drug treatment system, and for inpatient programs operated by the former mental health department, were merged within one agency. The department's current vision is an integrated, recovery-oriented care model for behavioral health in Connecticut.

While state substance abuse treatment is evolving toward this model, mental health and addiction services in many ways still are parallel systems within DMHAS. Further, the state Judicial Branch and the Department of Correction (DOC) continue to play major roles in substance abuse treatment for those involved in the criminal justice system. Services for those under age 18, which were not included within the scope of the committee's current study, are overseen by another state agency (Department of Children and Families).

The PRI study revealed publicly funded alcohol and drug treatment for adults actually is provided through six different service delivery and/or funding structures:

- the private, primarily nonprofit provider network funded by DMHAS to provide community-based substance abuse treatment;
- the state-operated treatment facilities, which provide intensive residential and some outpatient care for the neediest adults with substance use disorders;
- the General Assistance Behavioral Health Program (GABHP) system, a publicly managed behavioral health care program for adults covered by State-Administered General Assistance that is administered by DMHAS;
- the substance abuse treatment system for incarcerated adults operated by the Department of Correction;
- the continuum of treatment services the Department of Correction funds for its parole clients with alcohol and drug abuse problems, which are provided primarily by the same providers that DMHAS funds; and
- the continuum of treatment services the Court Support Services Division of the Judicial Branch (CSSD) funds for pretrial diversion and adult probation clients with alcohol and drug abuse problems, which also are obtained primarily from the DMHAS-funded provider network.

The scope and complexity of state administration and funding for adult substance abuse treatment prevented the committee from examining, in detail, specific programs and processes of all six system components within the study timeframe. Research efforts focused on determining how well DMHAS is carrying out its critical lead agency functions to plan, coordinate, and oversee an effective treatment system for adults. In addition, the committee tried to identify the extent to which best practices known to contribute to effective substance abuse treatment are in place throughout the current state system.

Based on national and state-level research, it appears the system elements most important to successful treatment outcomes are related to access and quality of service delivery. Multiple studies show substance abuse treatment is more effective when services are: readily available to clients; provided for adequate amounts of time; and address individual needs in a comprehensive way.

From its examination of the state substance abuse treatment system, the program review committee found client access to substance abuse treatment is restricted by limited capacity. There is substantial unmet demand for services, particularly for residential treatment, although there are no reliable estimates of the number of adults in the state who are requesting but not receiving care.

At present, the state substance abuse treatment system for adults is decentralized and disjointed. There are gaps in the continuum of services available and uniform policies and procedures are missing in many areas of practice. Many promising cross-agency initiatives and innovative practices are underway but they tend to be “micro” collaborative projects, occurring on a pilot basis and limited to small target populations. In particular, more attention must be given to coordinating treatment resources, as well as planning and monitoring efforts, to meet the special and significant substance abuse treatment needs of the criminal justice population.

Monitoring of treatment quality across providers, levels of care, and funding sources is neither consistent nor comprehensive. A major impediment to quality assurance and quality improvement efforts is the absence of formally established performance goals and benchmarks for publicly funded treatment services.

The committee additionally found considerable amounts of outcome data and research on treatment effectiveness are produced by all three state agencies. However, this information is not aggregated, analyzed, and reported in ways to promote accountability and guide policy and funding decisions system wide. Information sharing across state agencies and with the private provider network remains a challenge for both technical and administrative reasons.

Clearly, DMHAS, as the state lead agency, needs to take a strategic approach to statewide planning that begins with setting clearly defined, measurable goals for the treatment system. It also needs to strengthen efforts to coordinate services and practices across agencies to: address gaps and avoid duplication; promote more cost-effective delivery; and combine agency efforts to better meet client needs. Most importantly, the department must assume responsibility for continuous quality improvement throughout the treatment system; it should be regularly reviewing the effectiveness of publicly funded treatment programs and services and determining how they can be improved.

The program review committee findings and proposals for addressing them presented in the following sections center on issues related to treatment access; monitoring of treatment quality; and system wide planning, coordination, and oversight. Overall, the committee recommendations are aimed at system wide improvements that can: expand treatment options; enhance treatment quality and service delivery; and achieve better treatment outcomes for adults with substance use disorders.

Organization. The program review committee findings and recommendations are presented in three sections: access; program monitoring and treatment quality; and lead agency role. Background information and more detailed descriptions of the monitoring and quality assurance functions carried out by DMHAS, CSSD, and DOC are provided in Appendix A.

Access to Treatment

This section provides a discussion of issues surrounding access to substance abuse treatment, followed by related program review committee recommendations. There are three aspects of accessing substance abuse treatment of concern: the demand for treatment, the length of time elapsed from identifying a need for treatment and the actual receipt of treatment, and the length of treatment. Each of these elements has an impact on the effectiveness of substance abuse treatment.

In brief, the committee finds that DMHAS, the lead state substance abuse agency, does not:

- *assess or estimate unmet demand for substance abuse treatment;*
- *maintain an information system on treatment availability for the public;*
- *monitor the length of time it takes to receive substance abuse assessments and treatment; or*
- *track the length of treatment that clients receive.*

Unmet demand. As discussed in the briefing document, data that compares those in need of substance abuse treatment and those receiving it (called the “treatment gap”) are collected by the federal government each year through Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health. In 2006, 8.2 percent of persons 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.

This treatment gap is slightly larger in Connecticut than the national average (7.5 percent for alcohol and 2.3 percent for illicit drugs). The federal data do not capture the extent of the overlap among those with both alcohol and drug use problems.

The need for treatment is not the same as the demand for treatment. Determining how many people have a substance use problem is different from determining how many people with a problem will show up for treatment services. However, DMHAS does not measure the demand for treatment in Connecticut, making it impossible to plan on how to best meet the needs in the state.

Although a comprehensive picture of unmet treatment demand is not available, some examples of unmet demand can be found among the state agencies that were part of this review.

- CSSD has noted that as of July 2008, there were over 480 clients waiting for residential treatment services. In 2007, there were over 4,000 referrals to

- residential treatment services, although only about 1,800 people received them. This means that about 2,200 people who sought a residential level of treatment did not receive it. The average wait time for nonresidential outpatient services for CSSD clients is about two to six weeks.
- A 2005 study of active probationers found 48 percent of probationers had a current substance use disorder, but two out of three (66 percent) of those needing treatment were not receiving care. About one-third of probationers with a substance use disorder cited the lack of space at a treatment facility as a barrier.
- In 2007, about 12,000 incarcerated pre-trial and sentenced inmates housed by DOC were in need of addiction treatment services and about 5,500 were admitted for treatment. About 2,400 offenders were on a wait list to receive services at the end of 2007.
- During FY 08, about 9,600 individuals who were released from DOC direct admission facilities (i.e., jail) had a verified need for substance use treatment. Only about 10 percent (1,012) of those individuals received any treatment (Tier 1 program) before their release. One factor contributing to this low percentage is that direct admission facilities generally only hold people for a short period of time.
- Similarly in FY 08, about 10,900 individuals who were released from a DOC sentenced facility (i.e., prison) were assessed with a substance use disorder and about 26 percent (2,841) received treatment. It could not be readily determined how many inmates were placed on parole and probation and received treatment post-incarceration.
- DMHAS does not collect or track wait list information from its funded providers or the programs it operates.

In interviews, DMHAS has asserted that maintaining wait lists would not give a true picture of the demand for services because a person could sign up for treatment services with multiple providers. Therefore, demand for services could be vastly overstated. However, the committee believes that if a person has to sign up with multiple treatment providers, there is a widespread problem that DMHAS should be aware of. The department's annual client survey does not include any assessment of client satisfaction with the wait for admission to treatment services.

Regional Action Councils (RACs) are supposed to assist in identifying unmet needs. The councils are public-private partnerships comprised of community leaders. Their stated purpose is to establish and implement action plans to develop and coordinate needed substance abuse

prevention and treatment services in their regions. According to DMHAS, two of a RAC's primary functions are to: 1) identify gaps in services along the continuum of care (including community awareness, education, primary prevention, intervention, treatment and aftercare), and 2) develop an annual action plan to fill gaps in services and to submit the plan to DMHAS. There is no formal quantitative assessment of treatment needs completed by the RACs. The RACS identify priorities in their regions and develop strategies to address perceived gaps within each service area. However, each RAC, within broad guidelines issued by DMHAS, develops its own data using different methodologies making comprehensive comparisons about unmet need impossible. There is no consistent statewide assessment of capacity or demand for any level of service (e.g., detoxification, residential, outpatient)

Although there have been some limited attempts to collect information about treatment availability, there is no central, well-publicized statewide source of information about capacity or service availability. DMHAS, for example, does conduct a census on residential bed availability each weekday morning. This information is available to other residential providers and could be available to the public if they happened to call the DMHAS central office directly. However, providers have noted that bed availability can change significantly during the day making the census inaccurate.

In addition, testimony at the program review committee's public hearing on this topic in October indicated inconsistencies in intake processes (e.g., whether a person was currently using a drug or not) and extended wait times to be admitted to treatment facilities that were cited as barriers to treatment.

It should be noted that there is one example of a comprehensive treatment delivery system that has a round-the-clock access capability. The Hartford region is served by the Substance Abuse Treatment Enhancement Project (SATEP), which maintains a dedicated centralized 1-800 number available 24 hours per day, 365 days per year, for accessible and timely substance abuse assessment and referral services in the North Central Region. According to SATEP staff, its "ACCESS" line allows both substance abuse providers and clients the ability to initiate intake to residential or outpatient services on a 24-hour-a-day basis. SATEP provides access, transportation, housing, treatment, and coordination, as well as case management to its clients.

Good management and planning practices would require that the demand for treatment services be measured or estimated. Basic strategic planning and business management principles require an agency to compare where it is now in relation to any problem it is trying to address to where it wants to be in order to know what progress it is making and the success of its interventions. Knowing what the substance abuse service gaps are is an essential step in this process.

Time to treatment. Related to knowing the demand for treatment is the time it takes for clients to get an assessment and start receiving treatment. DMHAS does not measure the length of time elapsed between when a person makes initial contact with a substance abuse treatment provider and when that person receives an assessment and substance abuse treatment services. There are many barriers that could prevent the timely intake of potential clients, including

lengthy telephone trees or answering machines, limited hours for services, and inattention to intake practices.

Research literature suggests that successful interventions require the time between when substance abusers decide to seek help and when they actually receive services to be as short as possible. In fact, one National Institute on Drug Abuse (NIDA) principle of effective treatment requires that treatment be readily available. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

In addition, the literature notes that reducing the time between intake and treatment increases the number of patients who show up. Often addicted individuals who are forced to wait for treatment lose their motivation to change. By not monitoring and managing this critical time period, opportunities are lost to support the addicted individual from getting timely treatment assistance.

While DMHAS has considered collecting this information, its automated information system for all treatment providers does not currently have the capacity to do so. It has been reported that some treatment providers in Connecticut try to make an appointment within 24 hours of the first contact with a potential client or make accommodations to see people on a walk-in basis. While it is clear some providers do track this information for internal management purposes, it is not known how many actually do track the information or what the results of their efforts are.

Length of treatment. Treatment interventions should be responsive to an individual's needs and particular problems. The exact length of time a person must remain in treatment is difficult to determine because people progress at different rates. However, the National Institute on Drug Abuse stated that "research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment."

In addition, the American Society of Addiction Medicine's patient placement criteria state "research shows a positive correlation between longer treatment and better outcomes." Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness. Multiple studies show treatments 90 days or longer often are indicated for certain substance use problems. This 90-day standard can encompass several levels of care (e.g., detoxification, residential, intensive outpatient). For methadone maintenance, 12 months of treatment is viewed as the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

Treatment duration may be less than the recommended period because of various fiscal concerns such as low reimbursements from health insurers or because of individual preferences. National literature suggests the length of substance abuse treatment has declined over the years as health insurers have increasingly turned to implementing managed care practices. On the other hand, many individuals drop out before they receive the full benefits of treatment for a variety of reasons. Some are related to personal motivation and level of support from family members. Program characteristics can also be a factor in client retention. Various strategies

must be employed to ensure appropriate client engagement with treatment services, especially as the system evolves to more recovery-oriented environment.

DMHAS does not monitor the total length of substance abuse treatment provided to clients and compare it to research-based standards of effectiveness. Nor does DMHAS compare the effectiveness of treatment among individual providers in Connecticut in regard to length of stay. DMHAS' current tracking system can measure length of stay based on each separate level of care.

For the one segment of the population, GABHP clients, DMHAS does monitor what it calls "the connect-to-care" rate. The department's connect-to-care rate measures the percent of clients that link to a less intense level of care following discharge from a higher treatment level. DMHAS has stated that the "connect-to-care" rate is a good proxy indicator for a length of treatment measurement. It is loosely related to length of treatment because it attempts to gauge the success at getting clients to engage in longer treatment.

It does not, however, fully capture whether the client receives all the necessary components of treatment. That would require DMHAS to capture data on an episode of care basis that would include multiple levels of care. Tracking clients by an episode of care is a broader concept. It is more consistent with DMHAS' recovery philosophy that stresses the long-term nature of addiction. The committee believes a key element of treatment success is ensuring clients enter and completes each level of care that their care plans require. Measuring length of treatment episodes would be a more informative indicator of the system's overall effectiveness.

DMHAS has, however, noted the advantages of meeting the 90-day standard. DMHAS along with the Department of Labor initiated a study of substance abuse treatment effects on wages. Among the several positive effects found was the following: "Time in treatment or length of stay (LOS) has been shown to be an important determinant to successful client outcomes. This held true in Connecticut's wage study. Persons with a LOS of 90 days or more had quarterly earnings one year after entering treatment 1.5 times greater than those with a LOS of less than 90 days. This wage advantage for persons with a longer LOS continued two years after treatment."¹

Inadequate lengths of treatment may result in unsuccessful treatment outcomes. This can lead to the ineffective and wasteful use of finite state resources. As it is, many addicted individuals have multiple courses of treatment; the treatment provided should align with effective practices to reduce the number of recurring treatment episodes.

Program review committee recommends DMHAS shall:

- 1) assess demand for substance abuse treatment services on a periodic basis through the coordination of wait list information or other methods to identify gaps and barriers to treatment services and report the results in the department's biennial report;**

¹ 2004 Biennial Report, *Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs*, Department of Mental Health and Addiction Services, May 2005 p.16

- 2) **determine a method to track the availability of substance abuse treatment services and provide that information to the public through websites, a toll free hotline, through the statewide human service help line, 2-1-1 (formally Infoline), or other similar mechanisms;**
- 3) **develop and report on process measures in its biennial report that measure the length of:**
 - **time to receive substance abuse assessments and treatment through its provider network and for state-provided services; and**
 - **treatment services received, using the 90-day standard, on an episode of care basis.**

Treatment access for DOC inmates. As described in the committee briefing report, there is a well documented relationship between addiction and crime. Research has shown that in-prison treatment, when linked with post-release recovery supports, can reduce post-release drug use and recidivism.

As noted above, thousands of inmates have indicated an interest in participating in substance abuse treatment who can not be served. The DOC system is unable to provide a sufficient supply of addiction services under its current programs and staffing structure. It is unlikely the department will receive funding for any expansion in the near future. However, the committee finds it may be possible to reallocate existing DOC counselor positions to increase in-facility treatment capacity.

As discussed in the briefing, the community service counselors are employees of the DOC. The seven counselors primarily provide outpatient substance abuse counseling services to offenders on transitional supervision and are under the direction of the Addiction Services Unit. Preliminary cost estimates show that it is less expensive to provide residential treatment to an offender in a DOC facility, who is serving an extended sentence, rather than in the community while on parole. The average cost for a residential treatment bed in a DOC facility is about \$12,000 per year, based on the salary and fringe benefit costs of counselors, while the cost of residential treatment from a community provider averages about \$28,000 per year.

The other costs of incarceration (i.e., facility, other overhead) have been excluded because they are required costs regardless of whether the inmate chooses to participate in treatment or not. The offenders being served by the community service counselors would need to be provided outpatient treatment services comparable to what they are receiving now and those costs would have to be factored in.

- 4) **Program review committee recommends DOC should assess:**
 - **the costs and operational implications of transferring community services counselors to DOC facilities to expand intensive outpatient and residential treatment offerings in DOC facilities; and**

- **in the absence of transferring community counselors, the costs savings that may accrue to treating additional inmates in DOC facilities rather than in residential treatment in the community while on parole.**

Program Monitoring and Treatment Quality

The quality of substance abuse treatment services provided to adults in Connecticut is regulated, reviewed, and assessed in a variety of ways. The Department of Public Health (DPH) requires licensing for private providers of clinical care at all levels -- inpatient, residential, or ambulatory/outpatient-- and professional clinical staff who provide substance abuse treatment services. Many treatment facilities and programs in Connecticut also participate in national accreditation processes, such as those carried out by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, and the Council on Accreditation.

Furthermore, each state entity that funds substance abuse treatment services for adults has its own policies and procedures for assuring external providers comply with grant and/or contract provisions related to quality. The two departments that also operate treatment programs, DMHAS and DOC, have established internal quality assurance standards and improvement processes that pertain to the clinical services they provide directly. All three agencies included in the PRI study also have established ways to evaluate and conduct research on the efficiency and effectiveness of the alcohol and drug services provided to their clients.

The program review committee reviewed national research and academic literature regarding model service systems and generally accepted “best practices” for promoting high quality alcohol and drug abuse treatment. After identifying what many consider the key elements for effective treatment programs and services, the committee tried to determine whether these practices, along with model quality assurance and quality improvement procedures, were in place in the state’s substance abuse system.² It was not possible, within the study timeframe, to review whether these practices and procedures were implemented fully or how well they were working. Committee findings are limited to identifying the absence or presence of best practices within the state system.

This section explains the specific practices related to monitoring and treatment quality used by the committee for this review and provides a summary of the major findings and proposed recommendations for each area. A detailed description of the main monitoring activities and practices of CSSD, DOC in-facility programs, DOC parole division, and DMHAS is provided in Appendix A. This description of activities and practices support the major findings.

Specific Practices Related To Monitoring and Treatment Quality

The program review committee focused on policies and procedures each agency has in place that relate to the following activities in four areas: program monitoring and quality assurance, selected best practices, outcome and performance measures, and monitoring and

² A number of fundamental best practices are required by statute or regulation. Some are monitored by the Department of Public Health, as described in this section, such as the requirement for a treatment plan and it be updated on a regular basis. Consequently, several of these best practices were not included in our discussion.

evaluation resources. Each of these areas is briefly described below and summarized in Table II-1.

