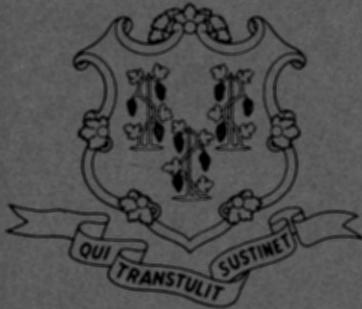


Connecticut Alcohol and Drug Abuse Commission

Connecticut
General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

January 1985

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 as the Legislative Program Review Committee to evaluate the efficiency and effectiveness of selected state programs and to recommend improvements where indicated. In 1975 the General Assembly expanded the committee's function to include investigations and changed its name to the Legislative Program Review and Investigations Committee. During the 1977 session, the committee's mandate was again expanded by the Executive Reorganization Act to include "Sunset" performance reviews of nearly 100 agencies, boards, and commissions, commencing on January 1, 1979. Review of the original schedule of sunset entities was completed in 1984. Review of the list will begin again in 1988.

The committee is composed of twelve members, three each appointed by the Senate President Pro Tempore and Minority Leader, and the Speaker of the House and Minority Leader.

1985-86 Committee Members

Senate

Fred H. Lovegrove, Jr., Cochairperson
Frank D. Barrows
John C. Daniels
Richard Eaton
Joseph C. Markley
Anthony D. Truglia

House

Abraham L. Giles, Cochairperson
Carleton J. Benson
Richard Foley, Jr.
Dorothy K. Osler
William J. Scully, Jr.
Irving J. Stolberg

Committee Staff

Michael L. Nauer, Ph.D., Director
George W. McKee, Chief Analyst
Anne E. McAloon, Program Review Coordinator
Carrie E. Vibert, Staff Attorney
L. Spencer Cain, Senior Analyst
Catherine McNeill Conlin, Program Analyst
Debra S. Eyges, Program Analyst
Jill E. Jensen, Program Analyst
Michael O'Malley, Program Analyst
Nancy J. Treer, Program Analyst
Lillian Crovo, Administrative Assistant
Mary Lou Derr, Administrative Assistant

Staff on this Project

Michael O'Malley, Nancy J. Treer

THE CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION:
A PERFORMANCE AUDIT

LEGISLATIVE PROGRAM REVIEW AND
INVESTIGATIONS COMMITTEE

JANUARY 1985

TABLE OF CONTENTS

SUMMARY.....	i
INTRODUCTION.....	1
I. DESCRIPTION.....	3
Commission Operations.....	4
CADAC Staff Operations.....	5
Other CADAC Activities.....	15
II. ANALYSIS AND RECOMMENDATIONS.....	19
Centralization of Treatment Programs.....	19
Annual Plan.....	23
Prevention.....	25
Outcome Measures.....	28
Client Follow-up.....	29
Unique Client Identifier.....	30
Budgeted Capacity.....	32
Underutilized Programs.....	34
Frequency of Site Visits.....	34
Consistency of Regulation.....	38
Changes in the Composition and Operation of the Commission.....	41
Statutory Mandate.....	42
PAES Data.....	43
Restrictions on PAES Participation.....	43
APPENDICES	
A. Performance Audit Methodology.....	47
B. History of the Connecticut Alcohol and Drug Abuse Commission.....	49
C. CADAC Summary Sheet.....	55
D. State Agencies Involved in Substance Abuse Activities.....	58
E. Types of Alcohol and Drug Abuse Services.....	59
F. Survey of CADAC Commissioners.....	61
G. Survey of Programs Funded by CADAC.....	70
H. Survey of Grantees Funded by CADAC.....	75
I. Legislative Changes Needed to Implement Committee Recommendations.....	79

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Connecticut Alcohol and Drug Abuse Commission: A Performance Audit

SUMMARY

The provision of substance abuse services has shifted in recent years from predominantly institutional settings to a variety of community-based programs. However, jurisdiction over these services in Connecticut is divided.

