Key Points

SUBSTANCE ABUSE TREATMENT FOR ADULTS

Section I: Access to Treatment

- DMHAS does not assess or estimate unmet demand for substance abuse treatment, making it impossible to plan how to best meet the needs in the state.

- Several examples of unmet demand were found among state agencies that were part of this review: CSSD referred over 4,000 people to residential treatment services, in 2007, but only 1,800 received that level of care; the average wait time for nonresidential services for CSSD clients is two to six weeks; and only 26 percent of offenders with a substance use problem in DOC's sentenced facilities received treatment while in a DOC facility.

- 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 does not maintain an information system on treatment availability for the public.

- Research literature suggests that successful treatment interventions require the time between when substance abusers decide to seek help and when they actually receive services to be as short as possible. DMHAS does not monitor the length of time it takes to receive substance abuse assessments and treatment in state-operated or funded facilities.

- Generally, research shows that for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness. DMHAS does not track the length of treatment that clients receive.

1) **DMHAS shall 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;**

2) **DMHAS shall 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) **DMHAS shall 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.**

- Research has shown that in-prison treatment, when linked with post-release recovery supports, can reduce post–release drug use and recidivism.

- 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.

- 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.

4) 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.**

Section II: Program Monitoring and Treatment Quality

Program Monitoring and Quality Assurance

- 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.

- 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, are done so sporadically.

- CSSD has begun to implement a risk reduction model for probationer supervision that identifies core practices as well as processes and tools to implement them, as a guide for 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.

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.**

Selected Best Practices

- CSSD has adopted most of the best practices identified by PRI staff 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.

- 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 referring an offender 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.

- 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.

- 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 it funds or directly operates, or whether programs are evidence-based or nationally accredited.

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

- DMHAS and the 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.

- 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 DOC is at 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.

- Data on completion rates were unavailable for all but one of CSSD's program models and for none of DOC's parole division clients because neither of those entities calculate them.

- 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 PRI staff with performance and outcome information on the PAES and PDEP programs within the study timeframe.

- 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.

- DMHAS collects and reports little outcome data regarding the methadone maintenance and other opioid replacement treatment. Given the importance of this level of care in Connecticut, and the stigma and controversy associated with it, this lack of information is problematic.

- 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.

- 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 publicly. 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 days 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. Committee staff find 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 PRI staff 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 PRI staff 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).

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 outcome 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 evaluate and 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 proposed improvements regarding outcome information are presented in Section III (below), which concerns the role of DMHAS as lead state agency on substance abuse.

Monitoring and Evaluation Resources and Data Systems

- Data systems and research capabilities vary widely among the agencies. 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.

- 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.

- 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.

- All three agencies have developed relationships with academic institutions to supplement their internal resources for research and data analysis.

- 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. A major data integrity improvement project started in 2005 is expected to be completed early in 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.

- The DMHAS system for its state facilities has little ability to produce management information. Upgrades of both the provider and facility systems are planned and should be in place by the spring of 2010.

- 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.

22) DOC should conduct an assessment of its management information system to determine how it could better meet its research and management needs.

Additional monitoring and evaluation recommendations are included in the following section regarding the lead agency role of DMHAS.

Section III: Lead Agency Role

- The Department of Mental Health and Addiction Services needs to take a stronger role in planning, coordinating, and overseeing the state's substance abuse treatment

system for adults.

- DMHAS has no strategic planning process for the publicly funded substance abuse treatment system.
- Comprehensive strategic planning is the cornerstone of effective management and clear accountability.
- The state's many current planning efforts related to substance abuse are disjointed and piecemeal.
- Well-defined goals and related benchmarks for state alcohol and drug abuse services have not been established.
- Good information linking resources with treatment service outcomes is lacking.
- State statutes do not refer to DMHAS as the lead agency for substance abuse but it is mandated to carry out a number of statewide coordination and oversight functions that give it that role.
- The department engages in many joint planning processes and collaborative initiatives; these efforts have improved interagency communication and cooperation. However, greater coordination is needed to address unnecessary duplication, inefficient use of resources, and better meet the needs of clients. Also, DMHAS has been deficient in promoting consistent standards and use of best practices across state agencies and the private provider network.
- DMHAS also has made considerable progress in maintaining a central repository of substance abuse treatment data and reporting on trends as required by law. However, the extensive amount of performance and outcome data currently produced by all state agencies involved in substance abuse treatment is not aggregated and analyzed to assess strengths and weaknesses across levels of care, client populations, and the entire service delivery system.
- DMHAS does not collect, monitor, and report data on the effectiveness of the state substance abuse treatment system for adults on a regular basis.
- There is a general lack of public information on what impact publicly funded treatment services are having on the state's substance abuse problems.

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.

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.

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.

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 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) **DMHAS 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.**