Table II-1. Monitoring and Quality Assurance Summary				
	CSSD	DOC Operated	DOC Parole	DMHAS
Monitoring and Quality Assurance				
• Contract Compliance Process	Yes	n/a	Limited	Yes
• Corrective Action Plans	Yes	Yes	Limited	Yes
• Dedicated Staff	Yes	Limited	Limited	Yes
• Program Fidelity	Limited	Yes	Pilot	Limited
• Stakeholder Feedback	Yes –not clients	Yes	Yes- not clients	Yes
Selected Best Practices				
• Substance Use Monitoring				
○ Monitoring Policy	Yes	Yes	Yes	No
○ Graduated Sanctions Policy	Yes	Yes	Yes	No
• Research- or Evidence-Based Practices				
○ Assessments	Yes	Yes	Yes	Limited
○ Programming	Yes	All but one	Yes	No
○ Motivational Interview (CSSD and DOC staff; DMHAS providers)	Yes	Partial	Develop	No
○ Therapeutic Alliance	Limited	No	No	No
• Discharge Planning and Aftercare				
○ Required by Contract/Available	Yes	Yes	Yes	Yes
○ Checked by Agency	Yes	n/a	No	Yes
• External Credentialing				
○ All Direct Care Staff	No	Yes	No	No
○ Programs/facility	All but one	n/a	All but one	Yes
Outcome and Performance Measures				
• Defined	Develop	Develop	Yes	Yes
• Monitored	No	No	No	Yes
• Publicly Reported	No	No	No	No
Monitoring Resources and Data Systems	Some Capability	Little to None	Little to None	Some Capability
Source: Indicated agencies and PRI analysis				

In brief, the committee finds the following in regard to the available resources as well as the policies and procedures each agency has in place to monitor programs, promote best practices, and develop and report outcome and performance measures:

- *DMHAS, DOC, and CSSD all perform various contract compliance activities of varying intensity with nonprofit providers to ensure treatment services are delivered as required; however, the DOC parole division's monitoring appears to be the least comprehensive. CSSD and DMHAS engage in the most extensive monitoring efforts.*
- *CSSD has adopted most of the best practices identified the committee as related to effective treatment. DMHAS encourages but does not require its provider network to adopt many of the best practices; it does not know the extent to which they are used in state-funded or -operated programs.*
- *DMHAS and DOC parole division have developed outcome and performance measures for their substance abuse treatment providers; CSSD and DOC-operated programs are in the process of developing such measures. Currently, only DMHAS monitors its performance and outcome measures, but primarily on an individual provider basis. No agency regularly reports the results of its outcome and performance monitoring efforts to the public.*
- *CSSD's and DMHAS' resources for monitoring and evaluating service delivery and their electronic data systems appear to be adequate. The Department of Correction's electronic data systems and internal monitoring and evaluation capability do not appear to be sufficient to meet its needs.*

Program Monitoring and Overall Quality Assurance

The appropriate monitoring of programs should ensure that the contracted services are delivered in the manner required under contract and that service delivery is measured to assess the quality of care. Broadly speaking, quality assurance refers to a process that includes: defining performance goals and/or standards; assessing outcomes in comparison to these goals and standards; and identifying ways to improve performance where desired results are not achieved. This means, at a minimum, each agency should regularly check compliance with contract or program requirements and use the results of monitoring efforts to identify corrective actions to address deficiencies. In addition, an adequate number of staff should be dedicated to this function.

For substance abuse treatment programs, this concept of quality assurance includes obtaining stakeholder feedback and a process for checking fidelity to a treatment program's model practices and required procedures. Stakeholder feedback includes obtaining information about program satisfaction and operations from involved agency personnel and clients. The

program fidelity function is key to evidence-based programming, another generally accepted best practice identified by the committee as described below.

Generally, evidence-based programs have shown, through rigorous scientific evaluations, that they can significantly affect important outcomes for participants. To achieve proven positive results, it is important to assure that a program is implemented as designed and tested. The introduction of new staff or changes in treatment duration due to budget limitations can significantly change the delivery of treatment and its effectiveness. Periodic standardized checks help to assure that programs are implemented correctly.

Findings: Program Monitoring and Quality Assurance

- DMHAS, DOC, and CSSD all perform various contract compliance activities of varying intensity with non-profit providers to ensure treatment services are delivered; however, the DOC parole division's monitoring appears to be the least comprehensive.
- All the agencies develop corrective action plans with providers addressing issues of noncompliance or less than satisfactory performance. However, no annual summaries of identified deficiencies are compiled for management purposes by any agency.
- All three agencies plus the Department of Public Health perform field inspections of providers. In general, they cover some of the same treatment quality issues for the same providers, but the emphasis of each type of field monitoring is different.
- Efforts to check fidelity are very limited, except in one agency. DOC checks for program fidelity for all of its in-facility programs and CSSD is checking program fidelity for three of its 23 program models. The other agencies do not require program fidelity checks and, if performed, they are done sporadically.
- Stakeholder feedback is obtained by each agency but the extent of that feedback varies. DMHAS administers the most comprehensive consumer survey of substance abuse clients and shares results with the criminal justice agencies. Feedback on DOC in-facility programs from program participants and DOC agency personnel are obtained during the annual audit process. DOC parole division and CSSD receive feedback at least annually from providers and related community and department personnel, but not from program participants.
- CSSD has begun to implement a risk reduction model for probationer supervision that identifies core practices as well as processes and tools to

implement the practices to guide probation officers and supervisors in doing their work. While the procedures to implement the model are not a formal quality assurance process, it provides staff with a guide to implement the risk reduction model with fidelity. The DOC parole division does not have such a model for parole officer supervision.

- DMHAS produces an extensive amount of substance abuse treatment provider performance and outcome information. It is not routinely distributed to other agencies to assist with their compliance and quality assurance efforts. In general, the results of contract compliance and other monitoring efforts are not shared among the agencies.

Recommendations: Program Monitoring and Quality Assurance

- 5) The DOC parole division should improve its contract monitoring practice and quality assurance processes by including a periodic audit check of its contracted providers to ensure all contract requirements are being met and treatment services are being delivered appropriately.**
- 6) DMHAS should investigate, with CSSD, the DOC parole division, and DPH, the development of joint quality assurance and monitoring teams for substance abuse treatment facilities or of a common approach for reviewing and checking similar areas of concern and coordinating such review efforts. Either activity should include the development of a corrective action plan summary of compliance issues identified regarding substance abuse treatment providers and the sharing of that information among all agencies.**
- 7) CSSD should expand its quality assurance process to include its other program models that contain a substance abuse treatment component.**
- 8) CSSD should further develop and DOC parole division should consider developing a quality assurance process that assesses the work of probation and parole officers with regard to core practices that assist in reducing criminal behavior and enhancing offender motivation to change, especially for those offenders with a substance abuse problem.**

Also, see related recommendation pertaining to the sharing of the results of DMHAS' performance reports and outcome information later in this section.

Selected Best Practices

Described below are selected best practices, identified in the substance abuse treatment literature that relate to improving treatment outcomes.

Substance use monitoring during treatment. The National Institute on Drug Abuse (NIDA) has recognized the importance of regular monitoring of substance use while individuals are in treatment. Because lapses can occur during treatment, objective monitoring for drug and alcohol use can help a client resist the urge to use drugs or alcohol. Early evidence of drug use can also help the provider in adjusting the treatment plan. For those individuals involved with the criminal justice system, recognition of the relapsing nature of addiction requires a graduated sanctions policy for those in treatment.

Use of evidence- or research-based practices. Definitions of evidence- and research-based practices vary in the literature. However, what is common to both is the requirement that assessment tools and treatment approaches are based on the best available, current, valid and relevant evidence. The amount and rigor of evidence is usually the distinguishing characteristic between the two, with more stringent substantiation required for evidence-based practices.

Various federal reports over the years, such as the federal Institute of Medicine's report "Bridging the Gap between Practice and Research" and the National Treatment Plan (Center for Substance Abuse Treatment, 2000), as well as SAMHSA's science-to-service initiative, have called for the adoption of research findings into routine clinical practice. The limitations of current research about particular populations should also be understood and factored into any evaluations of programs.

Often, intentional and unintentional adaptations are made to evidence-based programs. As noted above, improperly trained or monitored staff or fiscal concerns can change how a program is implemented - emphasizing the importance of program fidelity checks. However, many of those interviewed by committee staff have cited a mismatch, such as cultural differences, between evidence-based programs and the actual participants as a reason for altering evidence-based programs. This is sometimes cited as a reason not to adopt an evidence-based program in the first place. However, the research literature suggests that not all adaptations are fatal.³ Certain adaptations, such as language changes, replacing cultural references or images, or modifying certain activities, do not appear to limit effectiveness. Other changes that impact the core of the programs, such as the length of the program or using improperly trained or fewer staff, will impact program effectiveness.

In addition to evidence-based assessment tools and programs, the committee also considered motivational interviewing and the measurement of the "therapeutic alliance" as important evidence-based practices. Motivational interviewing techniques include strategies such as asking open-ended questions not easily answered with a single word or phrase, listening reflectively to a client and repeating what was said back to them, affirming the client's recognition of a problem and intention to change, and eliciting self motivational statements from the client that recognize his or her problems and express an intent to change. Assertive outreach and motivational interviewing assists individuals in initiating and maintaining the path to recovery. Motivational interviewing is not only an important skill for counselors but also for

³ Cailin O'Connor, Stephen A. Small, And Siobhan M. Cooney, Program Fidelity And Adaptation: Meeting Local Needs without Compromising Program Effectiveness, *What Works, Wisconsin Research to Practice Series*, 4. Madison, WI: University of Wisconsin-Madison/Extension.

those who perform assessments and develop and monitor case plans of offenders, such as parole and probation officers.

The therapeutic alliance refers to the relationship between the counselor and the client. A positive therapeutic relationship has been cited as a principle factor in treatment success. An analysis of 79 studies that examined the therapeutic alliance between the therapist and the client found a positive relationship between the strength of that alliance and a successful treatment outcome.⁴ The NIDA principles for effective treatment also note the importance of the counselor establishing a positive therapeutic relationship with the patient to help keep the patient in treatment long enough to gain the full benefits of treatment.

Discharge planning and aftercare. Recovery from substance use disorders can be a long, complex process. Research shows better outcomes are achieved when formal clinical treatment is followed by aftercare services and combined with other recovery supports. Referrals to community-based self-help groups and assistance with housing, transportation, employment, and basic needs are among the practices found effective in helping clients sustain recovery and maintain abstinence. The NIDA principles suggest that substance abuse treatment providers should be expected to assist in ensuring a transition to continuing care.

External credentialing of facilities/programs and treatment providers. A variety of substance abuse treatment authorities emphasize the importance of a well-trained, competent workforce in delivering effective services. More complex treatment issues call for more sophisticated and competent treatment skills. Research and evaluation studies are identifying new methods and tools for facilitating change and recovery requiring on-going professional development. Treatment programs also are seeing clients who have co-occurring disorders and present with complex life situations and issues. The promulgation of new methods and clients with multiple disorders emphasize the need for a broad spectrum of counselor competencies that may not be sufficiently learned through on the job training.

Proxy measures for a well-trained workforce that are used in this report include the extent to which substance abuse treatment professionals and facilities are credentialed (i.e., have appropriate licenses or certification from the Department of Public Health). Another measure is the extent to which substance abuse treatment programs and facilities are accredited by nationally recognized organizations, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF).

The Department of Public Health is responsible for the licensing of treatment programs in the state and administers the licensing and certification program for drug and alcohol counselors. As part of its licensing responsibility, the department conducts a biennial inspection of treatment facilities. This inspection assures that treatment programs are meeting a regulatory minimum standard of care. The department's inspections encompass a number of areas including the condition of the physical plant, the presence of staff with certain training and credentials, and the adequacy of treatment plan documents and other patient records. The inspection does not include items not covered in regulation or statute, including best practices or effectiveness of

⁴ Daniel Martin, John Garske, M. Katherine Davis, Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review, *Journal of Consulting and Clinical Psychology*, Vol. 68, No. 3, 438-450

treatment, staffing ratios, intake practices, or the existence of evidence-based assessment tools or programs. Most of the current regulations were promulgated in 1988, though some portions were updated in 1999.

Findings: Selected Best Practices

- The criminal justice agencies all have general policies regarding testing individuals in treatment for substance use and have a graduated sanctions policy to handle substance use during treatment. DMHAS does not have a general policy and does not compile or analyze information about provider testing procedures or testing results.
- CSSD and the DOC parole division require that contracted substance abuse treatment providers assessment tools and programs be evidence- or research-based, though the definitions of research or evidence-based practices are not always clearly defined. DOC and CSSD also use evidence-based and validated assessment tools to determine offender needs.
- The DOC parole division does not consider treatment received in prison when making a referral to treatment services and may be filling residential treatment beds inappropriately.
- The Board of Pardons and Paroles does not receive a complete picture of offender needs when the offender's case is presented to the board because a needs assessment is administered after parole decisions are made.
- The DOC's in-facility assessment tools are evidence-based but one is not validated against a correctional population; its treatment programs all are evidence-based, except for one.
- DMHAS requires use of specific evidence-based screening tools but providers can use whatever process and tools they want to assess client treatment needs as long as a comprehensive biopsychosocial assessment is performed and standardized placement criteria are followed.
- CSSD has trained its probation officers in motivational interviewing (MI) techniques, while the DOC parole division is in the process of training its parole officers in this technique. New counselors that are employed by DOC for in-facility treatment programs are trained in MI, and the training is offered to existing counselors but is not required. DMHAS offers training in MI and other evidence-based practices through its education and training division courses.

- DMHAS encourages providers to use evidence-based practices but does not mandate their use.
- CSSD is the only agency currently trying to measure the therapeutic alliance through the use of an evidence-based, validated assessment tool; however, it is doing so in only one of its program models.
- Each of the agencies has discharge planning requirements that must be followed by all its funded or operated treatment programs. Data on the number of substance abuse clients who receive services to support their recovery and related outcome information is not systematically tracked.
- All facilities that provide substance abuse treatment services must be licensed by DPH. However, both the DOC parole division and CSSD report that one of their providers is not licensed by DPH.
- Only DOC alcohol and drug treatment counselors must be licensed or certified. All other agencies, including DMHAS, do not require that programs employ only credentialed counselors to provide clinical treatment services.
- State law does not require that treatment counselors be licensed or certified but does require noncredentialed staff of substance abuse treatment facilities to be supervised by licensed professionals if they render clinical services, such as assessments. It is unclear how well this is monitored and enforced. Supervision is not defined in either statute or regulation.
- Making licensure a “blanket” requirement could create problems as providers report there is a shortage of credentialed staff now. Mandating higher qualifications for direct care staff also is likely to be costly to providers and funding agencies.
- Information on the substance abuse assessment instruments and procedures used by treatment programs, or their supervision policies for staff who are licensed or credentialed, is not compiled by DMHAS.
- Specific information about client populations served, language competence of staff, problems and disorders treated, and program specialties is not compiled by DMHAS although it is collected from providers who are certified to participate in GABHP.

- DMHAS maintains no centralized inventory of the types of substance abuse treatment services the programs it funds or directly operates provide, or whether programs are evidence-based or nationally accredited.
- DMHAS does not collect and report data on the number of substance abuse clients who receive services to support their recovery or any outcome information related to such services.

Recommendations: Selected Best Practices

- 9) **DMHAS should compile and analyze information about provider substance use testing procedures, create a uniform policy, and ensure that regular testing is performed and that best practices are followed.**
- 10) **DMHAS shall establish a clear definition of research- and evidence-based practices and develop a strategy to encourage the use of such practices for substance abuse assessments and treatment, including program fidelity checks and measuring the therapeutic alliance. The strategy shall be developed by January 1, 2010.**
- 11) **DMHAS should collect and report data on the number of substance abuse clients who receive services to support their recovery and any related outcome information.**
- 12) **The DOC parole division should ensure that all treatment information is considered when referring clients for additional substance abuse treatment, including the treatment received while in DOC facilities and any discharge planning developed by the Addiction Services Unit. The division should ensure that all referrals to residential treatment are appropriately made.**
- 13) **The Board of Pardons and Paroles should consider having the evidence-based assessment tool, called the Level of Service Inventory, administered by parole officers before a final decision is made by the board regarding parole eligibility and conditions of parole.**
- 14) **DOC and CSSD shall ensure that all substance abuse treatment providers are properly licensed as required by law.**
- 15) **DMHAS shall develop a strategy to encourage the development of licensed or credentialed staff in providing clinical services among all funded and state-operated substance abuse treatment providers. Such strategy shall consider a long-term phase-in of such a requirement. The strategy shall be developed by January 1, 2010.**
- 16) **DMHAS shall compile a profile of each substance abuse treatment provider that receives state funding. This provider profile shall be updated on an annual basis**

and be maintained on the department's website. Both DMHAS and DOC shall also create a similar profile for the programs they operate. The profile shall include:

- **client populations served;**
- **language competence of staff;**
- **types of care available and the number served at each level of care;**
- **extent to which services are evidence-based or not;**
- **accreditation status of the provider;**
- **client survey results;**
- **the percent of employees who are licensed or credentialed who perform assessment, treatment plan development, and treatment delivery services; and**
- **treatment completion rates by level of service, average wait times for treatment services, and outcome information, including the federally required National Outcome Measurement System data, and any other information DMHAS deems relevant.**

Outcome and Performance Measures

Collecting information on outcome and other performance measures is critical providing to ensuring system accountability and identifying strengths and weaknesses of various treatment approaches. Outcome measures assist organizations in continually measuring how well services or programs are achieving the desired results. Ultimately, they should provide a basis for collecting reliable evidence about program operations that can be used as a basis to guide the development of budgets, allocating resources, and improving services.

Findings: Outcome and Performance Measures

- Only DMHAS gathers outcome and performance measures for the substance abuse treatment programs it funds and operates. This information is generally not shared with other state agencies that also use the programs.
- There is no systemwide systematic tracking of the connection to the next level of care for clients, or success in maintaining recovery for people with substance abuse problems who are discharged from DOC and CSSD custody to the DMHAS system.
- While some academic studies have examined substance abuse treatment and recidivism for the criminal justice agencies, there is no consistent, on-going check of those participating in particular programs and recidivism, though CSSD is in the process of developing this capability.