In May 1984, the Legislative Program Review and Investigations Committee decided to conduct a performance audit of the Connecticut Alcohol and Drug Abuse Commission (CADAC), which is responsible for planning and coordinating statewide substance abuse services as well as funding and monitoring the community-based programs. The committee was particularly interested in the scope and execution of CADAC's statutory mandate, and what changes were needed to improve the commission's performance.

The Connecticut Alcohol and Drug Abuse Commission is composed of 22 members including 8 representatives of state agencies and 14 appointed members, several of whom must be former alcohol or drug abusers. The commission meets monthly. There is a staff of 53 headed by an executive director. The principal functions of the CADAC staff are planning, coordination, funding, and monitoring substance abuse services.

The CADAC budget for state FY 85 was \$14.6 million. Nearly \$10.9 million in grants was distributed to 66 community-based organizations that provide prevention, intervention, and treatment programs. In addition, \$1.7 million was spent on the Pretrial Alcohol Education System, an education and treatment program for first-time offenders charged with driving while intoxicated.

One of the primary issues considered during the performance audit was the division of substance abuse treatment services between the Department of Mental Health and the Connecticut Alcohol and Drug Abuse Commission. Currently, the Department of Mental Health provides treatment services in state hospitals and community mental health centers while CADAC oversees statewide substance abuse planning and coordination as well as the administration of grants to community-based programs. It was the finding of the program review committee that a three-year plan should be developed to centralize responsibility for treatment services within the Connecticut Alcohol and Drug Abuse Commission.

At the same time the committee identified the need for improved planning efforts by the commission. Some community programs are directly involved in the development of budget priorities for expanding or reducing services, but a number of community-based providers expressed dissatisfaction with the existing planning process and the opportunities they had for input. The program review committee also found a need for additional efforts by both CADAC and the State Board of Education to ensure that substance abuse prevention programs are provided by all local and regional school boards.

Several other areas of commission operations examined by the committee were procedural in nature, focusing on the types of data collected and evaluated by CADAC as part of its funding and monitoring process. The program review committee also identified the need for some changes in the composition and operation of the commission itself as well as a reassessment of the specific wording of its statutory mandate. Two recommendations concerning the Pretrial Alcohol Education System were also made.

RECOMMENDATIONS

1. Responsibility for the state's substance abuse treatment programs should be centralized by gradually replacing institutional programs currently operated by the Department of Mental Health with community-based programs funded by the Connecticut Alcohol and Drug Abuse Commission. A three-year transition plan to accomplish this recommendation shall be developed by a transition group composed of CADAC, Department of Mental Health, Office of Policy and Management, and community-based provider representatives. The House and Senate majority and minority leaders shall each appoint one community-based provider representative to the transition group. The plan shall be submitted to the Appropriations and Public Health Committees by February 1, 1986.
2. Amend C.G.S. Sec. 17-155gg(1), regarding the planning responsibilities of the Connecticut Alcohol and Drug Abuse Commission, to provide for:
 - development of an annual alcohol and drug plan with long- and short-range priorities;
 - creation of a state plan steering committee composed of CADAC commissioners and representatives of community programs;

- o an annual survey of alcohol and drug service providers to elicit planning input; and
- o regional hearings on a draft of the annual plan to allow input from the community and the public.

Upon passage of legislation to effect these changes, CADAC should meet with its grantees to develop a method of selecting representatives for the plan steering committee. The selection method chosen should be reported to the Public Health Committee within six months of the effective date of the legislation implementing this recommendation.