- Results from DMHAS' many research and evaluation activities are not compiled in a central location and there is no unit or group of staff dedicated to promoting systemwide best practices and quality improvement.
- At present, there is no link between cost of services and program outcomes and none of the agency contracting is based on provider performance outcomes.
- DMHAS collects an extensive amount of performance and outcome data regarding all the behavioral health services it funds and operates. It tracks substance abuse treatment effectiveness in many ways, but mostly on a program and individual client basis.
- Outcome information for treatment that is funded and operated by DMHAS is not routinely aggregated or periodically summarized and reported publically. As the lead state agency for substance abuse, the department should be compiling and analyzing all available outcome data and research findings to evaluate overall effectiveness of the publicly funded treatment system.
- While considerable amounts of performance and outcome data are produced about publicly funded substance abuse treatment, there is little internal capacity for analysis and research within any state agency.
- Research projects carried out specifically to assess substance abuse treatment in Connecticut have produced findings that echo national studies and show:
 - state substance abuse treatment is positively related to subsequent improvements in substance use, homelessness, criminal behavior, employment, and use of health and mental health services;
 - completing state treatment programs has a positive impact on employment status and treatment lasting 90 day or more had the best results;
 - state substance abuse treatment has a positive impact on recidivism; and
 - recovery supports like housing, transportation, vocational assistance, and basic needs, provided with state substance abuse treatment is more effective than treatment alone.
- DMHAS gathers and reports on the federally mandated National Outcome Measures (NOMS) for all substance abuse providers. The committee finds the measures currently to be inadequate as they only provide a gross sense of the effects of the state's substance abuse treatment system. However, the

- NOMS are the best available data regularly produced about the effectiveness of publicly funded substance abuse treatment.
- DMHAS does not regularly compile or publicly report the national and any of its other outcome measures for the state substance abuse treatment system.
- NOMs information developed by the department at the request of the committee shows that for a recent three-year period, about one-third of all discharged clients (both those completing and not completing their state treatment program) showed improvement in the alcohol abstinent measure, and around one-quarter showed improvement in the drug abstinent measure, for each year.
- DMHAS also provided the committee with data on completion rates by level of care that shows, in total, about two-thirds of adults who entered state substance abuse treatment completed their level of care. Completion rates varied greatly among the care levels and were higher for residential than outpatient programs. Completion rates for more intensive residential programs were highest (80 to 85 percent) while outpatient levels of care had the lowest rates of completion (45 to 55 percent).
- The department did not provide NOMs data for state methadone maintenance programs and does not compile or report results information related to this level of care. Given the importance of this treatment approach in Connecticut, and the stigma and controversy associated with methadone and other opioid replacement treatment, developing and reporting information about its effectiveness should be a DMHAS priority.
- DMHAS also does not compile and report performance and outcome information specifically for the four substance abuse facilities it operates.
- Treatment completion is linked to successful outcomes. It is unclear how successful DOC program completion rates are when compared to those of private providers. Completion rates are over 60 percent for private provider long-term residential treatment, while at DOC it is 35 to 48 percent, depending on the program. Intensive outpatient completion rates for private providers are between 48 to 55 percent, while the DOC is 75 percent. Outpatient treatment completion rate for private providers is 45 to 51 percent, and 15 to 45 percent in DOC's Community Addiction Service Programs.
- Together, DMHAS and CSSD operate two drug and alcohol education diversion programs for certain first time offenders: the Pretrial Alcohol Education System (PAES); and the Pretrial Drug Education Program (PDEP).

Although they serve over 12,500 individuals a year, the programs have not been formally evaluated. Neither agency could provide the committee with performance and outcome information on the PAES and PDEP programs within the study timeframe.

Recommendations: Outcome and Performance Measures

- 17) CSSD and DOC should calculate completion rates for those clients enrolled in their substance abuse treatment programs. CSSD and DOC should benchmark their completion rates against programs offered by other similar criminal justice and correctional agencies. In addition, DOC should evaluate whether its contracted community private providers produced better completion rates and outcomes than offenders on parole and receiving services from DOC.**
- 18) DMHAS, in conjunction with CSSD, should conduct an evaluation of the effectiveness of PAES and PDEP in terms of their impact on participant substance use and criminal justice involvement. The agencies should also develop outcomes measures for both programs that are reported, at a minimum, in DMHAS' biennial report, beginning in 2010.**
- 19) DMHAS should develop and review the performance and outcome information related to the state's methadone maintenance and other opioid replacement treatment programs by July 1, 2010. The information should be summarized and reported on the agency's website and the department's biennial report. At a minimum, it should include how long people remain in treatment, whether providers are in compliance with all state and federal standards, and what improvement clients have experienced in their substance use and quality of life because of the treatment they received.**
- 20) The annual State of Connecticut Recidivism Study generated by the Criminal Justice Policy and Planning Division of the Office of Policy and Management should report the effects of substance abuse treatment received by offenders on subsequent criminal justice involvement.**
- 21) DMHAS, as the lead state substance abuse agency, should expand and strengthen its role in developing, gathering, analyzing, and reporting outcome measures regarding the effectiveness of the state's substance abuse treatment system. Other specific proposed improvements are discussed in the following section regarding DMHAS as the lead state agency on substance abuse.**

Monitoring and Evaluation Resources and Data Systems

An agency's monitoring and evaluation capability is dependent on the resources the agency commits to such efforts. A brief overview of the resources each agency has devoted to monitoring and evaluation of programs is provided in Appendix A. This also includes any

research conducted by outside consultants or through academic partnerships. In addition, because a high-quality management information system supports the collection and retrieval of data that allows for the analysis of program information, a discussion of the various electronic data systems available in each agency is also provided in the appendix.

Findings: Monitoring and Evaluation Resources and Data Systems

- Data systems and research capabilities vary widely among the agencies.
- CSSD has 17 staff dedicated to performing contract compliance activities and another 17 employees who staff two separate offices dedicated to best practices and quality assurance.
- Generally, both DOC in-facility programs and parole division contractors are monitored by in-house staff who have other job responsibilities in addition to performing monitoring audits. The parole division reports not having sufficient staff to perform the contractor monitoring oversight function.
- In total, about 29 DMHAS professional staff are assigned full-time to contract compliance and program monitoring functions for the department's entire network of behavioral health service providers (approximately 200 programs) and its four state-operated facilities.
- DMHAS has four professional staff for all internal planning and research functions. It has established partnerships with several universities to conduct prevalence and treatment need studies as well as outcome evaluations of treatment services.
- DOC, partially because of its limited automated information systems, has little capacity for internal data analysis. CSSD current automated system is limited but is developing a comprehensive contractor database that will collect key treatment data on individual clients to gauge performance of its provider network.
- DMHAS collects the most information about substance abuse treatment services from all licensed providers in Connecticut, as well as from DOC-operated and its own programs. It has experienced extensive data quality issues within its treatment provider information system. Corrective actions have been on-going since 2005, but this effort will not be complete until early 2009. Technical problems also have impeded DOC access to the system and it contains only a portion of that agency's substance abuse treatment data.
- DMHAS has three automated information systems: one that collects data from substance abuse treatment providers; a separate system for department-

operated facilities, and one for the General Assistance Behavioral Health Program.

- Data quality has been an ongoing issue for DMHAS' provider information system; a major data integrity improvement project started three years ago is expected to be completed early in 2009. The system for the state facilities has little ability to produce management information. Upgrades both the provider and facility systems are planned and should be in place by the spring of 2010.
- A separate automated system, with generally more reliable data, is maintained by the program's ASO. It is capable of producing any number of routine and ad hoc reports about GABHP clients, the treatment and recovery support services they receive, and costs of care provided.
- All three agencies have developed relationships with academic institutions to supplement their internal resources for research and data analysis.
- At this time, results from the DMHAS' many research and evaluation activities are not compiled in a central location and there is no dedicated best practices unit.

Recommendations: Monitoring and Evaluation Resources and Data Systems

22) DOC should conduct an assessment of its management information system to determine how it could better meet its research and management needs. Additional related recommendations regarding DMHAS' role as the lead state substance abuse agency are provided in the next section.

Lead Agency Role

Lead responsibility for the state's substance abuse treatment system for adults rests with the Department of Mental Health and Addiction Services under a number of statutory mandates. State law requires the department to develop and implement a statewide substance abuse plan and to chair the state interagency council on alcohol and drug policy, which also has statewide planning and coordination duties. The department is charged with maintaining a central data repository for all substance abuse services provided in the state and reporting on the use, quality, and effectiveness of the publicly funded treatment system every two years.

DMHAS is Connecticut's designated single state agency for substance abuse treatment and prevention for federal funding purposes. In this capacity, and in accordance with several state statutory mandates, the department must coordinate state policies and resources, as well as publicly funded programs and services, for treating adults with substance use disorders. As discussed below, the committee found the department, as the lead agency, needs to take a stronger role in planning and in coordinating and overseeing the state's substance abuse treatment for adults.

In brief, the committee finds DMHAS has:

- *no strategic planning process for the publicly funded treatment system;*
- *been deficient in promoting consistent standards and the use of best practices across agencies and the private provider network; and has*
- *not compiled, monitored, and reported information about the overall impact of the state treatment services on the adult substance use problem in Connecticut.*

Comprehensive Strategic Planning

DMHAS is involved in multiple planning processes concerning substance abuse treatment and prevention. Under C.G.S. Sec. 17a-451, the department must develop and implement a statewide substance abuse plan, which is defined as: a comprehensive plan for prevention, treatment, and reduction of alcohol and drug abuse problems that includes statewide, long-term goals and objectives that are revised annually. Another statute requires the state Alcohol and Drug Policy Council (ADPC) to develop and coordinate an integrated, interagency plan for substance abuse programs and services; it must submit a report evaluating plan implementation, with recommendations for proposed changes, to the legislature each year.

DMHAS views the council's annual substance abuse reports as meeting the mandate for a comprehensive state substance abuse plan; it does not prepare another document. The committee found the ADPC reports identify major substance abuse problems in the state, make

recommendations for addressing them, and outline necessary implementation activities and resources. However, while the council reports set priorities for statewide policy and practice, they do not constitute a comprehensive plan for delivering effective treatment to adults.

By law, the department's statewide substance abuse plan must be developed in consultation with the state's regional planning and action councils for substance abuse treatment and prevention (RACs). DMHAS carries out an extensive regional priority planning process with the RACS (described in the committee briefing report) but the councils have not had any role in the Alcohol and Drug Policy Council's planning process.

Further, the current regional planning process primarily is a systematic way for the department to bring together information on gaps and cross-regional needs. It is used to reach consensus, with broad stakeholder input, on state funding priorities but it does not result in a comprehensive state plan of action for providing effective substance abuse treatment.

This process also contains no formal tracking of progress made in addressing the identified regional and state priority needs. For example, over the past five years, housing and transportation always have been identified as two top priority unmet needs of substance abuse clients by all RACS. While a number of initiatives have been undertaken at the state and local levels to address these issues, their effect, in terms of improving clients' treatment outcomes, is not measured or reported. In interviews with PRI staff, RAC members noted they receive little feedback on the actions taken in response to their regional priority plans and whether recommended changes are having any positive impact.

In recent years, a top state priority is effective substance abuse treatment and recovery support for adults involved in the criminal justice system. As discussed in the committee briefing report, DMHAS is involved in a number of collaborative projects with CSSD and DOC intended to increase and improve services for offenders with substance use disorder who are remaining in or returning to the community. Many initiatives in all three agencies are targeted to providing treatment to this population, but there is no formal plan with goals and outcome measures guiding them at present.

By law, the Criminal Justice Policy and Planning Division within the Office of Policy and Management must develop a reentry strategy to promote successful transition of offenders from incarceration to the community. One of the many areas the strategy must address is how to link newly released offenders with community-based programs and services proven effective in reducing recidivism, such as substance abuse treatment and recovery supports. The final draft of the division's community reentry strategy is expected to be issued for review in December 2008 and finalized by the following February. The committee believes the strategy could partially address the need for better planning for the delivery and coordination of treatment services to the criminal justice population.

Overall, PRI staff found the state has no strategic planning process for its publicly funded substance abuse treatment system. Current planning efforts are disjointed and existing plans and reports provide piecemeal approaches for meeting the needs of adults with substance use disorders. For the most part, these documents identify priorities and initiatives for addressing

them, not measurable goals and comprehensive strategies for achieving them. They also fail to provide a framework for assessing progress toward state goals for substance abuse treatment.

In addition, the program review committee found there is no clearly articulated state policy on substance abuse treatment in statute or any state agency document. Current law does not directly address the purpose of the department's services for adults with substance use disorders or establish goals across the entire treatment system.

The department's main statutory requirement regarding the publicly funded treatment for alcohol and drug dependent persons is to provide programs and services, within available resources, for the purpose of "early and effective treatment." The commissioners of DMHAS and DOC also are directed by law to cooperate in establishing treatment and rehabilitation programs for alcohol and drug dependent persons confined in correctional institutions. State statute additionally requires that substance abuse treatment funded or directly provided by DMHAS be guided by the following standards:

- Treatment on a voluntary rather than involuntary basis, if possible.
- Initial assignment or transfer to outpatient or intermediate treatment, unless inpatient treatment is found to be required.
- No denial of treatment solely because of withdrawal from treatment against medical advice on a prior occasion or relapse after earlier treatment.
- Preparation and maintenance of a current individualized treatment plan for each patient.
- Provision for a continuum of coordinated treatment services so a person leaving a facility or form of treatment will have available and utilize other appropriate treatment.

However, none of these mandates have been incorporated into a vision and mission statement for state substance abuse treatment or developed as goals and objectives for DMHAS programs and services. Providers, regional planning council members, and advocacy group representatives interviewed by the committee were unaware of any official department policy concerning goals or expected outcomes specific to the state's alcohol and drug abuse treatment system.

At present, there is no state plan or written policy that contains formal, well-defined performance goals, or related benchmarks, to guide DMHAS and other state agencies in providing and evaluating substance abuse treatment services. Without clear goals that address how well the system is getting and keeping people in treatment and what difference the treatment provided is making in terms of improvements in a person's substance use and quality of life, it is difficult to assess the effectiveness of the state's substance abuse treatment system.

As described in the committee briefing report, the department has adopted clear vision and mission statements, developed with broad stakeholder input, for its recovery-oriented system of care, which apply to all behavioral health services DMHAS supports. They are contained in formal policy statements issued by the commissioner and lay a foundation to guide agency

operations and resource allocation. They are also reflected in a detailed manual of practice guidelines for all department funded and operated treatment programs.

According to the commissioner, the recovery-oriented care policies and guidelines are intended to serve as a framework for ensuring a system of "... quality care [that] is safe, timely, person-centered, effective, efficient, and equitable..." It has also been stated in department presentations that, while the eventual goal of treatment is to end dependence, a recovery-oriented system: decreases severity of symptoms; and increases duration of abstinence. The committee believes these various recovery-oriented policies and guidelines could serve as a foundation for a comprehensive strategic planning process focused on the agency's substance abuse treatment system.

Comprehensive strategic planning is the cornerstone of effective management and clear accountability. As noted in SAMHSA technical assistance documents, a good strategic plan: specifies what will be accomplished over a three-to-five year period; sets annual performance targets related to the plan; and every year reports on the degree to which those targets are met. In addition, planning should be based on clear, succinct, and widely supported mission and vision statements developed in collaboration with stakeholders. The many benefits of good strategic planning include: clear, consistent goals to guide policy and resource decisions; relevant measures of progress; and well-defined actions steps.

A strategic statewide plan for the adult substance abuse treatment system would address a number of current deficiencies. It would create a formal, clearly articulated state policy to guide development, implementation, and evaluation of all publicly funded adult substance abuse programs and services. The process would promote systematic analysis of existing capacity and current and projected demand. Given the likelihood of significant funding constraints in the coming years, the plan could be valuable guide for allocating resources in a cost-effective manner. Finally, it would provide a formal framework for tracking progress, holding private providers and state agencies accountable for results, and informing managers and policymakers about areas of success and areas in need of improvement.

Therefore, **the program review committee recommends:**

- 23) Current statutory provisions for a statewide substance abuse plan shall be repealed and replaced with a requirement for a strategic planning process for the state substance abuse treatment system for adults that is overseen by DMHAS.**

Beginning in 2009, the department shall prepare and annually update a three-year strategic plan for providing state treatment and recovery support services to adults with substance use disorders. The plan shall be based on a mission statement, a vision statement, and goals for the state treatment system, including all state-funded and state-operated services, that are developed by DMHAS, in consultation with its regional action councils, consumers, and their families representing all client populations including those involved in the criminal justice system, treatment providers, and other stakeholders.

The strategic state substance abuse plan shall outline the action steps, timeframe, and resources needed to address the goals developed with stakeholders. At a minimum, the plan shall address the following areas:

- access to services, prior to and following admission to treatment;
- comprehensive assessment of the needs of those requesting treatment, including individuals with co-occurring conditions;
- quality of treatment services and promotion of best practices, including evidence- and research-based practices and models;
- provision of an appropriate array of treatment and recovery services along a sustained continuum of care;
- outcomes of specific treatment and recovery services and of the overall system of care; and
- department policies and guidelines concerning recovery-oriented care.

The plan also shall define measures and set benchmarks for assessing and reporting on progress in achieving the plan goals, statewide and for each state-operated program. These should include, but not be limited to: timeliness (e.g., portion of clients admitted to treatment within one week after referral); penetration rates (percent of those needing treatment who receive it); completion rates; connection-to-care rates; length of treatment episode (e.g., portion of clients receiving treatment of 90 days or more); and rates of client improvement regarding substance use, employment status, stable housing, criminal activity, and relationships with family and community.

The first three-year plan shall be completed by July 1, 2010. DMHAS shall submit final drafts of the initial plan and its annual updates to the state Alcohol and Drug Policy Council for review and comment. Progress in achieving the plan's goals shall be summarized in the department's biennial report on substance use that is submitted to the legislature and the council under C.G.S. Section 17a-45.

In addition to the plan content areas outlined above, the committee identified two additional issues that should be addressed by the department's new strategic planning process, at least for the initial plan. First, to ensure an integrated approach is taken in addressing the substance abuse needs of adults within the criminal justice population, **the program review committee recommends:**

- 24) provisions of the community reentry strategy developed by the Criminal Justice Policy and Planning Division regarding substance abuse treatment and recovery services needs of the offender population shall be incorporated within the state strategic plan.

Further, DMHAS shall consult with the Criminal Justice Policy Advisory Commission in developing goals related to the special treatment and recovery service needs of adults involved in the criminal justice system, as well as strategies

for meeting them, for the new state substance abuse plan. A work group composed of staff from CSSD, DOC Addiction Services, DOC Parole, and the DMHAS Forensic Services Division and representatives of private nonprofit providers of adult substance abuse treatment services should be formed to assist with this process.

The second issue is related to the lack of good information linking funding and service outcomes that could be used for strategic planning purposes as well as better accountability. At present, there is little to no data on the actual costs of providing care to the different client populations. Also, there is no document outlining the resources required to continue providing services at current or alternative levels.

At the committee's October public hearing and in interviews with staff, private providers reiterated on-going concerns about their financial viability given continually rising operating costs and essentially stagnant state funding over the last decade. Private providers described the state's nonprofit human services as "grossly underfunded" and "severely challenged." According to the Connecticut Community Providers Association, compounded cost of living adjustments (COLAs) to state payment to nonprofit providers from 1987 to 2008 totaled 29.3 percent, while the compounded inflation rate (CPI) was 95.4 percent. Providers have received only one cost of living adjustment to rates paid under the General Assistance Behavioral Health Program since its inception in 1998.

The community providers association pointed out that decades of underfunding has lead to many problems, including pay disparity and a high employee turnover rate. According to providers, nonprofit staff, in some cases, are paid at about one-half the rate of comparable state employees. This disparity causes employees to leave the nonprofits to join state agencies or pursue other more lucrative employment opportunities. The turnover rate is reported to be about 26 percent for direct care staff and a vacancy rate of 8 percent. This impacts the quality and effectiveness of care as it can be disruptive to the relationships built between clients and therapists. In addition, other providers have pointed to shrinking programs and deferring maintenance and repair of buildings because of a lack of funding.

Determining the impact of the state's funding methods and potential underfunding of the nonprofit treatment community is beyond the scope of this study. However, it is notable that in interviews with PRI staff, none of the individuals from state agencies who provide funding to nonprofits had a firm understanding of the financial status of the state's provider network. Even though DMHAS collects a considerable amount of fiscal and operating information about its nonprofit agencies, it was unable to provide PRI staff with: any assessment of the financial condition of its network; or complete data on the costs associated with different levels of care.

The private provider network could not be easily or economically replicated by direct state services. Because of the vital role that nonprofit providers fulfill, combined with the lack of information about their financial viability, **committee recommends:**

25) DMHAS shall conduct a financial viability assessment of its private provider network. This assessment should estimate the extent to which the community

providers have the ability to appropriately meet their clients' needs and their mission in a sustainable way over the next five to ten years.

Coordination and Oversight

State statutes do not refer to DMHAS as the lead agency for substance abuse. However, it is mandated to carry out a number of statewide coordination and oversight functions for alcohol and drug abuse treatment and prevention that give it that role. For example, the department must:

- Prepare and issue regulations for administration and operation of all DMHAS, state-operated, and community programs for persons with substance use disabilities.
- Establish and enforce standards and policies for care and treatment of persons with substance use disabilities in public and private facilities.
- Coordinate all activities in the state relating to substance abuse treatment including activities of the Judicial Branch and all other departments or entities providing such services.
- Collect, make available, and specify, for public and private agencies, uniform methods for keeping, statistical information on alcohol and drug abuse treatment and prevention that includes: numbers treated; demographic and clinical information; information on admission and readmission, and discharge and referral: treatment frequency and duration; and levels of care provided.
- Establish, and with OPM ensure compliance with, uniform policies and procedures for collecting, standardizing, managing, and evaluating data on all state substance abuse programs including: use of services, demographic and clinical information, and service quality and effectiveness.
- Submit to the legislature a biennial report on the above substance abuse program data that summarizes: client demographic information; trends and risk factors; service effectiveness (outcome measures); and a state-wide cost analysis.

As described in the committee briefing report, DMHAS engages in many joint planning processes and collaborative initiatives to promote interagency coordination of substance abuse treatment policies and resources. The department is leading many of the ADPC interagency coordination efforts and is an active participant in the Criminal Justice Policy Advisory Commission. A number of promising collaborative projects have been developed by the agency's Forensic Services Division and the state's criminal justice agencies. The Access to Recovery program is another example of a successful collaborative effort, lead by DMHAS, to link treatment and recovery services and provide them to adults with substance use disorders in criminal justice, child welfare, and behavioral health care systems.

In most cases, it is too early to know the outcomes of these joint programs in terms of reducing clients' substance use and criminal involvement. However, staff from the participating

agencies report positive initial results, including better communication among all departments and significantly improved interagency cooperation. Independent, formal evaluations of program effectiveness are planned and will be used to determine effectiveness as well as areas for improvement and expansion.

DMHAS has implemented a collaborative contracting process, also described in the committee briefing report. The project has streamlined the procurement and contract management process for obtaining residential treatment services for DMHAS, DOC, and CSSD adult clients with substance use disorders. According to the department, the project has kept the rates paid by each agency for residential treatment beds more uniform and significantly reduced the administrative burden on the 12 providers who participate in the collaborative contract.

Conceptually, the project seems to be a cost-effective practice that could be expanded to other services. However, there has been no formal review of direct or indirect cost savings for the state or the provider agencies. Also, while CSSD feedback on the project has been very positive, DOC has been dissatisfied with certain procedures and its access to residential treatment beds.

As noted in Section II, DMHAS has been deficient in promoting consistent standards and coordinating agency efforts to achieve substance abuse treatment in several important areas. In addition, the committee staff identified several instances where a lack of interagency coordination is contributing to unnecessary duplication, inefficient use of resources, and, in some cases, quality of care issues for clients. At its public hearing in October 2008, the PRI committee received testimony from providers that, when funded by multiple state agencies, they must file essentially the same financial data on up to three or more forms. Committee staff confirmed this during site visits of several contracted substance abuse treatment agencies.

Providers also cited cases where they are required for billing reasons to schedule substance abuse and mental health treatment sessions on consecutive days, rather than having clients receive both required services during one trip to a facility. Some providers also believe they must close out client records prematurely to be in compliance with administrative reporting requirements, even though this results in duplication of effort for the provider and client, and unnecessary expense for the service funder, when an individual returns to active treatment in a short amount of time.

Another example of costly duplication is the fact that agencies providing both mental health and substance abuse services must have two separate licenses from the Department of Public Health. DMHAS has been involved in a public health department project to develop a combined behavioral health care license for such providers. Until about six months ago, it also was working with DPH staff to update the long-outdated regulation on substance abuse treatment.

At this time, it appears both initiatives are under internal review with DPH and the timeframe for completion is unclear. Opportunities to streamline administrative procedures and create efficiencies should not be missed, particularly given the state's current fiscal climate.

In terms of coordinating information, DMHAS has made considerable progress in maintaining a centralized repository of substance abuse treatment data as required by state statute. Also, as mandated, it is producing the statewide biennial report on substance abuse. The report is a true interagency document that contains: cross agency data on inputs and outputs for substance abuse treatment; and information on trends in substance use and abuse based on consistent definitions and methodologies.

While the biennial report is required to contain a summary of service effectiveness in terms of treatment outcomes, along with a state-wide cost analysis, only agency-level expenditure information is provided at this time. In general, examination of spending by level of care, by type of treatment program, or per client is not possible with current data systems and staff resources.

The lack of coordinated information systems across state agencies and systems is a long-standing issue throughout state government that many groups are trying to address. For several years, DMHAS has been working through ADPC to improve data sharing, particularly concerning clinical behavioral health treatment information, among all state agencies serving individuals with substance abuse problems as well as the Judicial Branch. The two main barriers are: technical issues related to interoperability of state automated systems; and administrative, which primarily concern privacy laws and differences in agency policies about informed consent and release of information.

The Alcohol and Drug Policy Council has been focusing on these issues and its latest report (December 2008) contains recommendations to improve information coordination, including development of an interagency Memorandum of Agreement that will facilitate sharing of client-level information related mental health and substance abuse treatment. The council report also outlines steps for technological improvements to promote sharing of treatment information among criminal justice and health care agencies.

The committee believes the council's data sharing proposals are effective ways to coordination of information all agencies need for better treatment planning, service delivery, and outcome monitoring. Implementation should be made a priority by DMHAS, as co-chair of ADPC and the state's lead agency for substance abuse.

In regard to resources for data analysis, the committee found there is little internal capacity for data analysis within any of the three agencies that fund and provide substance abuse treatment at present. As noted in the previous section, DMHAS and CSSD have small numbers of employees allocated to research and evaluation for all programs and services they fund while DOC has no staff solely dedicated to this function.

In addition, the body of research about state treatment programs and services all three agencies are producing is not being brought together and reviewed as a whole. As a result, DMHAS, as lead agency, is losing opportunities to identify patterns and trends about treatment outcomes, as well as missing chances to share research resources and potentially avoid duplication of effort.

The committee found there is a general lack of public information on what impact the treatment system is having on state's substance abuse problems. The current biennial report is the department's best effort at system wide assessment of treatment outcomes but its value to informing policy and funding decisions is limited by its current scope and timeframe. At this time, DMHAS does not produce any type of "report card" information regarding the state treatment system.

As a SAMHSA technical assistance document notes, report cards are a way to present systematically organized data on standardized measures that are associated with specified standards and goals. Increasingly, private organizations and state agencies are using them to examine individual program as well as system wide performance. They allow managers, policymakers, consumers, and the general public examine and compare information about key outcomes, determine whether programs and systems are meeting goals, and identify unmet needs as well as areas for improvement.

Producing reports cards can require significant investment in the infrastructure necessary to collect standardized, reliable information on outcomes. DMHAS has a strong foundation for a report card through its current automated data systems (e.g., SATIS and GABHP). In addition, the commissioner recently established an internal workgroup to develop and implement a strategic process for: defining organizational goals and direction; evaluating performance and outcomes; and communicating strategic initiatives to internal and external stakeholders. Developing and implementing a report card for the state substance abuse treatment system could be a task for this group. The workgroup also could have primary responsibility for carrying out the strategic planning process recommended above.

Finally, the department should be using the considerable data produced about clients and services to track more than program-specific or individual treatment effectiveness. It needs to aggregate available information to identify where there are strengths and weaknesses across levels of care and client populations.

When DMHAS has used performance and outcome information to inform policy and resource allocation decisions, results have been impressive. One example is the department's Opiate Agonist Treatment Protocol (OATP) initiative, a program that identifies opiate-addicted clients with multiple admissions to expensive residential detoxification programs and helps connect them with a continuum of lower intensity, and less costly, treatment and recovery support services. Agency analysis of OATP results shows the program addresses both ineffective treatment practices and inefficient uses of state resources.

For all of the reasons outlined above, efforts like OATP tend to be special projects rather than routine operating procedure. The committee believes, that DMHAS, in its role as lead substance abuse agency, should be collecting, monitoring, and reporting data on the effectiveness of the publicly funded treatment system on a regular basis. It also should be actively researching and promoting consistent best practices across agencies and throughout the system. Specifically, the department should be:

- Tracking performance measures and outcomes for the overall system and its component parts (e.g., the state-operated and state funded treatment programs, all levels of care and recovery support services), as well as monitoring individual client outcomes;
- Reporting to policymakers, stakeholders, and the general public on system wide and individual provider performance on regular basis; and
- Ensuring adequate internal and external capacity, including good quality data, for research and evaluation of treatment effectiveness.

Therefore, the program review committee recommends:

26) The statutes shall be amended to establish clearly that DMHAS is the state lead agency for substance abuse.

27) DMHAS should create and lead an interagency workgroup, composed of its own staff responsible for fiscal, contracting, and provider monitoring functions, as well as staff from other state agencies that fund and/or oversee substance abuse treatment services, including CSSD, DOC, and DPH, to study and address such matters as:

- **rules and regulations that are at odds with best care practices (e.g., appointments on separate days) and needless duplication of effort (e.g., repetitive financial forms);**
- **a standard plan of care so no matter what “door” a person comes in for treatment, there will be a consistent approach to developing the care plan, each plan will address a full continuum of services (from detoxification, if needed, to aftercare), and it will follow the client through the publicly funded system;**
- **better sharing of data, including regular distribution of DMHAS monthly and semi annual provider performance reports and profiles to CSSD and DOC; and**
- **ways to track and report on connection to services and treatment outcomes for DOC and CSSD clients with substance use disorders following discharge from the criminal justice system.**

28) DMHAS should begin working closely with the Department of Public Health to have updated substance abuse treatment regulations and the new combined license for dual behavioral health care providers in place by July 1, 2010.

- 29) The department should also conduct, with assistance from DOC and CSSD, a formal analysis of the costs and benefits of the collaborative contracting project to determine its impact on: standardizing rates paid by participating agencies; reducing administrative expenses of providers; and improving access to, and utilization of, available residential treatment resources.
- 30) DMHAS should restructure its existing staff resources allocated to planning, monitoring, and evaluation to create a centralized unit responsible for comprehensive strategic planning and quality improvement. It should also serve as the department's best practices unit, identifying effective treatment approaches and performing a clearinghouse function on policies, programs, and activities followed by Connecticut programs with good outcomes. Further, it should be a central repository for all state agency internal and external research products on treatment effectiveness.
- 31) Finally, the department shall prepare a "report card" for the publicly funded substance abuse treatment system that addresses, but is not limited to, the following areas: access to treatment; quality and appropriateness of treatment; treatment outcomes, including measures of abstinence and reduced substance use, as well as quality of life improvements related to employment, living arrangement, criminal justice involvement, and family and community support; and client satisfaction. At a minimum, the report card should be posted on the agency website and included in the biennial report.

APPENDIX A

APPENDIX A

Agency Monitoring Activities

The program monitoring and treatment quality activities of the Department of Mental Health and Addiction Services (DMHAS), as well as the two criminal justice agencies involved in substance abuse treatment for adults, were examined by the committee to determine the absence or presence of identified best practices. In addition to generally accepted models for effective quality assurance, program review committee staff identified several other best practices specific to substance abuse treatment that have been found to contribute to successful outcomes. These include agency policies and procedures related to: substance use testing; evidence- or research-based practices; discharge planning and aftercare; and external credentialing.

The committee also gathered information on the resources each agency allocates to monitoring of the substance abuse treatment services it funds or operates, and on the agency's data systems that support monitoring efforts. Finally, information was compiled about the outcome and performance measures each agency uses in monitoring substance abuse treatment services and any internal and external research projects conducted on treatment services.

Results of the analysis are presented below. Separate descriptions are provided for DMHAS, the Court Support Services Division (CSSD), the Department of Correction (DOC) facility-based treatment system, and the DOC parole-based treatment system.

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Within the Department of Mental Health and Addiction Services, the Health Care Systems (HCS) Division has primary responsibility for quality assurance and quality improvement functions related to the agency's network of contracted behavioral health service providers. It also has certain monitoring responsibilities for the state-operated treatment programs at DMHAS facilities.

Another division, Evaluation, Quality Management and Improvement (EQMI), supports the Health Care Systems program monitoring function by assuring the quality of the client and service data within the department's automated information systems for all external providers and for its own facilities. EQMI staff also capture and report certain program-based information (e.g., monthly provider performance reports) and has some capacity to analyze key operational data, such as critical incidents (e.g., client death or serious injury) or the use of client restraints and seclusions, for specific providers, levels of care, or the overall system.

At present, the HCS staff oversee approximately 200 private, primarily nonprofit, mental health and substance abuse programs funded through DMHAS grants and/or fees for service. Almost half (89) provide clinical substance abuse treatment services, from inpatient detoxification to outpatient counseling, to DMHAS clients. The division also monitors 79 private providers that receive state and federal funding to carry out certain recovery support

programs (e.g., housing, transportation, vocational/employment assistance and other nonclinical services) targeted to help clients with alcohol and drug abuse problems.

The HCS division's main monitoring efforts, highlighted below, are aimed at: checking private provider compliance with state and federal regulations and DMHAS standards, policies, and contract requirements; ensuring access to and delivery of quality services that meet client needs; and assuring consistent service delivery statewide. HCS staff review provider compliance with the provisions of their state human services contracts if they are grant-funded, and, when applicable, with requirements of their fee-for-service agreements under the department's managed care program, the General Assistance Behavioral Health Program (GABHP).

Of the 89 current DMHAS funded providers, 40 are nonprofit programs that receive state grants to provide clinical substance abuse treatment to the department's client population. All but one of the grant-funded nonprofits also participate in the agency's fee-for-service managed care program. (Only nonprofit agencies are eligible for state human services grants.) Another 52 private providers, including 25 general hospitals, provide clinical treatment services to eligible adults with substance abuse disorders just on a fee-for-service basis through GABHP. There is one additional general hospital that receives both GABHP and grant funding.

Monitoring and quality assurance. Routine monitoring activities carried out by HCS staff to assess quality and compliance of substance abuse providers include:

- semi-annual desk analyses of every funded provider as well as state-operated programs;
- on-site program reviews of varying intensity, as needed, based on desk analysis results, and at least every two years;
- bi-annual on-site program review meetings with top management of each provider;
- analyses of grant application provisions each funding cycle; and
- focus groups and client/consumer interviews during site visits, and as needed.

Desk analyses are twice yearly reviews of program data reports prepared by the EQMI Division and the agency's fiscal and information technology offices that permit HCS staff to compare key measures of provider performance to benchmarks, statewide averages, agency standards, and contract requirements. Results from the department's annual consumer survey, which include several indicators of client and family satisfaction with services, also are reviewed during a provider desk analysis.

Results of each desk analysis are summarized in a written report that identifies areas of concern, noncompliance issues, and program strengths, and contains any staff recommendations for improvement. Reports that find unfavorable results trigger additional monitoring, such as on-site visits by the division staff, and can require the provider to prepare and implement a corrective action plan (CAP). All private providers are visited by HCS staff at least once every two years that involves, at a minimum, a meeting with the agency leadership to go over operations and performance.

In addition to routine monitoring activities, HCS staff are responsible for following up on all critical incidents that occur in state-funded private provider programs, as well as consumer complaints related to any of the agency's mental health and substance abuse services. Site visits and corrective action plans can be triggered by what the division calls "egregious" critical incidents (e.g., a client death) and complaints or if other DMHAS divisions have major concerns (e.g., fiscal issues, failure to submit required data reports) about programs. Nonroutine monitoring also can occur when HCS staff are notified of provider licensing issues by the Department of Public Health or disciplinary actions taken by other funders or regulators (e.g., federal agencies or accreditation organizations).

According to the division director, at any time HCS staff are tracking the compliance progress of between 10 and 15 mental health and substance abuse provider CAPs. On average, division staff conduct about 10 provider site visits per month, which may be focused (limited to reviewing specific concerns) or comprehensive (thorough review of entire operation).

Providers found in compliance with contract requirements and department standards, are determined to be "In Good Standing," meaning additional monitoring or special conditions, such as limits on service expansion or funding restrictions, are unnecessary. Program in need of corrective action are placed in one of three HCS division categories that correspond to increasingly intensive levels of oversight, depending on the severity of the provider's deficiencies. These range from periodic written progress reports or phone calls ("Watch List"), to monthly reports and quarterly on-site meetings ("Under Review"), to biweekly reports, monthly on-site meetings, quarterly reviews, and funding/service restrictions ("Under Serious Review").

In nearly all cases, it appears the department is able to work with providers to resolve compliance and performance issues satisfactorily with its corrective action process. The HCS director noted, over the past two years, only one provider has been defunded and another, at the department's suggestion, shifted its program from residential treatment to a lower level of care (i.e., a recovery house). According to the director, providers return to good standing within 12 months about 90 percent of the time.

During FY 08, the division conducted desk analyses for 62 substance abuse provider agencies. At the end of the fiscal year, 55 (89 percent) were in good standing; seven agencies were under review or serious review. Most were expected to return to good standing within a year.