3. The Connecticut Alcohol and Drug Abuse Commission and the State Board of Education should jointly develop a plan by January 1986 to ensure that substance abuse prevention programs are provided by all local and regional school boards. Upon completion of the plan, CADAC should fund up to one full-time position within the Department of Education to oversee school-based substance abuse programs. The plan shall be available to all private, parochial, and technical schools.
4. The Connecticut Alcohol and Drug Abuse Commission, after seeking input from substance abuse service providers, should develop objective outcome measures to evaluate the effectiveness of services offered by commission-funded programs.
5. Connecticut Alcohol and Drug Abuse Commission staff should investigate the merits of requiring CADAC-funded programs to follow-up on discharged clients.
6. The Connecticut Alcohol and Drug Abuse Commission should develop unique client identifiers for all commission-funded treatment programs.
7. The Connecticut Alcohol and Drug Abuse Commission should revise its procedures for determining the budgeted capacity of substance abuse treatment programs by:
 - developing written guidelines;
 - documenting the standards applied to determine budgeted capacity and the reasons for any changes; and
 - reviewing annually the budgeted capacity of individual programs to ensure that written guidelines are consistently applied and the reasons for change are clearly documented.

8. Once CADAC standardizes programs' budgeted capacities, programs that are consistently underutilized should receive reduced funding as provided in their letter of award.
9. The Connecticut Alcohol and Drug Abuse Commission should conduct one programmatic site visit per year to each commission-funded service component; additional visits should be scheduled as needed to programs having difficulty meeting CADAC standards.
10. Improve coordination between the regulatory functions of the Connecticut Alcohol and Drug Abuse Commission and the Department of Health Services (DOHS) by:
 - requiring by statute that CADAC and DOHS substance abuse regulations be consistent;
 - requiring the Department of Health Services, once consistent substance abuse regulations are developed, to provide detailed reports of licensing inspections to CADAC for use in its program evaluations; and
 - requiring CADAC and DOHS to meet to resolve any inconsistencies between the final draft of the proposed DOHS substance abuse licensing regulations and the current CADAC regulations. If these conflicts have not been resolved by the time DOHS regulations are submitted to the legislature for final approval, both agencies should submit reports addressing the inconsistencies to the Regulations Review Committee.
11. Amend the statutes concerning the composition and operation of the Connecticut Alcohol and Drug Abuse Commission to:
 - remove the executive director from membership on the commission;
 - allow representatives of community-based programs to serve as commissioners, but prohibit all commissioners from voting on matters that specifically affect a program with which they are affiliated; and
 - implement model sunset recommendations on commissioners' attendance and number of terms.

In addition, the commission should amend its bylaws to conform with state statutes.

12. The statutory mandate of the Connecticut Alcohol and Drug Abuse Commission should be revised to focus on the agency's basic mission of planning, coordinating, funding, and monitoring substance abuse activities in the state. The proposed revision should be included in their legislative proposals for the 1986 session of the General Assembly.
13. Recidivism data for Pretrial Alcohol Education System participants should be analyzed to evaluate the effectiveness of the program and determine if changes in its structure are needed.
14. Amend C.G.S. Sec. 54-56g to ensure that second-time driving while intoxicated offenders, prior Pretrial Alcohol Education System participants, and persons dismissed from that program are not allowed to enter or re-enter the Pretrial Alcohol Education System.

INTRODUCTION

In recent years substance abuse services have moved from predominantly institutional setting to a variety of community-based programs. While jurisdiction over alcohol and drug abuse services the state is divided among several state agencies, the Connecticut Alcohol and Drug Abuse Commission is responsible for planning and coordinating statewide substance abuse services and for funding and monitoring the community-based programs.

In May 1984 the Legislative Program Review and Investigations Committee voted to undertake a performance audit of the commission at the request of the speaker of the house. The committee was particularly interested in the scope of CADAC's mandate, how well the commission was performing its mandate, and what changes were needed to improve that performance. The focus of the committee's efforts was the commission and the functions performed by its staff. CADAC's role in the alcohol and drug abuse system was examined, but neither the substance abuse system as a whole nor individual service providers were evaluated.

This audit report is divided into two chapters. The first chapter describes the structure, duties, and operation of the commission and its staff. The second chapter provides an analysis of areas of concern identified by the committee during the audit as well as the specific changes recommended by the committee.