A total of 16 provider agencies encompassing 44 different substance abuse treatment programs received either a focused or comprehensive site visit by the division's regional teams during FY 08. HCS staff also visited 14 providers as a result of complaints or critical incidents.

The division does not aggregate information about compliance and performance issues included in corrective action plans or noted during site visits. However, the HCS director reports the most frequent areas noted for corrective action are: data documentation; data submission; documentation of service quality and frequency; and underutilization.

Other contract compliance. As noted above, the division has oversight responsibility for the department's managed behavioral health care and recovery supports programs. One of its main duties is to monitor adherence by the program's Administrative Service Organization (ASO), Advanced Behavioral Health, with its contract provisions.

Compliance with administrative performance standards and with agency policies regarding the GABHP and Access to Recovery (ATR) programs is checked primarily twice monthly meetings with ASO management staff and by reviewing monthly data reports generated by the ASO. For example, the division's GABHP program supervisor receives reports on: timeliness of response (to provider and consumer telephone calls); claims processed; clinical reviews and authorizations; denials and appeals; and provider and consumer satisfaction ratings. According to the department, the ASO's performance to date has been satisfactory.

HCS staff also review routine provider profile reports produced by the ASO, which include admissions data, utilization rates, length of stay information and certain performance measures. At present, the profile reports are generated twice a year and mailed directly to the provider agencies. The department can and does request the ASO to generate ad hoc reports in order to look at trends and patterns among the different client populations, types of services, levels of care, geographic areas, or other areas of special interest for monitoring or planning purposes. GABHP and ATR payment data are reviewed every week by the agency fiscal office and cost information is also included in provider profile reports submitted to HCS monitoring staff.

State-operated programs. As described in the committee briefing report, DMHAS operates inpatient treatment programs for adults with substance use disorders at three state facilities and directly provides outpatient services at another state facility operated in cooperation with Yale University. The program review committee found the department's monitoring and quality assurance process for its state-operated programs is in transition. Furthermore, there is little centralized operational or outcome information on the state-operated alcohol and drug treatment drug programs.

The agency's automated data system for its facilities is in the process of a major upgrade. The current system produces little management information and is of limited use for reporting even basic performance data from state-operated programs. To meet a PRI staff request for client and service information (e.g., admissions and discharges, length of stay and utilization by level of care), data had to be obtained separately from each facility. While each facility has developed its own systems and databases for monitoring and reporting purposes, they appear to vary in quality and capacity.

PRI staff toured one DMHAS substance abuse treatment facility (Connecticut Valley Hospital) and interviewed selected staff to gain a better understanding of how state-operated programs are monitored. Based on this field work, it was determined multiple site visits of all four DMHAS facilities programs would be required to fully assess their quality assurance processes. This was not feasible with the study timeframe. Therefore, the following description highlights the main central office oversight activities in place at the time of the committee study

Under a relatively recent reorganization of agency top management (effective March 2008), all state-operated mental health and substance abuse programs report to one deputy commissioner. Routine reporting requirements and other monitoring procedures for the state-operated treatment programs are still being developed by this deputy commissioner.

At present, the deputy commissioner reviews the critical incident reports from all state-operated programs and monthly readmission rate and daily census reports from the state residential treatment programs. The EQMI division prepares monthly performance profile information for the state-operated substance abuse treatment programs, as well as regular analysis of seclusion and restraint data from the inpatient programs. According to the division director, one way managers use this information is to develop training initiatives and other support for inpatient treatment programs with higher than expected use of seclusion and restraints.

The department's health care systems staff also conduct semi-annual reviews of performance data from the state-operated substance abuse treatment programs. Unusual trends or concerns based on the review are reported the deputy commissioner for state facilities. If requested by the DMHAS executive team, the division's regional teams will conduct site visits to follow up on complaints received about state-operated programs. The department was unable to provide monthly performance reports or any summary of information based on HCS reviews or site visits of state operated programs to the committee in time for inclusion in this report.

While DMHAS substance abuse treatment programs are not subject to DPH licensing requirements, all department facilities are nationally accredited. In accordance with accreditation requirements, the facilities must have certain quality assurance and improvement procedures in place. For example, each department facility has an internal quality improvement team or committee for its substance abuse treatment programs that, among other duties, reviews critical incidents and audits compliance with clinical practice standards (e.g., treatment planning, supervision, client record documentation).

Samples of internal quality improvement materials provided to the committee indicated the state facilities have similar, but not standardized, processes. DMHAS central office has not compiled information about each program's quality assurance policies, procedures, or structure. In addition, the department has: no inventory of the types of assessment tools, treatment programs, or evidence-based practices in place at each state-operated program; no centralized information on wait lists and other access indicators at each facility (other than the daily census report); and no single source of information on licensure/certification status of each program's clinical professionals and counselors.

System monitoring. On a regular basis, the HCS Division director reviews certain standard reports on provider performance to assess the overall network of mental health and substance abuse treatment services. These include: the monthly provider profile reports prepared by EQMI that summarize compliance with data quality standards as well as key performance measures; the semi-annual, as well as any ad hoc, performance reports produced by the ASO for providers certified to participate in General Assistance Behavioral Health Program; summaries of the regional team desk analyses; and daily census and other utilization rate reports compiled for all state-funded or –operated residential treatment programs.

Currently, provider performance information from all sources is not aggregated or compiled into any type of “report card” document for the service system, although that concept has been under discussion at DMHAS. Further, the department does not, on a routine basis, share the provider performance and outcome information it develops with other state agencies that fund substance abuse treatment services for adults. One exception is provider site visit reports completed for the residential programs that are part of the collaborate contract; those are shared with CSSD and DOC. Additionally, the department’s annual consumer satisfaction survey results are forwarded to the correction department commissioner and the CSSD director.

Selected best practices. Findings concerning application of the selected best practices by DMHAS are summarized below.

Substance use testing. Under DPH regulations, licensed providers that operate detoxification and/or chemical maintenance programs have provisions in place for regular urine testing. DMHAS has guidelines concerning testing for substance use during certain types of treatment but has not adopted any general policy about testing practices including consequences for positive results.

Some agency contracts do contain provisions regarding drug screening (e.g., the collaborative contract with criminal justice agencies for residential treatment services requires random testing on all CSSD and DOC program participants at least once per week). In addition, the minimum criteria for GABHP certification for some types of treatment programs require certain drug use screening procedures. Information about provider testing policies and procedures, or the results of such activities, is not compiled and analyzed. On an individual basis, HCS regional teams would review a provider’s substance use testing activities during their on-site monitoring visits.

Evidence- or research-based practices. Providers are encouraged under DMHAS policies and guidelines to use evidence-based practices, including Motivational Interviewing and Motivational Enhancement Therapy, as well as what it has identified as best practices, such as trauma-informed, gender specific, and culturally competent care. Evidence-based or best practices are required for some specific types of care (i.e., chemical maintenance, two types of enhanced co-occurring care, and one kind of outpatient treatment).

Training and technical assistance on a variety of evidence-based and best practices is offered to department staff and employees of contracted providers through the DMHAS Education and Training Division. The department does not compile information on the types or amounts of training in evidence-based practices the employees of substance abuse treatment programs have received. A database of individuals who participate in any of training division offerings is maintained.

Under the department’s *Practice Guidelines for Recovery-Oriented Care (2nd edition)*, services and supports funded or directly provided by the agency are expected to be consistent with the following national Institute of Medicine quality measures: person-centered; timely/responsive; effective; equitable; efficient; and safe. The guidelines also expect providers to use best available practices that are linked with positive outcomes on the basis of expert opinion, promising research, or scientifically established evidence.

Programs are required by contract or by GABHP certification criteria, in a few cases, to employ an evidence-based treatment model (e.g., certain intensive outpatient programs funded by DMHAS must use the evidence-based “Matrix” model of care). Many DMHAS providers are known to incorporate evidence- and research-based practices within their substance abuse treatment programs. At present, there is no centralized inventory of the types of care and services available through the state system of alcohol and drug abuse treatment.

As part of their monitoring site visits, HCS staff may review model fidelity if specific treatment or service designs are required, such as some evidence-based and emerging best practices. This appears to occur infrequently; recently, some effort has been made to monitor certain best practices related to co-occurring disorders. Also, in the past, particularly for mental health program, providers have been sent materials to conduct self-assessments of fidelity to evidence-based practice models, which were then reviewed by HCS staff.

The department does not conduct any formal, systematic assessment of the therapeutic alliance between a program’s treatment staff and their clients. However, HCS staff do interview program participants and/or conduct focus groups during site visits to get feedback from clients on their treatment experience. Data on client satisfaction ratings of treatment program staff also is collected through the annual consumer survey.

The department recently mandated all of its funded and operated behavioral health programs to use standardized screening tools, which are scientifically validated tools recommended by SAMHSA, to identify clients at risk of co-occurring conditions during the admission process. Substance abuse program providers are required under DPH regulations and DMHAS policy to conduct a complete biopsychosocial assessment of all clients admitted for clinical treatment.

In addition, as discussed in the committee briefing report, all providers must use the certain standardized criteria for pre-admission screening (i.e., the department’s Connecticut Client Placement Criteria, which are based on the American Society of Addiction Medicine criteria). However, the department does not specify any particular instrument or group of evidence-based assessment tools be used.

State law and department policy do require that clinical substance abuse treatment services, which include assessment and treatment planning, be performed by, or under the supervision of, a licensed health care practitioner. It is possible, therefore, for staff members who are not licensed or certified, to conduct assessments (and perform other clinical services) if supervised by credentialed clinicians. Supervision is not specifically defined in statute or regulation; it appears, based on discussions with DPH staff, that review of noncredentialed staff who provide clinical services by a licensed professional clinician must occur at least weekly.

According to DMHAS staff, most providers use one or more of the many evidence-based assessment tools available for determining client alcohol and drug abuse treatment needs and planning appropriate clinical and support services. Information on the substance abuse assessment instruments and procedures used by treatment programs, or their supervision policies for staff who are not licensed or credentialed, is not compiled by the agency’s monitoring units.

Discharge planning/aftercare. DMHAS clients, in accordance with state law and/or regulation, as well as agency policy, must be treated in accordance with an individualized treatment plans that include a plan for discharge that addresses appropriate aftercare. Department policies and guidelines emphasize the importance of providing aftercare and recovery supports to sustaining positive treatment outcomes. At this time, data on the number of substance abuse clients who receive services to support their recovery following treatment, the types of services provided, and outcome information related to aftercare, is not tracked systematically by the department.

The department, as required by federal grant requirements, does conduct follow-up interviews six month after intake with individuals participating in the Access to Recovery program; at least 80 percent of all clients must be interviewed about the outcomes of the services they received. DMHAS also gathers some information about the aftercare services provided through its Telephone Recovery Support program, described briefly below. Data on referrals made at time of discharge are gathered through the department's substance abuse provider information system but are not compiled and analyzed at this time.

The value of nonclinical services that support recovery like housing, transportation, employment assistance, and help with basic needs, is widely recognized. However resources for these services for DMHAS clients are limited. The only widely available services for adults in recovery are community-based self-help groups like AA and NA. DMHAS recommends that all of its funded providers and state-operated programs, when discharging clients, make referrals to community-based self-help organizations.

At present, DMHAS operates two main recovery support programs, the federally funded Access to Recovery program and the state-funded General Assistance Recovery Supports Program (GA RSP). Now in its second phase, the Access to Recovery program (ATR II), is focused on providing a broad range of recovery support services and assistance to adults with alcohol and drug abuse problems, with an emphasis on those who are involved in the criminal justice or child welfare systems. Services also are available to those DMHAS clients with an opioid dependence for which buprenorphine is an appropriate treatment. Over the three-year funding period of ATR II, the department expects to serve about 9,000 individuals, with federal grant monies totaling about \$14.5 million.

The state GA Recovery Supports Program helps with housing and other basic needs (e.g., food, clothing, personal care items) for eligible SAGA clients who are engaged in mental health or substance abuse treatment. Over the past three years, the state recovery support program has served about 7,000 individuals a year.

DMHAS also has undertaken several initiatives that provide intensive case management for certain SAGA clients identified as having serious challenges achieving and maintaining recovery. Two of its General Assistance Intensive Case Management Program initiatives targeted to clients with substance use disorders are: Alternative to Hospitalization, which diverts clients from emergency rooms to more appropriate co-occurring residential services; and the Opioid Agonist Treatment Protocol (OATP), which helps opioid dependent clients with frequent readmissions to residential detoxification programs enter less intensive treatment such as methadone maintenance and receive recovery supports.

Even taken together, the agency's various recovery support initiatives can serve only a portion of the thousands of adults who receive care through the state's substance abuse treatment system and could benefit from such services. Recognizing this unmet need, the department began funding telephone recovery support services in 2004 as a relatively low-cost way of providing some level of aftercare to more of its substance abuse client population. The Telephone Recovery Support (TRS) program was expanded statewide in 2007 and is carried out by the nonprofit community-based organization, Connecticut Community for Addiction Recovery (CCAR) .

Through this program, adults newly discharged from a substance use treatment program receive a phone call once a week for at least twelve weeks from trained volunteers to check on their recovery. The volunteers provide encouragement to those who are sustaining recovery and can assist individuals reporting a relapse to return to treatment if necessary. As of January 2008, there were almost 500 individuals enrolled in the CCAR telephone support program.

To promote participation in the program, DMHAS recently recommended strongly that providers make clients aware of the telephone recovery support program at time of admission to treatment. The department also recommends providers seek each client's permission to give the program operator his or her contact information.

External credentialing. All private providers funded by DMHAS must be licensed as substance abuse treatment facilities by DPH. Many private providers funded by the department also are accredited by the Commission on the Accreditation of Rehabilitation Facilities or the Joint Commission. DMHAS does not maintain aggregated information on the accreditation status of its private providers.

DMHAS has established its own, additional certification process for providers that participate in GABHP. Certification requirements were developed for each level of care that set standards in addition to public health department licensing regulations. These include minimum criteria, relevant to each type of treatment program, related to: facility accreditation; staff credentials, admissions and assessment procedures; discharge planning and referral to aftercare; drug screening; and educational and therapeutic programming.

The GABHP certification form also gathers supplemental information from each provider about: access to services (e.g., availability of assessment within a certain timeframe); coordination of care (e.g., communication policies with other providers regarding shared clients); procedures for handling clients with co-occurring disorders; and use of evidence-based practices. Specific data are gathered regarding the client population served, language competence of staff, problems and disorders treated, and program specialties (i.e., types of services and therapies provided in which two or more staff have education, training, and supervised experience).

Provider of services funded through the department's Access to Recovery program are subject to a similar certification process. However, none of the detailed program or supplemental information gathered through either certification process is aggregated or compiled as any type of provider profile report by DMHAS.

All professional health care providers employed by the DMHAS funded or state-operated substance abuse programs (e.g., physicians, nurses, psychologists, professional counselors and social workers) must have appropriate licenses from the Department of Public Health. DMHAS, however, does not require that all staff providing clinical services to clients of alcohol or drug programs it funds or operates be credentialed. Direct care staff who may provide alcohol and drug counseling and conduct assessments do not have to be licensed or certified.

As noted above, state law does require noncredentialed staff of substance abuse treatment facilities to be supervised by licensed professionals if they render clinical services, although supervision is not defined in either statute or regulation. Supervision requirements for staff who are not licensed or certified are outlined in the DMHAS minimum criteria for GABHP certification and program policies.

DMHAS does not maintain centralized information on the license/certification status or education, training, and experience of staff at its funded or operated substance abuse treatment programs. A survey conducted by the department in 2002 indicated just over 90 percent all of the addiction counselors working in the state-operated or funded programs that responded to the survey (80%) had at least a college-level associate's degree; experience in the addictions field averaged almost 10 years.

Source data for the survey could not be located and the information has not been updated in any systematic way. However, the department is beginning to examine a number of behavioral health workforce issues, partly in response to a projected shortage of qualified substance abuse and mental health clinical staff, as well as high staff turnover rates many providers are experiencing. Through its federally funded Mental Health Transformation initiative, DMHAS is creating a permanent public-private body (the Connecticut Mental Health Workforce Collaborative) to plan, coordinate, and implement interventions to strengthen the behavioral health workforce.

Outcome and performance measures. DMHAS collects a considerable amount of performance and outcome data regarding all the behavioral health services it funds and operates. As discussed above, detailed information about substance abuse clients and treatment services is gathered through two provider information systems (i.e., the SATIS and GABHP automated data systems) and is the basis for: 1) information on outcome measures included in the agency's provider profiles and performance reports; and 2) tracking compliance with outcome measures contained in provider contracts.

National outcome measures. Much of the outcome information gathered by the department is mandated by federal law and block grant funding requirements. Annually, all states must report to SAMHSA on National Outcome Measures (NOMs) related to mental health services and substance abuse treatment and prevention. At present, the NOMs for substance abuse treatment are:

- Abstinence from *alcohol and drug use* or decreased use;
- Increased/retained *employment/education* participation;
- Decreased *criminal justice involvement*;
- Increased stability in *housing/living arrangement*;

- Increased social supports/*social connectedness* (e.g., as federal indicators are still under development, Connecticut uses participation in community-based self-help groups for this measure);
- Increased *access* to services (i.e., service capacity as measured by unduplicated counts of persons served and penetration rates); and
- Increased *retention* in treatment (length of stay data).

Three additional substance abuse treatment NOMs related to client perceptions of care (gathered through consumer surveys), cost effectiveness, and use of evidence-based practices, still are under development by SAMHSA. There is little or no state reporting in these areas at this time and no federal requirement to do so.

DMHAS uses the five NOMs that concern client status in terms of substance use, employment, crime, housing, and social supports, to evaluate its funded and operated substance abuse treatment programs. (The access and retention measures are treated by the department and SAMHSA as system performance indicators.) The department also requires providers to report on, and regularly review, four additional outcome measures related to substance abuse treatment effectiveness:

- *Treatment completion* (based on client discharge status, to measure how many persons admitted to a program complete it);
- *Improved functioning* (based on changes in a client's GAF score, which is a standardized assessment of ability to function, to measure overall progress toward recovery);
- *Connection to care/continuity of care* (based on discharged clients receiving treatment services at a less intensive level within a certain timeframe, to measure whether clients connect with further appropriate treatment to facilitate recovery); and
- *Readmission* (based on discharged clients receiving treatment services at an equally or more intensive level within a certain timeframe, to measure whether clients cycle repeatedly through the same levels of care or continue toward recovery through programs of decreasing intensity).

Some NOMs information is posted on the agency website and reported in the agency's federal block grant application during the public comment period. However, neither the national outcome data nor the department's other provider performance information are routinely aggregated or periodically summarized and reported to the public. At the request of the committee, the department compiled treatment completion and certain NOMs for the major components of the state system over a three-year period.