CHAPTER I

DESCRIPTION

The Connecticut Alcohol and Drug Abuse Commission (CADAC) was created in 1977 when the State Alcohol Council and the Drug Council were combined to form the commission. CADAC's goal is to plan, establish, maintain, coordinate, and evaluate projects and programs to effectively deal with alcohol and drug abuse.

CADAC has a "continuum of care" model of services that recognizes three principal approaches to dealing with substance abuse. Prevention is designed to reduce the probability that members of the general population will need remedial health care. Intervention attempts to identify individuals in need of remedial health care and facilitate provision of appropriate levels of care. Treatment provides remedial health care services appropriate to the needs of the individual.

Prior to the creation of CADAC, the alcohol and drug councils had been part of the Department of Mental Health (DMH). Community service providers raised a number of objections to the department's role in the substance abuse system. Specifically:

- community-based programs believed that they could not successfully compete with Department of Mental Health state institutions for department funding;
- the department favored an institutional rather than a community-based approach to substance abuse treatment;
- the department was not accountable to any other organization for its own programs, yet all other service providers receiving grants were required to account to the department for their operations;
- the planning process for alcohol and drug abuse programs was lost within an organization the size of the Department of Mental Health; and
- the department was too oriented toward treatment rather than prevention.

With the establishment of CADAC, responsibility for funding and supervision of the community-based programs was transferred from the Department of Mental Health to the commission.

Commission Operations

The Connecticut Alcohol and Drug Abuse Commission is composed of 22 members including 8 representatives of state agencies and 14 appointed members. The commissioners of children and youth services, corrections, education, mental health, and motor vehicles are members of CADAC as well as the director of adult probation, the chief of the Bureau of Health Planning of the Department of Health Services (DOHS), and the executive director of CADAC.

There are four legislative appointees to the commission, one each selected by the speaker of the house, the president pro tempore of the senate, and the House and Senate minority leaders. The terms of legislative appointees are coterminous with the appointing authority.

The governor appoints 10 commissioners reflecting the geographic balance of the state with 5 of these appointees knowledgeable in the treatment and prevention of alcohol abuse and 5 knowledgeable in the treatment and prevention of drug abuse. Two gubernatorial appointees must be former alcohol abusers, and two must be former drug abusers. Gubernatorial appointees serve three-year staggered terms.

The statutes provide for the election of the chairperson of the commission by the members. The executive director is appointed by the governor with the advice of the commission.

The duties of the Connecticut Alcohol and Drug Abuse Commission are specified in C.G.S. Sections 17-155gg and 17-155hh. The primary duties of the commission are the planning and coordination of substance abuse services and the allocation and supervision of state and federal funds distributed to community alcohol and drug programs. In addition, the statutes require CADAC to develop educational material, conduct research, and collect and analyze statistics about substance abuse. (See Appendix C for a complete list of the commission's statutory duties.)

The commission has a Policy and Planning Committee and a Budget and Operations Committee, each of which is composed of 10 commissioners. The executive director of CADAC and the chairperson of the commission serve as ex officio members of both committees. These two committees meet monthly, usually just prior to a commission meeting, to consider planning and budget issues respectively. The committees review the issues in detail and vote on recommendations to be made to the full commission.

The commission also has an Executive Committee composed of the chairperson, the two vice-chairpersons, the two committee

chairpersons, and the executive director. It is responsible for acting on behalf of the commission between regular meetings.

The commission normally meets once a month for approximately two hours. During fiscal year 1984, an average of 14 commissioners attended meetings. Each commission meeting begins with an "open forum" at which any person may address the commission. The open forum is followed by the approval of minutes and a report from the chairperson. The budget and planning committees then present their reports, and the commission votes on any committee recommendations that require action.

Most commission decisions concern the funding of alcohol and drug abuse programs. The commission normally approves committee recommendations with little or no change. After the committee reports, the executive director briefs the commission on any developments related to CADAC operations and reports on commission staff activities.

CADAC Staff Operations

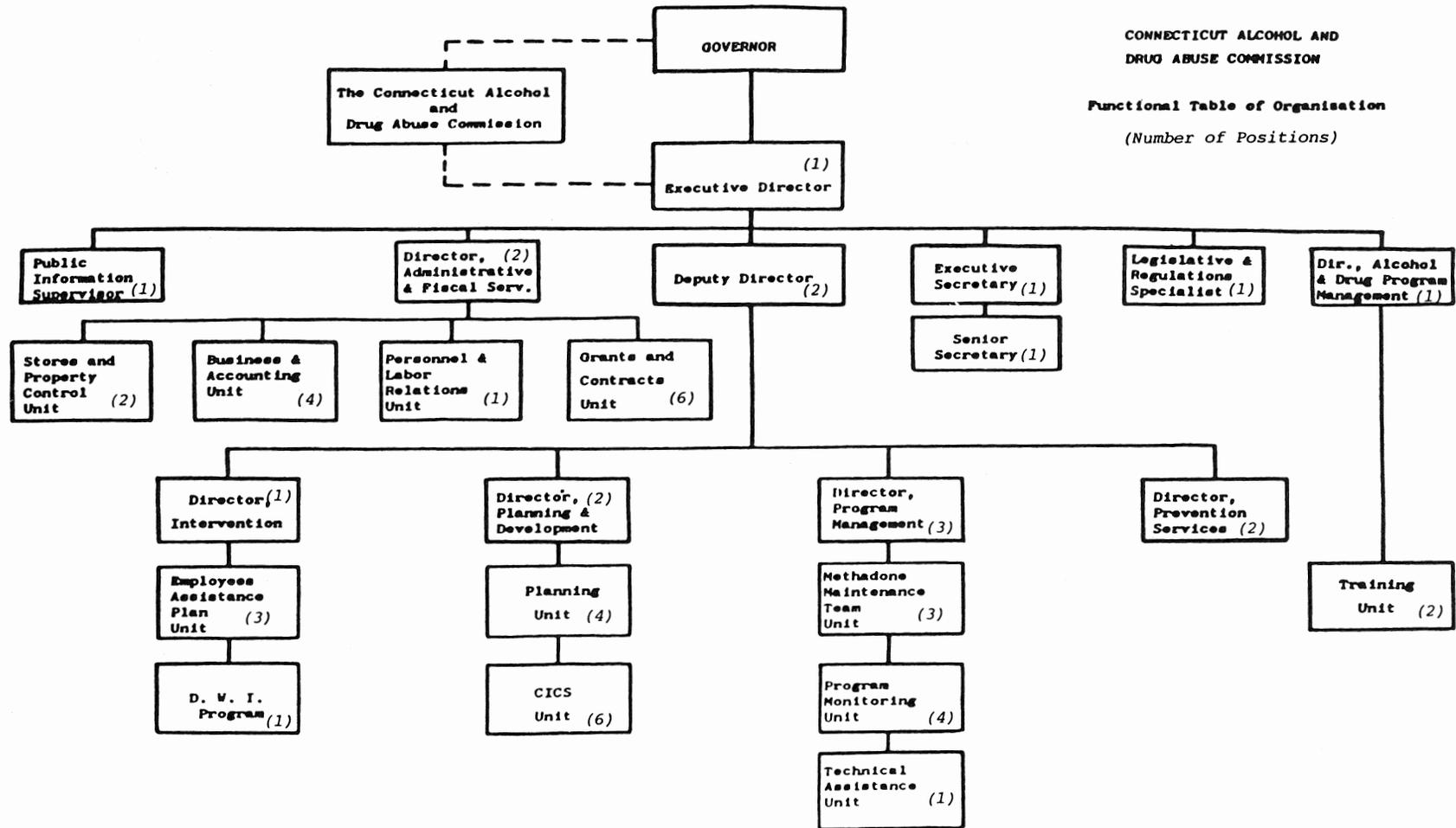
The Connecticut Alcohol and Drug Abuse Commission has a staff of 53 persons, headed by an executive director, and an operating budget of \$2 million for state FY 85. The organization of CADAC staff is shown in Figure I-1.