Table 1 shows treatment completion rates for adults discharged during three recent fiscal years, overall and by level of care. (Methadone maintenance program data are not included here.) The rate is the number discharged as completing treatment divided by the total number admitted to the care level. (excluding those with missing matching data). Completion is defined as having a discharge status of completing treatment with or without referral to another level of

care, or having left treatment with staff advice and a referral (e.g., transferred to another level of care).

Table 1. Connecticut Treatment Completion Rates by Level of Care: Percent Completing Treatment (%) and Total Discharged (N)*						
Treatment Level	FY05		FY06		FY07	
	%	N	%	N	%	N
SA Detox Hospital	82.8	2,902	84.0	3,369	81.7	3,318
SA Detox Res	77.7	10,937	76.6	9,505	77.4	9,079
Rehab Res Hospital	67.0	1,553	74.0	1,644	75.8	1,703
Rehab Res ST	83.9	2,674	82.1	2,414	81.8	2,385
Res LT	62.8	2,999	61.2	3,111	65.8	2,873
IOP	55.3	2,938	47.9	2,941	51.0	2,821
OP	47.7	10,936	45.5	11,209	51.0	9,645
Ambulatory Detox	80.1	870	84.3	857	85.4	714
All	66.3	35,809	64.4	35,050	67.6	32,538
* Total discharges with matching admission data Source of Data: DMHAS						

In total, about two-thirds of those who entered treatment completed their level of care. Completion rates vary widely by level of care and are higher for residential than outpatient programs. Rates were highest (80 to 85 percent) for two types of detoxification programs (hospital and ambulatory) and short-term residential care. Both outpatient and intensive outpatient levels of care had the lowest rates of completion (45 to 55 percent).

Completion rates for methadone maintenance programs were provided for a different three-year period (FYs 06- 08). As shown in Table 2, they are comparable to the outpatient program rates and range from around 52 percent in FY 06 and FY 07, to 59 percent in FY 08.

Table 2. Connecticut Methadone Maintenance Treatment Completion Rates: Percent Completing Treatment (%) and Total Discharged (N)						
Treatment Level	FY06		FY07		FY08	
	%	N	%	N	%	N
Methadone Maintenance	52.9	4,227	52.0	4,212	59.1	4,263
* Total discharges with matching admission data Source: DMHAS						

Results on six National Outcome Measures are presented for FY 05 through FY 07 for Connecticut’s substance abuse treatment system overall and by level of care in Table 3. (These data, however, exclude all methadone maintenance and inpatient and residential detoxification clients.) In each case, the outcome measure represents the portion of clients with an improved status between admission and discharge. Measures are only calculated where appropriate data exist at both admission and discharge.

Table 3. Connecticut National Outcome Measures by Level of Care:
Percent with Improved Status (%) and Total Discharged (N)

	FY 05		FY 06		FY 07	
Employment Status	%	N	%	N	%	N
ALL	6.6	9,919	7.0	9,984	9.4	10,188
Rehab Res Hospital	1.7	1,169	0.8	1,308	1.1	1,339
Rehab Res ST	1.0	502	1.8	381	0.5	613
Res LT	15.1	636	11.8	756	13.7	713
IOP	4.3	1,363	5.4	1,454	7.6	1,561
OP	8.0	5,906	8.7	5,851	12.3	5,775
Ambulatory Detox	2.0	343	0.9	234	4.8	187
Living Situation	%	N	%	N	%	N
ALL	15.1	17,006	15.8	16,430	14.6	15,834
Rehab Res Hospital	20.5	1,251	22.8	1,353	22.0	1,368
Rehab Res ST	17.6	2,465	23.1	2,125	22.0	2,108
Res LT	36.8	2,141	40.9	1,953	32.2	1,701
IOP	9.5	2,309	7.1	2,505	12.9	2,425
OP	9.1	7,917	8.7	7,656	8.3	7,567
Ambulatory Detox	16.5	842	17.8	838	8.4	665
CJ Involvement	%	N	%	N	%	N
ALL	6.9	21,154	6.5	21,758	6.7	19,685
Rehab Res Hospital	8.9	1,323	6.8	1,502	9.9	1,531
Rehab Res ST	10.3	2,653	12.5	2,413	10.5	2,385
Res LT	9.0	2,978	7.9	3,104	6.9	2,865
IOP	6.4	2,918	7.1	2,939	7.0	2,821
OP	5.3	10,423	4.7	10,943	5.0	9,369
Ambulatory Detox	5.6	859	5.3	857	6.7	714
Alcohol Use: Abstinent	%	N	%	N	%	N
ALL	35.6	12,309	33.1	11,528	29.6	11,166
Rehab Res Hospital		710		695		766
Rehab Res ST	44.1	1,572	45.0	1,300	49.8	1,292
Res LT	39.9	1,675	38.1	1,610	25.4	1,488
IOP	45.2	1,785	42.6	1,722	38.9	1,545
OP	34.2	6,356	30.4	5,954	27.9	5,788
Ambulatory Detox	19.0	211	29.6	247	22.0	287
Drug Use: Abstinent	%	N	%	N	%	N
ALL	27.6	14,465	25.9	14,651	23.7	14,030
Rehab Res Hospital		1,116		1,220		1,293
Rehab Res ST	44.2	2,089	45.8	1,750	45.4	1,699
Res LT	34.0	2,371	33.7	2,533	25.7	2,274
IOP	36.0	2,242	34.5	2,286	30.4	2,180
OP	22.1	5,914	19.3	6,126	18.8	6,008
Ambulatory Detox	20.6	733	22.4	736	30.0	574
Social Support	%	N	%	N	%	N
ALL	32.8	16,105	33.1	17,227	35.1	17,291
Rehab Res Hospital	61.8	993	66.0	1,345	65.2	1,231
Rehab Res ST	55.2	2,536	57.2	2,276	60.6	2,247
Res LT	34.2	2,466	41.8	2,803	45.4	2,619
IOP	26.2	1,847	21.0	2,306	27.0	2,579
OP	23.8	7,470	21.8	7,782	22.7	7,955
Ambulatory Detox	21.2	793	20.6	802	34.2	626

Source of Data: DMHAS

The measures provide only a gross sense of the effects of the states substance abuse treatment system for a number of reasons. In general, they only capture immediate effects of a level of care at time of discharge. They do not reflect long-term impact or the cumulative effect of a complete treatment episode (i.e., total exposure to services when multiple levels of care are connected to meet client needs). In addition, these measures are based on all discharges, whether or not treatment was completed.

Finally, the way some measures are calculated limits their usefulness in indicating treatment effect. For example, the employment measure is only calculated for employed or unemployed at admission or discharge (those reported as not in the labor force, which tends to be a large category, are excluded). Regarding the criminal justice involvement measure, improvement is calculated only when: those who had been arrested in the 30 days prior to admission were not arrested in the 30 days prior to discharge. In general, at least 90 of those discharged had not been arrested within 30 days of admission, leaving a very small base number for the calculation. Similarly, for the social support measure, improvement is calculated only for those reporting having “no supports” at admission and are “supported” at discharge; all those reporting “not applicable” at admission are excluded.

Given these many limitations, analysis of the measures mainly leads to more questions than insights. It is important to note the NOMs system is still under development by the federal government; current measures really are prototypes for a more extensive reporting process that will provide better feedback on treatment effectiveness. For example, data collection methods still vary by state, making comparisons of outcome measures unreliable. For similar reasons, SAMHSA has not established any benchmarks for state performance on the measures. The information included in Table 3 is presented primarily to indicate the type of outcome data being gathered about substance abuse treatment, and their potential use in evaluating what types of programs and services help what types of clients get better. With continued refinement, the measures are what the committee believes DMHAS should be tracking in order to report about effectiveness of the state’s substance abuse treatment system.

Overall, Table 3 shows the employment and criminal justice measures for all discharges had the lowest levels of improvement (6.5 to 7 percent, except for improved employment status which was just over 9 percent for FY 07). Improvement in the measures for social supports and living arrangements were, respectively, around 33 percent and 15 percent each year.

About one third of discharged clients showed improvement in the alcohol abstinent measure, and around one-quarter in the drug abstinent measure, for each year. Improvement is calculated for those who used at admission and were abstinent at discharge. The rates also reflect clients who did not complete treatment as well as those who did.

The department did not provide any NOMs information for the methadone maintenance level of care. According to DMHAS, this is primarily because of the long length of time between admission and discharge (typical time in methadone maintenance treatment is over one year). DMHAS is planning to develop additional measures and collect outcome data at intervals prior to discharge to provide feedback on the more immediate impact of this treatment level. However, the lack of information about results of this important level of care is problematic for several reasons.

Decades of research on methadone show it is one of the most cost and clinically effective methods of treating addiction to heroin. As heroin use is a major problem in Connecticut, methadone maintenance is a critical component of the continuum of care, serving a large number of clients every year (over 12,500 in FY 08). Despite the scientific evidence, there still stigma and controversy associated with methadone and other opioid replacement treatments. In addition, testimony at the PRI committee's October 2008 public hearing, concerns were raised about adequacy of department oversight of the program providers.

Better information on both provider compliance and methadone treatment effectiveness could increase public confidence and acceptance. The department needs to give special attention to compiling and reporting outcomes for methadone maintenance and other opioid replacement therapies. It should at least be tracking and reporting on how long people remain in the program, whether they receive required counseling, and what, if any, if any improvement they experience in their quality of life because of the treatment they receive.

Provider performance report and profiles. The department generates and reviews a substantial amount of information on individual treatment provider performance and outcomes through its extensive provider accountability monitoring process. For example, all DMHAS human service grant contracts contain performance outcome measures. In general, the contract outcomes are a combination of expectations about service delivery and some NOMs and department provider measures listed above.

Contract outcome measures for DMHAS substance abuse providers vary for different types of service but typically include standards regarding: utilization rates; service intensity standards (e.g., number of contacts, hours of face-to-face service); treatment completion rates (e.g., percentages that complete, leave against medical advice (AMA), left with referral to other care); and customer satisfaction (e.g., positive consumer survey results). Most also contain goals regarding the portion of clients showing improvement in: substance use; living arrangements, employment status, and functioning level. Some newer contracts also contain outcome measures related to readmission and criminal justice involvement.

The performance and outcome data developed from the substance abuse provider contracts is not aggregated in any systematic way. As a result, this information cannot be used to identify programs, services, or practices within the provider network that appear more effective or to compare outcomes across providers. DMHAS does use the information to evaluate and monitor individual performance; at times, contract compliance information like residential program utilization rates is reviewed to assess system gaps and access issues.

Similarly, little of the outcome data captured in the department's provider profile and performance reports is examined beyond an individual program basis. At present, the monthly provider performance reports produced for all state funded and operated substance abuse treatment programs by the EQMI Division include: some client-based outcome measures (e.g., regarding substance use, living arrangement, employment, functioning); treatment completion and discharge status rates; and data on retention and length of stay. The semi-annual performance profiles of GABHP providers focus on two main outcome measures of treatment effectiveness: connect-to-care rates and readmission rates.

At most, these outcome measures are compared among providers within a level of care. Certain key indicators from the HCS desk analyses (e.g., utilization rates or AMA discharge rate) are compiled for all providers, by region, for general review by the division director and other managers. The information is used mainly to identify providers with unusually high or low performance statistics (“outliers”).

Comparative reports. The EQMI Division also prepares monthly statewide and regional analyses of all critical incident reports that funded and operated programs must submit to DMHAS. These data are used by regional managers and the department’s medical director to identify systemic issues or trends that require a comprehensive quality improvement approach (e.g., statewide training or new policy).

However, the department was unable to provide the committee, within the timeframe of the study, any type of “report card” on its private provider network, the state-operated treatment programs, or the state substance abuse treatment system overall. In the recent past, DMHAS has developed some prototypes for report cards based on other state and national models and reports it is in the process of refining some for future implementation.

Data reliability problems within the agency information systems (noted earlier) have been one impediment to more extensive reporting on provider performance and treatment effectiveness. Once they are addressed, the EQMI division is planning to revamp its information reporting process and products. The division is part of a recently created internal work group on information quality that is examining ways to improve the usefulness of all agency reports. It is also seeking to increase consistency, eliminate duplication, and centralize and standardize source data.

Cost effectiveness. In addition, the agency has long-range plans to match expenditure and outcome data as one way to identify the cost-effective programs and services. A prototype report in development for GABHP program providers will include several cost indicators (e.g., unit cost, average cost per person and per admission) in addition to client, length of stay, and outcome data. Better links between information on costs and services is viewed as a first step toward performance-based contracting.

Tracking cost-effectiveness is a challenge for several reasons. The department is able to monitor GABHP payments for substance abuse services easily, and in many ways (e.g., per client, by provider, by level of care, over time), because that program is a claims-based system. However, most nonprofit providers also are supported with state grant funding, making it complicated to determine the actual cost of the care DMHAS clients receive. Agency fiscal staff are just beginning to develop “blended” spending data that will allow more accurate comparisons of treatment costs among providers.

Longitudinal information. Another weakness of the agency’s automated outcome information is the limited timeframe of many of the measures. The NOMs and most of the department’s outcomes indicators are based on data collected about clients at admission and at discharge. In general, there is limited longitudinal information about treatment outcomes, as it is difficult and expensive to gather. Upgrades planned for the department’s provider and facility

automated information systems, however, will allow data to be collected at different intervals and provide the agency with greater outcome monitoring capability.

Research studies. DMHAS periodically conducts and participates in formal research studies and analyses of its substance abuse treatment services, including their long-term impact on clients. Since 2000 the department has been involved in at least five projects that directly address the effectiveness of substance abuse treatment in Connecticut. Two were done in collaboration with state criminal justice agencies and the results are discussed in descriptions of CSSD and DOC quality assurance activities.

During the late 1990s and early 2000s, DMHAS participated in a federal research initiative called Treatment Outcomes and Performance Pilot Studies (TOPPS II) that provided funding for outcome studies of treatment services for two special populations of substance abuse clients: 1) adults with concurrent mental health disorders (co-occurring conditions); and 2) pregnant and parenting women in treatment.

The first study focused on assessing the prevalence of those with mental health problems within the general addiction population and the treatment experiences and outcomes of clients with co-occurring conditions. The pregnant and/or parenting woman study evaluated the effectiveness of different treatment approaches for this special population. The results of both studies, reported in 2003, showed substance abuse treatment was positively related to subsequent improvements that clients reported in substance use, homelessness, criminal behavior, employment, and use of health and mental health services.

In 2004, DMHAS, in collaboration with the Department of Labor and Yale University, undertook a federally funded research study designed to examine the effect of substance abuse treatment on wages. Wage information for two years before and two years after entering treatment were examined for a study group of 3,000 adults admitted to treatment during FY 01. The main study findings were:

- On average, one year after admission to treatment wages for all persons in the study nearly doubled; comparing the two years before and after treatment, wages increased by 37 percent.
- Persons successfully completing treatment had greater wage gains than those who did not; completers' wages were double the earnings of noncompleters after one year and increases continued for the second year.
- The wage study confirmed previous research that shows treatment lasting 90 days or more works best. One year after entering treatment, persons with lengths of stay of at least 90 days had earnings 150 percent greater than those with treatment stays of less than 90 days.
- Two years after entering treatment, persons who received vocational or educational services while in treatment had more than twice the percentage increase in earnings (263 percent vs. 115 percent) as those who did not receive such services.

From time to time, DMHAS will use internal staff resources to examine the impact of various initiatives. In 2007, department staff, with the assistance of the agency's ASO, conducted a review of the accomplishments of the agency's first Access to Recovery (ATR I) program, as the SAMHSA grant funding it did not provide for an independent evaluation. Over a three-year period, the nearly \$23 million program served over 18,000 unduplicated individuals with substance use disorders by providing a complement of clinical substance abuse treatment and recovery support services. About 40 percent of those receiving ATR I services had no prior history with DMHAS.

The department's analysis of ATR I client and service data showed, at time of discharge from the program, the overwhelming majority of program participants were abstinent from alcohol and drugs (87 percent) and reported no arrests, jail, or prison time (98 percent). Forty percent had an increase in employment. DMHAS also found:

- Recovery supports like housing, transportation, vocational assistance and basic needs, provided with clinical services, appeared more effective than treatment alone in decreasing substance use.
- In general, the combination of clinical and recovery supports were predictive of better outcomes (decreases in substance use, criminal justice involvement, increases in employment, and stable housing).
- People were 1.5 times more likely to achieve positive outcomes if they received short-term housing support through ATR.

An internal review completed in October 2008 examined the impact of department's General Assistance Recovery Supports Program on treatment retention, as measured by connection to care. DMHAS found that 70 percent of GA RSP participants in FY 08 connected to the next level of care following inpatient treatment; in comparison, only 49 percent of individuals in the department's managed behavioral health care program (GABHP) who did not receive recovery supports continued in treatment. Further, only 11 percent of clients receiving GA RSP services dropped out of treatment after admission to inpatient care versus 25 percent of those who were not in the program.

The DMHAS Forensic Services Division (FSD) also is involved in research and evaluation of the behavioral health programs it develops and implements in collaboration with the state's criminal justice system. (Description were presented in the committee briefing report.) Several of the division's current collaborative initiatives are continuity of care programs based on national studies that demonstrate: integrated care systems for substance-involved offenders reduce recidivism; and continuing treatment post-release is critical.

According to the division, evaluations of successful continuity of care programs in other states found comprehensive drug abuse treatment in prison, coupled with treatment and aftercare following release from prison, resulted in 40 to 50 percent of offenders being drug-free one year later (compared with only 15 percent of those who were untreated). Also, only about 20 percent of offenders who completed treatment were rearrested during the first year after prison

(compared to nearly 60 percent of untreated offenders), and benefits appeared to be long-lasting (continuing at least four years after release.)

The division has evaluated early results of Connecticut's two current reach-in programs: the Connecticut Offender Reentry Program (CORP), which serves about 60 persons annually but may be expanded during FY 09; and Transitional Case Management (TCM), which serves about 110 people a year at present but also may be expanded. As both programs are relatively new and very small, outcome findings must be considered preliminary. However, FSD staff report that: CORP participants (76) had a recidivism rate of 13 percent following discharge from the program; TCM participants (156) has a 3.3 percent rearrest rate and a 4.6 percent reincarceration rate. Further analysis of longer term results is planned.

Two of the department's largest criminal justice collaborative programs are the drug and alcohol education diversion programs the division operates with CSSD for certain first-time offenders: Pretrial Alcohol Education System (PAES) and Pretrial Drug Education Program (PDEP). Together, the programs, which are funded primarily by participant fees, serve over 12,500 individuals a year. While based on best practices, neither has been formally evaluated. Also, data related to the programs are not reported through the DMHAS substance abuse treatment information systems (SATIS) as they are considered to provide alcohol and drug education rather than clinical treatment. Neither DMHAS nor CSSD could provide the committee with performance and outcome information on the PAES and PDEP programs within the study timeframe.