C.G.S. Sec. 17-155ii requires the executive director to employ staff, evaluate and plan for substance abuse services, identify service needs, establish priorities, and coordinate state regulatory activities. CADAC's staff functions reflect the four basic duties of the commission: planning, coordination, funding, and monitoring.

Planning. The Planning and Development Division of CADAC is responsible for the planning of alcohol and drug abuse activities in the state. Until 1982, CADAC developed a comprehensive annual plan for the prevention, treatment, and reduction of alcohol and drug abuse problems in the state. The federal requirement for this plan was eliminated in 1981.

Since then, CADAC has developed two planning documents. One is a comprehensive description of the alcohol and drug abuse problems in Connecticut and the state's response to those problems; the other is an examination of the operation and function of the CADAC-funded alcohol and drug treatment system. In addition, a Special Populations Advisory Committee formed by CADAC has published a report on the special service needs of Hispanic, gay, lesbian, black, disabled, and elderly individuals as well as women and youth.

Figure I-1. CADAC Organization Chart.



Source: Connecticut Alcohol and Drug Abuse Commission.

CADAC uses a variety of data sources in planning alcohol and drug abuse activities. All licensed alcohol and drug abuse treatment facilities (including private ones) are required to report client information to CADAC as part of the Client Information Collection System (CICS). Commission funded programs also submit financial and service delivery information in quarterly reports. In addition to data available internally, CADAC planners use alcohol and drug abuse information from other sources including driving while intoxicated and drug arrests, drug seizures by law enforcement agencies, alcohol-related accidents and deaths, and alcoholic beverage excise taxes.

Community programs have input into the CADAC planning process through a planning committee whose members include CADAC staff and representatives of the Connecticut Association of Substance Abuse Agencies (CASAA). This committee meets regularly to review planning and budget issues before they are presented to the commission. The recommendations of this committee are reported to the commission's planning and budget committees as well as the commission itself.

Coordination. The Connecticut Alcohol and Drug Abuse Commission is required by statute to coordinate all alcohol and drug abuse activities in the state. To meet its statutory mandate, CADAC must coordinate the activities of a broad range of privately funded service providers and 66 commission funded programs.

The commission also must coordinate the activities of more than 15 state agencies involved in the substance abuse system. Efforts to coordinate their activities are facilitated by the fact that seven of these state agencies are represented on the commission. (Appendix D describes the activities of the state agencies with major roles in the substance abuse system.)

CADAC, through its planning process, coordinates alcohol and drug services by identifying gaps and duplication in the state substance abuse system. The commission's funding process promotes coordinated services by requiring programs seeking CADAC funding to demonstrate a need for the proposed service. The commission also publishes and distributes a directory of substance abuse services available in the state.

The commission meets with other state agencies regulating substance abuse services to coordinate the enforcement of current regulations and the development of new regulatory standards. CADAC staff are currently working with the Department of Health Services to draft new DOHS licensing regulations for substance abuse treatment facilities. In the past, CADAC monitors also accompanied department staff on licensure site visits. While this

practice has been discontinued, CADAC still receives license inspection reports from the department.

Funding. The commission's budget is funded from state and federal sources. The main federal sources of funds for alcohol and drug abuse services are the Social Services Block Grant and the Alcohol, Drug Abuse and Mental Health Services Block Grant. CADAC expenditures for state FY 84 and its budget for state FY 85 are depicted in Table I-1.

Table I-1. CADAC Funding Sources and Expenditures.

	<u>FY 1984</u> <u>(Actual)</u>	<u>FY 1985</u> <u>(Estimated)</u>
<u>Funding Sources</u>		
State General Fund	\$ 5,865,577	\$ 7,197,805
Federal		
Alcohol, Drug Abuse, Mental Health Services Block Grant	6,057,522	4,727,090
Social Services Block Grant	1,615,051	2,557,100
Other	<u>80,389</u>	<u>115,931</u>
Total	\$13,618,539	\$14,597,926
<u>Expenditures</u>		
Personal Services	\$1,592,586	\$1,701,272
Other Expenses	344,591	362,330
Equipment	3,967	7,000
Grant Payments	10,341,485	10,871,324
Pretrial Alcohol Education System	<u>1,335,910</u>	<u>1,656,000</u>
Total	\$13,618,539	\$14,597,926

Source: Connecticut Alcohol and Drug Abuse Commission.

As Table I-1 shows, the bulk of CADAC's budget is devoted to grants. The commission funds 66 organizations that provide a variety of alcohol and drug abuse services in the state. These organizations operated 81 treatment and rehabilitation programs, 18 prevention programs, 11 intervention programs, and 8 community awareness/information and referral programs during state FY 84.

To receive CADAC funding, programs must submit an annual application that includes:

- a budget of income and expenses with supporting schedules;
- a description of the program philosophy and the type of services to be provided;
- projected program performance measures (e.g., number of patient days, counseling sessions);
- management objectives;
- an organization chart; and
- copies of any licenses needed by the program to operate.

Funding applications are reviewed by CADAC fiscal and programmatic staff and compared to the prior year's application to identify any changes in program operation. Awards to grantees from the previous year are made on a continuation basis if the grantee is in compliance with CADAC requirements. Commission funding may be in the form of a grant or a fee-for-service arrangement that pays programs a per diem rate for CADAC clients. New or expanded services are funded when resources become available through the closing of a program or increased appropriations. New or expanded programs are funded through a request-for-proposal process or approval of an unsolicited request for funds.

Once funding for a program has been approved by the commission, a letter of award that outlines the terms and conditions of the funding is signed. Programs must submit quarterly reports of income and expenditures to CADAC, and payments are usually made to the programs each quarter. In addition, CADAC fiscal monitors make field visits to programs during the year to review compliance with CADAC financial requirements. Funding may be reduced, suspended, modified, or terminated by CADAC upon 30 days written notice to the grantee.

Table I-2 shows the amount of funds provided by CADAC to various types of programs for state FY 84. As can be seen from the last column in the table, programs receive a significant percentage of their revenue from non-CADAC sources, such as third party payments and client fees. (The types of services offered by CADAC-funded programs are described in Appendix E.)

Table I-2. Connecticut Alcohol and Drug Abuse Commission Grants
By Service Category--State FY 84.

<u>Type of Service</u>	<u>Total CADAC Funding</u>	<u>Percent of All CADAC Funding</u>	<u>Percent of Budget Funded by CADAC</u>
Shelter	\$ 485,586	4.7%	42.5%
Long Term Care	557,345	5.4%	51.8%
Detoxification	1,125,825	10.9%	53.6%
Outpatient	1,932,751	18.6%	45.5%
Residential (Intensive and Intermediate)	3,483,748	33.6%	33.9%
Methadone Treatment	1,795,290	17.3%	58.5%
Primary Prevention	349,581	3.4%	59.3%
Early Intervention	245,092	2.4%	44.1%
Community Awareness and Information and Referral	291,369	2.8%	56.4%
Other	<u>98,140</u>	<u>.9%</u>	31.2%
Total	\$10,364,727	100%	43.4%

Source: Connecticut Alcohol and Drug Abuse Commission.

Table I-3. presents projected activity levels and unit cost data for various types of treatment programs funded by CADAC. The total cost per patient day for residential programs and the annual cost per "slot" for outpatient programs are reflected in the table as well as the portion of those costs paid by CADAC. Variances among programs in the cost per unit of service may be due, among other factors, to differences in the levels of service provided, staffing levels, staff salaries, and utilization rates.