Consumer survey. One additional way the department evaluates the quality of its behavioral health service system is through its annual consumer survey. DMHAS uses the survey, which is based on a national instrument, to measure client satisfaction with the mental health and substance abuse services they have received. Respondents are asked to rate their satisfaction in general and regarding each of the following areas: access; quality and appropriateness; outcomes; participation in treatment; and respect from staff.⁵ The department added a Connecticut-specific area, satisfaction with recovery-oriented services, to the latest survey.

Surveys are administered through treatment providers, peers and others. Providers can add up to five of their own questions. DMHAS publishes a report on the results, presented by provider and overall, that also is available on its website. The department issued the latest survey results in November 2008. In total, 24,188 surveys were completed; nearly equal numbers of respondents reported receiving mental health (44%) versus substance use disorder (45%) services.

In summary, DMHAS found the majority of its consumers were satisfied with the mental health and substance abuse services provided to them. In comparison to national results, Connecticut clients reported: higher levels of satisfaction with participation in treatment, quality and appropriateness and outcome; about the same level of general satisfaction; and somewhat lower levels of satisfaction with access.

⁵ Access refers only to accessibility of services once in treatment; it does not reflect any rating of waiting time for admission or availability of needed services prior to intake.

The department also found respondents receiving substance use treatment services reported significantly higher levels of satisfaction regarding outcome and recovery services than mental health clients. Respondents receiving mental health services expressed significantly higher levels of general satisfaction as well as satisfaction with access, quality and appropriateness, and respect than substance use clients. In addition, satisfaction levels for respondents receiving substance use services differed somewhat by:

- demographics (e.g., by age, those age 35 and older had significantly higher levels of satisfaction in general, and regarding access, than did those under age 34);
- level of care (e.g., those receiving residential services reported significantly lower levels of satisfaction with access, outcome, participation in treatment, respect and general satisfaction, than respondents receiving other types of services): and
- length of stay (e.g., respondents who received services for less than one year reported significantly higher levels of satisfaction with access than those who received care for longer times; those with lengths of stay of one to two years and more than five years expressed significantly higher levels of satisfaction with quality and appropriateness).

Monitoring resources. The HCS division has 19 professional staff responsible for monitoring all substance abuse service providers, and, with LMHA staff, all mental health providers funded by DMHAS, as well as the agency's contracted ASO for its managed behavioral health care and recovery supports programs. A monitoring supervisor, assisted by one staff person, oversees nine others, who are organized into four small regional teams, each headed by a regional manager, and carry out all desk and field audit work for the private treatment programs operating within their assigned areas.

A second supervisor, with the assistance of four professional staff, oversees all monitoring and other contract administration functions related to the agency's GABHP and ATR programs. The remaining two HCS staff are assigned to various special projects.

As noted earlier, the director and nine professional staff of the Evaluation, Quality Management and Improvement Division support the monitoring efforts of the HCS staff, including working with the agency information technology unit to resolve data collecting and reporting issues. DMHAS fiscal and purchased services units also provide information and other assistance as needed to support the agency's quality assurance and improvement functions. Altogether, there are about 29 professional staff assigned full-time to contract compliance and program monitoring functions for the department's entire network of approximately 200 behavioral health service providers.

The department's main internal resource for planning, analysis, and research is its Office of Program Analysis and Support (OPAS). At present, OPAS is staffed by three professionals and supported by the EQMI Division, which can help develop and analyze data about the agency's service system. Most of the office's staff time is devoted to developing and updating

the agency's federal block grant applications; monitoring and reporting on state compliance with federal funding requirements; facilitating the agency's regional planning and priority setting process; and preparing the department's biennial report to the legislature on substance use, abuse and addiction programs.

OPAS has very limited capacity to conduct its own evaluations of agency programs and services. More commonly, the office, in collaboration with the department's one-person Research Division, manages studies carried out by the agency's various academic partners. The Research Division has an on-going relationship with Yale University and the University of Connecticut Health Center to conduct a wide range of behavioral health research projects. Currently, the division and OPAS also are working with Dartmouth College and Brandeis University on several federally funded studies of substance abuse treatment issues.

At this time, results from the department's many research and evaluation activities are not compiled in a central location and there is no unit or group of staff dedicated to promoting best practices and system wide quality improvement. Periodically, the agency does produce, and make available on its website, one-page summaries called "Info Briefs" that describe programs and initiatives that have had positive results.

DMHAS also provides grant funding to a local nonprofit agency (Wheeler Clinic) to maintain a web-based statewide library and resource center on substance use and mental health disorders for professionals, consumers, and the general public. Known as the Connecticut Clearinghouse, the website provides links to research and statistics on a variety of topics including national information on model programs and evidence-based practices, local training opportunities, and treatment service locations in Connecticut and throughout the country. The clearinghouse, however, is not required to identify or maintain information on best practices and effective programs and services currently in use by DMHAS funded or operated treatment programs.

Data systems. DMHAS uses an automated information system called DPAS to collect and store data from all of its funded mental health and substance abuse service providers. Aside from some demographic information about clients, this system captures basic data on types and amounts of behavioral health services provided. The agency maintains a separate information system for client and service data for the facilities and programs it directly operates called BHIS.

Additional information that includes a variety of treatment need and outcome data is gathered from all alcohol and drug abuse treatment programs in Connecticut, primarily to meet federal reporting requirements, and is maintained in a subsystem to DPAS called SATIS. All state-operated addiction service programs and all private substance abuse clinical treatment providers licensed by the Department of Public Health (which includes all programs funded by DMHAS), are required to report the required client-level data to SATIS upon admission and discharge.

At present, the system collects information from all licensed providers in the state. Providers can submit their data directly to the department through a web-based application or send DMHAS electronic files of data extracted from their own automated systems. During the summer of 2008, DPAS/SATIS was made a web-based system, which allowed for internet

availability of many types of management and performance reports. However, this also led to data access issues for a number of private providers, as well as the Department of Correction. As a result, the system does not contain complete information on the state service system.

The department anticipated the new reports based on the SATIS data would provide useful feedback for providers on strengths and areas in need of improvement. However, it appears that, at least for larger providers with their own automated systems, this management and performance information duplicates what they already produce. The committee was made aware of several cases where the DMHAS reports contained incorrect and/or incomplete information on provider programs. Department staff provided technical assistance to help address these difficulties.

Data quality has been an ongoing issue for the agency's provider information system and became a major focus for EQMI staff starting three years ago. After finding extensive problems with missing and incorrect client and service information, the division initiated in-depth reviews of each provider's data, followed by on-site visits to discuss and implement corrective action in the fall of 2005. Bimonthly data quality calls to address problems also were conducted. The division completed this project in July 2008. It is now developing an enhanced data tracking system to monitor submissions and flag problems that should be in place by the end of 2008.

The review process revealed a wide range of data quality issues such as: not providing data at all; large amounts of missing data; client duplication; and clients not appropriately discharged. Approximately five substance abuse treatment providers (5 percent) still have serious data problems. EQMI staff are conducting on-going, focused teleconferences with these providers that detail required action steps and timelines for completion. This effort is expected to be completed early in 2009.

The division also is addressing the data integrity issue by developing training for providers on the most common data reporting issues. According to the EQMI director, this training also will serve as a "primer" on how the SATIS data are used by DMHAS for quality assurance and improvement and how providers can use it for those purposes. Additionally, modifications are being made to the agency's automated data systems to reduce reporting errors and poor quality data. The upgrade to both department information systems (DPAS and BHIS) are planned; both improved systems should be in place by the spring of 2010.

A separate automated database for the General Assistance Behavioral Health Program is maintained by the program's ASO. The managed care system data tend to be more reliable than the agency's other client and service information, in part because they are claims-based (giving providers a strong incentive to submit complete, accurate, and timely reports.) As noted earlier, this system also is capable of producing any number of routine and ad hoc reports on the number and types of clients and services provided by location, level of care, and cost.

To date, the department has used the GABHP information system to focus on examining patterns and trends within the highest (and most expensive) levels of care (i.e., inpatient and intensive residential services), although other levels also have been reviewed. At present, DMHAS is working to develop management reports that will contain performance measures and cost information by providers within care levels.

Current GABHP provider profiles that contain several key performance and outcome indicators are generated two times a year. They are used by the HCS staff to monitor the agency-funded treatment programs and also are sent to providers. The reports the providers receive allow them to compare their performance to statewide average and other provider programs with the same level of care, although no identifying information is included.

COURT SUPPORT SERVICES DIVISION

As discussed in the briefing document, CSSD staff administer assessments to assist in determining treatment needs for its clients and develop case plans to address the most pressing criminogenic needs, but the division does not provide direct treatment services. The division has a formal contract monitoring process in place and has research and quality improvement units that perform data collection, research, and evaluation activities as described further below.

Monitoring and quality assurance. The division classifies contracts into one of three levels according to specific criteria spelled out in policy for monitoring purposes. The level determines the intensity of monitoring that is performed. Contract oversight is a part of the overall quality assurance process. This system is being revised as a new quality assurance process is being phased in.

- Nearly three-quarters of CSSD's 190 contracts are classified as level one. At a minimum for level one contracts, CSSD staff :
 - analyze provider's monthly statistical management reports;
 - conduct an annual stakeholder meeting for certain programs and analyze satisfaction surveys completed by stakeholders;
 - conduct at least one visit per year at each program delivery location; and
 - complete an annual written report that documents the analysis of that information.
- Site visit activities include inspecting the physical plant and facilities, checking that contractual requirements are being met, verifying the case management process, observing program interaction with clients, seeking feedback from clients, and verifying certain policies and procedures are in place.
- Level one contracts are essentially for those programs that are certified or licensed by another authority, such as DPH, or the quality assured by another entity.
- CSSD's residential substance abuse treatment programs are all provided through DMHAS' collaborative contract. DMHAS is responsible for the monitoring and quality of these programs. CSSD's outpatient programs are licensed by the Department of Public Health, the contracts for all these programs are classified as level one contracts.

- At the highest end of the spectrum are level three contracts that are in whole or in part research- or evidence-based programs.
 - About 5 percent of CSSD’s contracts are classified at level three. Nineteen of the level one and two contracts also receive this additional monitoring.
 - Currently, the monitoring policy, issued in 2005, calls for CSSD staff to perform “group quality process assessments” of all level three programs. The group quality assessment process requires the review of various aspects of the program including judgments about the program staff’s facilitation skills and group facilitation process.
 - The policy also calls for these assessments to check each program’s fidelity to individual models.
 - CSSD staff have acknowledged that program fidelity checks have not been fully implemented given that the contract staff does not have the capability to assess program fidelity.

If any problems are noted at any level of review, a corrective action plan (CAP) with expected dates of completion is developed in consultation with the provider. Typical problems usually involve timeliness of reporting and performing intakes, appropriate referrals not being made, and reallocation of budget items without approval. Last year 226 corrective action plans were developed. Corrective action plans vary in severity and complexity. Depending on the issue(s) to be addressed the time taken to resolve these issues varies. The CAP issues are not aggregated or compiled into an annual summary.

One recent initiative begun in 2006 applies rigorous quality assurance, including program fidelity checks, to three of CSSD’s contracted programs - Adult Incarceration Centers (AIC), Adult Risk Reduction Centers (ARRC), and the Striving Towards Achievement, Renewal and Success (STARS) program.⁶

This quality assurance initiative includes assessing the degree of accuracy with which services are being performed as well as improving staff skills through coaching, training, and positive reinforcement.

Currently, only the AICs, which provide several services (including a substance abuse program called Treating Alcohol Dependence) have any quality assurance outcome data. The TAD quality assurance reports measure fidelity and integrity by which the curriculum is delivered. A process is in place to address low end performers.

⁶ AICs provide monitoring, supervision, and programming during the day and evening in a structured, center-based setting. AARCs are for probationers who are high risk and have high treatment needs. STARS is a program with developmentally appropriate, gender responsive services, and education programming designed for females, ages 16-21.

There is no formal quality assurance process around the work of probation officers. However, CSSD has developed a fairly comprehensive risk reduction model for probationer supervision that identifies core practices as well as processes and tools to implement the practices to guide probation officers and supervisors in doing their work. The policy is being implemented in December 2008. While the procedures to implement the model are not a formal quality assurance process, it is designed to allow the staff to implement the risk reduction model with integrity and fidelity.

Selected best practices. CSSD has adopted or is experimenting with many of the selected best practice measures.

Substance use testing. The frequency of substance use testing for CSSD clients varies. CSSD clients may be tested by probation and/or programs as part of a court order or condition of probation. CSSD is not able to connect substance use test data with an individual's time in substance abuse treatment. The division does maintain data for those on probation subject to substance use testing. For 2007, 35,665 drug tests were performed on 14,386 probationers. Just over 7,000 probationers failed a drug test at least once, and about 3,000 failed more than once. Probation officers implement graduated sanctions when clients have positive urinalysis results.

Evidence- or research-based practices. For substance abuse treatment providers, the division requires the use of an evidence or research-based assessment tool. As previously discussed in the briefing document, the division uses validated assessment tools (Level of Services Index and the Adult Substance Use Survey) to perform its assessments. The division also requires the substance abuse treatment programs be evidence or research-based programs. Part of the core practices for probation officers involves training in motivational interviewing techniques that assists probation officers in judging and enhancing a probationer's motivation to identify problem areas they want to work on and improve. The therapeutic alliance is measured for those probationers in the AICs through a validated instrument called the Working Alliance Inventory. The therapeutic alliance is not currently measured for those in other substance abuse treatment programs.

Discharge planning and aftercare. All treatment providers are required through DPH regulation to provide a discharge plan to those receiving substance abuse treatment upon discharge. Discharge reports are also required by contract and are reviewed by a Compliance Specialist during the CSSD audit process.

External credentialing. All substance abuse treatment facilities must be licensed by DPH. With the exception of one Adult Behavioral Health provider, all CSSD providers are licensed by DPH. CSSD does not require any other credentialing of substance abuse treatment providers or employee than what is required under DPH regulation.

Outcome and performance measures. CSSD does not currently collect any system wide performance or outcome data on its clients involved in substance abuse treatment programs. The committee could only obtain completion rates for the substance abuse treatment programs provided at CSSD's Adult Incarceration Centers, which was 50 percent since January 2008.

Improvements in the outcome and performance data are expected with the implementation of a new contractor data system, described below. It should be noted that individual probation officers know how well each probationer assigned to them is progressing because of regular reporting requirements of probationers based on level of risk. The focus here is on what is known and tracked regarding system wide performance for overall management purposes.

To date only one study, conducted by DMHAS in collaboration with CSSD, has been completed that directly addresses substance abuse treatment for CSSD's clients. The "Substance Abuse Need for Treatment among Probationers" was a study published in 2005 and administered by Yale University's School of Medicine. The study did not focus on treatment outcomes, however. The purpose of the study was to determine the substance use activities, co-occurring conditions, treatment barriers, and the motivation and access to treatment among active probationers. The study found:

- forty-eight percent of probationers had a current substance use disorder, but two out of three (66 percent) of those needing treatment were not receiving care;
- forty-five percent of probationers were found to have a positive urine screen, mostly for marijuana and cocaine;
- barriers to treatment included: denial; thinking they could handle the problem themselves; lack of resources; stigma; and lack of space at a treatment facility;
- of those motivated for treatment, 33 percent had not received treatment in the past year; and
- forty-three percent of those currently needing treatment also were identified as probably having depression.

The division is currently working on several projects that focus on the outcomes of the division's various assessment and treatment activities. This includes a recidivism analysis that will track cohorts of adult and juvenile offenders by risk level for up to three years post-treatment. In addition, the division is examining the collection of information regarding treatment completion rates and employment status gains.

Except for some information required by the DMHAS collaborative contract for residential providers, DMHAS has not made any of the performance or outcome information that it collects from programs that provide services to CSSD clients available to CSSD. In addition, the division maintains its own database for residential services from which it monitors daily counts and outcomes and can analyze rates and trends.

Monitoring resources. CSSD's grants and contracts unit has 17 people who are responsible for ensuring that 190 contracts adhere to contractual requirements as outlined above. The adult services contracts totaled about \$47.5 million in FY 2008.

CSSD also has a robust internal research capacity. The division created both the Center for Best Practices and a Center for Research, Program Analysis, and Quality Improvement in

2005. The Center for Best Practices has nine professional staff and the Center for Research, Program Analysis, and Quality Improvement has eight staff. Together these units assist the division in incorporating research-based principles into agency practice and in developing outcome and evaluation data about programs and operations. CSSD also has employed four full time consultants to assist in various technical activities from determining how to extract data from existing databases to developing data sets and reports for operational and research purposes.

Over the last several years, the division also has initiated a number of research projects that evaluate of some of its programs and its assessment tools in partnership with several academic institutions. This includes an evaluation of the Probation Transition Program and Technical Violations Unit, a validation of its Bail Decision Aid, and an evaluation of the Building Bridges Prisoner Re-entry programs.

Data systems. CSSD uses a client management information system (CMIS) to collect and store data for both juvenile and adult offenders. Aside from demographic information, the system maintains information on:

- arrests;
- the bail point scale for release recommendations;
- court-ordered and probation officer- required conditions;
- presentence investigation reports;
- violation activity and drug test results;
- evaluation and mediation of family civil cases assessments for court release;
- and
- pretrial status for family criminal matters.

CMIS also links to the adult court system and the state's offender based tracking system. The division provides limited access to some CMIS information to the Board of Pardons and Paroles and municipalities.

CSSD is in the process of piloting a new Contractor Data Collection System (CDCS), which is a web-based "quality improvement tool that obtains key measures of treatment data on individual clients within CSSD's network of contract services."

- Providers will be required to enter a range of data about client services directly into CSSD's system. These data elements include: demographic information, referral date, intake date, assessment information, date and type of services information, pre- and post-test scores, service discharge dates and reasons, referral to community based services, and program discharge dates and reasons.
- Once enough data has been entered, CSSD will be able to gauge the current performance of its provider network. As the information is analyzed, CSSD will begin to identify ways to improve the delivery of treatment services.

- The system is being phased in. Currently, all of the 17 Adult Incarceration Centers, six of the 42 adult behavioral health sites, and a youth program are using the system. Because of its recent implementation, no trend information is available at this time nor have performance benchmarks have been identified. CSSD will begin to identify performance benchmarks after enough data have been collected about the current system.

CSSD does not have access to DMHAS' Substance Abuse Treatment Information System (SATIS) nor to the substance abuse treatment information maintained by DOC.

DEPARTMENT OF CORRECTION: FACILITY-BASED TREATMENT PROGRAMS

As described in the briefing document, all correctional facility-based treatment programs are delivered by DOC employees through the agency's Addiction Services Unit (ASU); there is no need for any external contract compliance process. ASU performs its own internal program audit process on an annual basis and engages in several other best practices.

Monitoring and quality assurance. There are program standards developed by ASU based on the National Institute of Drug Abuse's Principles of Addiction Treatment for each of its treatment programs that are checked through an in-house program audit process. Each program is audited once per year through the use of an internal peer review team. The focus of the audit is on:

- program fidelity through direct observation of counselors;
- program quantity;
- case management and documentation process;
- counselor utilization and professional development; and
- program environment.

ASU audits result in Corrective Actions Plans (CAP) to address deficiencies for each program such as file documentation, clinical supervision and environmental needs. Corrective actions are usually issued for every program. Time frames are included in the CAP and issues are worked on throughout the year and assessed in the following annual audit. ASU does not annually compile any summary report on problem areas.

In addition to the annual audit, each addiction services counselor supervisor is required to submit monthly statistical reports to the DOC central office for programs they oversee. These reports include the following:

- various specific statistics on each treatment program offered (e.g., admissions, discharges, and urine screens);

- monthly narrative reports about five areas: 1) Major Projects and Special Events, 2) Goals and Objectives, 3) Major Issues, 4) Developments and Corrective Action and 5) Statistical Summary;
- inmate tracking reports which are a check/balance for the statistical report. These reports provide the name, Criminal Justice Information System number of the offenders admitted, and reason for discharge. This report also identifies offenders who have dependent children under the age of 17, and the child's birth year. This information is an important part of DOC's quarterly and FY report on TANF funding;
- clinical supervision monthly logs; and
- individual counselor training reports (i.e. professional development).

Other quality assurance initiatives. The ASU has a quality assurance process for the health services provided through its contract with the University of Connecticut. The quality assurance for the ASU consists of the program monitoring discussed above.

Selected best practices. The ASU engages in a number of best practices to improve treatment outcomes and are summarized below.

Substance use testing. DOC regularly checks for substance use. For those inmates enrolled in ASU treatment programs, DOC tests 20 percent of current program participants be tested monthly. In 2007, about 2,239 urine screens were performed on inmates enrolled in ASU treatment programs while in a DOC facility. Of those, 29 (1.3 percent) turned up positive. The department has a graduated sanctions policy for those inmates who have a positive urine screen while in treatment. Relapse into active substance use is viewed as a treatment issue for the addiction services unit.

For inmates who are being treated while on transitional supervision (i.e. a form of early release), 879 screens were performed and nearly 40 percent were positive. These urine screens administered during FY 07 show that DOC community staff screened 60 percent of the offenders receiving treatment. DOC believes that the rate is indicative of an observant clinical staff who can recognize a person in need of help because it is beneficial to identify those in need of more intense levels of treatment, supervision, and if necessary re-incarceration to a structured environment (i.e. Technical Violator Program, etc.). Inmates on transitional supervision that receive a positive drug screen while in treatment are seen in a case conference that involves the parole officer, the ASU counselor and the client. During this conference the offender's behavior is assessed, an appropriate clinical or custodial response is developed in the form of a case conference contract, which is similar to a treatment plan in that it identifies the problem, establishes goals, methods and objectives, and is evaluated/reviewed as needed, usually on a weekly or bi-weekly basis.

Evidence- or research-based practices. As noted in the briefing, nearly all inmates are screened and assessed for substance abuse needs through two standardized instruments – Texas Christian University Drug Screen II and Addiction Severity Index (ASI). Both are evidence-based tools but the ASI is not validated for a prison population. The treatment programs are evidence-based except for one; the Tier 1 program.

The therapeutic bond between counselors and participants is not formally measured. However, random samples of inmate participants from each program are interviewed by an auditor during the annual audit. Clinical reviews of counselors occur on a regular basis, ranging from weekly to quarterly, based on the experience of the counselor and according to clinical supervision standards. All new ASU counselors are trained in motivational interviewing (MI), which is offered regularly to current counselors through the ASU in-service and annual monthly training sessions. The total number of counselors trained in MI could not be readily determined.

Discharge planning and aftercare. Aftercare is available in most DOC facilities and is offered to anyone who has completed a Tier 2 or higher program. 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. Alcoholics and Narcotic Anonymous Fellowship meetings are provided at all DOC facilities. These meetings are provided by a network of volunteers. Both programs help to support treatment efforts by reinforcing recovery attitudes and practices. If an offender is eligible for early release, other supports may be identified at time of parole through the Parole and Community Services Division.

External credentialing. As noted, the Department of Public Health is responsible for the licensing of substance abuse treatment programs in the state. The Department of Correction as a state agency is exempt from licensing. All alcohol and drug supervisors and counselors who deliver substance abuse treatment in DOC programs are certified or licensed by DPH as required by PA 02-75.

Outcome and performance measures. There are no performance or outcome measures established for DOC treatment programs, such as expected admission or completion rates or percentage of clients who remain abstinent or reduce use after discharge from DOC custody.

The committee found that completion rates for DOC facility-based programs were between 35 percent and 75 percent depending on the level and/or intensity of the treatment program in 2007. The completion rate for offenders on transitional supervision was between 15 and 45 percent. A part of this low completion rate for facility-based programs can be explained by the movement of inmates due to security concerns (the exact number is not readily available). The department points out that the mission of the Department of Correction is primarily to provide safety and security and this often means that inmate movement to support that mission takes precedence over concerns such as program placement. The department contends that systems are in place to track program participation and are used to limit movement in order to maintain program enrollment when possible, though the department could not identify the number of inmates who had to drop out of programs because of safety and security concerns.

DOC is considering adopting a performance-based measuring system for substance abuse treatment services that has been developed by the state association of correctional administrators. Among the indicators this system monitors are: number of inmates released who received a substance abuse assessment during their incarceration compared to total number of inmates released, and number of inmates enrolled in treatment and number that completed treatment compared to those diagnosed with a substance use disorder that were released without any treatment.

Studies of DOC treatment programs have been conducted that examine treatment outcomes and recidivism. All have found a positive relationship between substance abuse treatment and recidivism. Three of these studies are described below.

In 2006, the DOC, the Department of Public Safety, and DMHAS conducted a study to determine the effects of treatment on correctional inmates with a history of substance abuse problems. The study included sentenced inmates who were released in FY 2003 and included those released for time served or placed in transitional supervision or in a halfway house. Primarily, the study investigated the rate of re-incarceration and re-arrest by this population in the two years following release from prison.

- Inmates who successfully completed in-prison substance abuse treatment had a lower rate of re-incarceration (39.3 percent), than inmates not completing treatment (45.3 percent).
- Overall, those who received treatment had a lower rate of re-incarceration than those not receiving treatment within five months of being released. The same held true for re-arrest rates
- When controlling for all risks for re-arrest, receiving treatment significantly increased the length of time to felony re-arrest across all treatment groups when compared to those not receiving treatment

An evaluation of DOC's treatment structure (the four tiers described in the briefing), conducted by Brown and Brandeis Universities in 2002, found that inmates who attended the Tier programs were significantly less likely to be rearrested. The study examined three time periods of six, 12, and 18 months after release.

- Of those inmates who participated in Tier programming (including drop outs), 32.5 percent were re-arrested within one year compared to a rate of 45.9 percent for those who did not attend. Those inmates who actually completed a Tier program were even less likely to be arrested (29 percent compared to 43.5 percent of non-completers and 45.9 percent of non-participants). In addition, the severity of the crimes committed was also reduced.
- There was also a relationship between the level or intensity of treatment and recidivism. Tier 4 participants were rearrested at a rate of 17 percent, Tier 3 at a rate of 20 percent, and Tier 2 at a rate of 32 percent. Tier 1 had virtually no effect on recidivism when controlling for other variables and could be related to higher recidivism.
- The same study indicated that the cost effectiveness ratio for Tier program participants ranged from 1.8 to 5.7 for all participants. The only benefits included in this analysis were the avoided costs for re-incarceration and not other societal benefits that may result in a lower crime rate.

Changes have been made to the Tier 1 and Tier 3 programs since the publication of this study. Although the 2006 study mentioned above is suggestive of the positive affects of the changes, it did not specifically examine the various effects of different Tiers.

Finally, a 1996 study of the Marilyn Baker House, a residential therapeutic program for women, by researchers from Central Connecticut State University, suggested that the inmates who completed the program were the least likely to recidivate.

Monitoring resources. The program monitoring described above is completed by in-house staff who have other job responsibilities in addition to performing the program audits. The audit is a peer review process and is composed of counselors who normally provide direct services to clients or perform administrative duties. The audit teams consist of licensed or certified correctional counselor supervisors and correctional substance abuse counselors and each team is managed by a correctional counselor supervisor. Staff are assigned to audit teams in accordance with their specific knowledge of the programs they will audit. Each team has a range of three to six members. Each program audit is scheduled to take three days annually, per site.

Program evaluation beyond internal audit and clinical supervision is limited. Any internal research is ad hoc and no individuals are dedicated to this function. There have been a few studies conducted by external consultants over the last several years examining outcomes as described above. Several more studies are being developed that tend to focus on populations with specific disorders that may be associated with substance abuse, such as psychiatric disorders and HIV infected individuals. These studies are not evaluations of DOC substance abuse treatment programs.

Data systems. DOC staff report that the information technology systems they access are dated or have had serious technical issues and appear to impede meaningful research. The ASU uses three databases to collect substance abuse treatment information.

- *RT3M Program Tracking Management System.* This is an agency-based system designed to allow the department to record information about inmate participation in programs. For example, it: provides information regarding how many inmates are participating in programs; can assist in determining how many staff are needed; identifies the amount of programming specific staff are providing; can be used to study recidivism; and can be used to review classification decisions.
- *Addiction Services Monthly Statistics Report.* This is an Excel-based data collection tool developed by ASU to track a myriad of statistical data specific to ASU staff, community programs, and information specific to each service offered by ASU.
- *DMHAS Substance Abuse Treatment Information System (SATIS).* DOC, like other providers, is required by law to report certain substance abuse treatment data to DMHAS. ASU staff have had the ability to provide treatment information to DMHAS' for a number of years. However, access to the electronic and/or computerized SATIS system has been erratic as there has been a series of technical problems since 2003. Currently, only a portion of DOC data resides in an electronic format on SATIS. The system allows DOC to obtain demographic and treatment admission and discharge history for

inmates who may have participated in any state licensed alcohol or drug program that can assist in program placement decisions. However, most client treatment information generated through SATIS by DMHAS is not shared with DOC.

DEPARTMENT OF CORRECTION: PAROLE-BASED TREATMENT PROGRAMS

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 division maintains a wide network of contractors with private non-profit community providers for residential and nonresidential supervision and treatment of offenders. Below is a summary of contract compliance and performance monitoring activities completed by the division.

Monitoring and quality assurance. The network of programs that the parole division uses includes 36 nonresidential and 49 residential providers. All levels of substance abuse treatment are available through this non-profit network. A detailed description of the types of programs available through the parole division was provided in the briefing report.

While there is not a formal quality assurance program within the parole division's contracting and monitoring process, there are a number of oversight measures the division performs.

- Parole officers receive daily information from the substance abuse treatment providers regarding individual parolee noncompliance and documentation of 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 information is used by division managers and individual parole officers to coordinate treatment and supervision efforts. This information is not, however, aggregated to examine overall trends or contractor performance and is output not outcome data.
- Twice a year representatives of all residential and non-residential programs attend a mandatory coordination meeting sponsored by the division. These meetings allow for feedback that addresses both treatment and supervision coordination between parole staff and contracted providers.
- Compliance audits are aimed at the full range of contractor activities including admissions and intake, client services and supervision, administration, and facility concerns. However, these audits are completed on an irregular basis for residential programs and have not been performed on nonresidential

programs since early 2007 because the staff person assigned was transferred to other supervisory duties. The division has revised audit procedures and documents but reports that there are not sufficient staff resources to complete the necessary audits on residential and nonresidential programs. Some limited review of record systems is completed by parole officers assigned to residential programs. When audits are performed, two staff are selected from the ranks of parole officers who must defer other duties to complete the audits. Corrective action plans are developed when compliance issues are found.

There is no regular monitoring of treatment plan compliance by parole division staff nor any checks on treatment program fidelity. Private providers may be performing this quality assurance activity on their own, but it is not known how many do perform this activity. Seventy-seven of parole's residential treatment beds are provided through DMHAS' collaborative contract. DMHAS is responsible for the monitoring and quality of these programs. The parole division reports that they do not receive any monitoring reports from DMHAS. Further, the parole division does not require providers to notify them if DPH has issued any violations about the providers program.

All current residential and non-residential contracts are going to be re-bid by the parole division within the next year. As part of this process, the division is planning to incorporate assurances for program fidelity.

In addition, the division is piloting a program fidelity project that involves six residential work release programs. One of these programs provides substance abuse treatment services, though all the programs may refer a client to such services. The division hopes to implement similar procedures with other providers after the pilot period.

While supervisors conduct performance reviews of parole officers on an annual basis, there is no quality assurance process around the work of parole officers. It should be noted that the parole officers have completed extensive training to administer new assessment tools, the Level of Service Index and Adult Substance Use Survey.

Selected best practices. The DOC parole division has adopted some of the selected best practices as discussed below.

Substance use testing. Substance use is checked for all parolees at least monthly and could be more depending on the risk profile of the parolee. For those receiving substance abuse treatment services, substance use is checked based on the risk severity that the parolee presents – the range is from once per month to twice per week.

It is the division's policy that when a parolee receiving treatment fails a substance use test, the parolee is subject to graduated sanctions, which could mean greater testing and case management up to a return to prison. The division notes that the graduated sanctions policy was suspended immediately following the Cheshire incident last year. The division estimates that about 7.8 percent of urine screens for those who are receiving treatment come back positive based on the results from the month of September 2008. The division could not readily

determine how many separate people this represented. The division is not able to obtain this type of information from its electronic information system.

Evidence- or research-based practices. The division requires that substance abuse treatment programs be evidence- or research-based programs. These programs may or may not be validated for criminal justice populations.

Assessments may be conducted by the parole division and the treatment provider and are required to be evidence or research-based. The criminogenic needs of paroled offenders are assessed by the DOC parole division. As previously discussed in the briefing document, the division is implementing validated tools (Level of Services Index (LSI) and the Adult Substance Use Survey (ASUS)) to perform its assessments. The division is in the process of training parole officers in motivational interviewing.

Substance abuse providers also perform assessments on those inmates referred to them for treatment. While there is no required 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 assessment tool.

The level of treatment need is determined by the private provider, 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.

One issue brought to program review staff's attention is that parole staff do not appear to consider substance abuse treatment received in prison when making a referral to treatment services. Parole staff have indicated that they may refer inmates, who have been initially assessed with an addiction, to residential treatment regardless of treatment received in prison. It appears that the availability of treatment slots in a more structured setting, in some cases, may be impacting placement criteria rather than clinical need.

It should also be noted that inmates that are released under the authority of the Board of Pardons and Paroles are evaluated by the parole board. 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 and may consider any in-facility DOC-generated assessment information to stipulate any special conditions on offenders, like substance abuse treatment. The needs of the offender are assessed by the parole division after the board has acted. The outcome of the assessment may result in additional stipulations added to the offender's release conditions.

Discharge planning and aftercare. All treatment providers are required by DPH regulation to provide a discharge plan to those receiving substance abuse treatment upon discharge. According to the parole division, each residential and nonresidential provider is

required under contract to develop a discharge plan for each offender within 15 days of discharge. The parole division's audit requirements call for this contract provision to be checked.

External credentialing. The parole division does not require any formal credentialing of its substance abuse treatment program contractors. The division reports that one of its contractors is not licensed by DPH. Substance abuse treatment providers (i.e., clinicians, counselors) are not required to be licensed or credentialed under the parole division's contracts though the division encourages them to be licensed by awarding credit in the RFP process for those bidders that have licensed treatment providers.

Outcome and performance measures. The parole division had developed performance measures for private nonprofit contractors in the mid to late 1990s. Currently, there is no monitoring or review of these performance measures. It is not known what overall completion rates are for the division's various programs. No provider's contract have been suspended or terminated because of poor performance in terms of these measures.

Two studies over the last several years have concluded that community supervision and the services offered through the parole division had a positive impact on recidivism. One such study -- the 2006 collaboration of DOC, the Department of Public Safety, and DMHAS -- found persons released to halfway houses and receiving treatment were 42 percent less likely to return to prison within two years of release and 37.4 percent less likely to be re-arrested than those released to halfway houses but not receiving treatment.

Further, the second annual recidivism study (2008) published by the Office of Policy and Management's Criminal Justice Policy and Planning Division found that inmates who were released from prison with some form of community supervision were less likely to recidivate. The 2008 report, which assesses recidivism rates of offenders released during the 2004 calendar year, made these findings:

- offenders with the highest success rate and least likely to recidivate were those under DOC community supervision. The study defined early release through parole in two ways – community release and transitional supervision. Of those released to community programs, 67.3 percent did not recidivate. Of those released to transitional supervision, 64.5 percent did not recidivate; and
- arrest, conviction, and new prison sentence rates were higher for offenders with no post-prison supervision.

The study also found that the majority (63.5 percent) of offenders with high substance abuse need scores (i.e. assessment scores of 3 or higher) were released with some form of community supervision, which is generally considered a good practice. It further showed offenders with high substance treatment needs scores did not have significantly different recidivism rates from those with low need scores. Since the study did not identify which programs or type of treatment released inmates actually participated in, it is not possible to link successful outcomes with specific treatment programs.

Monitoring resources. Within the parole division, three people are responsible for ensuring that 36 nonresidential and 49 residential providers adhere to contractual requirements as outlined above. The total value of all residential (\$30,596,827) and nonresidential contracts (\$6,507,122) for FY 2009 is \$37,103,949.

As discussed above, DOC, including the parole division, has extremely limited internal research capacity. Any internal research is ad hoc and no individuals are dedicated to this function for the parole division. There is no best practices unit for the division.

Data systems. The parole division has a limited and outdated management information system that inhibits administrative and research capabilities. The system is a case management system based on a Lotus platform. It was a prototype obtained for free from the State of Georgia, though only approximately 15 percent of the original program was retained. Parole staff report that the system was to be upgraded in stages to meet their particular and unique needs, but funding was not sustained to ensure the necessary upgrades. Reported problems include:

- the division has limited ability to query the system to understand overall trends or to develop customized management reports about the division's activities;
- there are few standardized reports and not enough to meet the management needs of the parole division;
- it is not a user friendly system; prototype drop down menus, for example, were developed by software designers but not field tested by the end-users and adjusted to their needs; and
- parole staff report often having to perform data collection manually or obtain information from paper files or cross-reference information with DOC's other systems to ensure accuracy.