Monitoring. The commission regularly monitors its funded programs to determine if program goals are being met and CADAC funds are being spent in accordance with grant or contract specifications. Two separate CADAC divisions, one for fiscal and one for programmatic monitoring, are responsible for overseeing program performance.

The Grants and Contracts Management Division has three auditors who review quarterly progress reports submitted by the programs and

Table I-3. State FY 84 Projected Activity Levels and Cost Data for CADAC Funded Programs.

Type of Service (No. Programs)	Activity Level	CADAC Average Cost	Total Average Cost	Range of Total Average Cost	
				High	Low
Residential-Drug (14)	132,738 patient days	\$16/day	\$50/day	\$85/day	\$23/day
Intermediate/ Halfway House(10)	47,014 patient days	\$16/day	\$32/day	\$40/day	\$15/day
Outpatient (27)	1,643 avg. census	\$1,126/ slot	\$2,336/ slot	\$50,090/\$1,118/ slot	
Methadone Maintenance (6)	1,159 avg. census	\$1,498/ slot	\$2,554/ slot	\$5,096/\$2,222/ slot	
Alcohol-Medical Detox (4)	16,875 patient days	\$94/day	\$113/day	\$198/day	\$99/day
Day/Evening Treatment (4)	34 avg. census	\$13/day	\$27/day	\$61/day	\$13/day
Shelters (5)	38,820 patient days	\$6/day	\$21/day	\$33/day	\$12/day
Alcohol- Intensive/ Intermediate (4)	19,360 patient days	\$24/day	\$44/day	\$68/day	\$27/day
Long Term Care/ Rehabilita- tion (2)	48,008 patient days	\$12/day	\$22/day	\$31/day	\$17/day
Methadone Detox (2)	29 avg. census	\$2,227/ slot	\$3,691/ slot	\$4,282/\$3,140/ slot	

Source: Legislative Program Review and Investigations Committee.

conduct field visits to monitor the fiscal performance of the commission's 66 grantees. Six staff members of the Program Management Division monitor compliance with programmatic requirements through their review of the program's quarterly progress reports and the performance of site visits.

All CADAC-funded programs are required to submit quarterly reports of their progress in achieving the fiscal and service objectives identified in their funding applications. CADAC fiscal and programmatic staff review these reports for problems in program performance. If a serious problem is found, the grantee is contacted immediately; less serious problems are discussed during regularly scheduled site visits.

Site visits allow CADAC monitors to do an in-depth review of the grantee's fiscal operations, service activities, and management procedures. The visits vary in length from one day to more than a week depending on the size and complexity of the program reviewed. In general, site visits are conducted according to the following format:

- the grantee is notified in advance of the visit;
- an on-site entrance conference is held with program personnel to discuss program operations;
- program records are reviewed by CADAC monitors;
- an exit conference is held with program personnel to discuss CADAC findings and recommendations;
- a site visit report is written by CADAC monitors after the completion of the visit; and
- the report is sent to the grantee.

Fiscal monitoring. Fiscal site visits are conducted by a single Grants and Contracts Division staff member who notifies the grantee of the visit two weeks in advance. Financial activities related to all grantee services are examined even if CADAC funds only a portion of these services. This enables monitors to get an accurate picture of the grantee's financial position and use of commission funds.

In preparation for site visits fiscal monitors examine financial data provided in quarterly reports including the grantee's quarterly budget, any program changes expected to affect the budget, and the program's progress in implementing fiscal recommendations from previous site visits. During a review of this information, CADAC's fiscal monitors compare quarterly budget

totals with those of the previous year and with projections in the current funding application.

During the site visit, fiscal monitors examine financial records including budget accounts, selected ledgers and journals, minutes of board of directors meetings, and bank reconciliations. Any discrepancies discovered by the auditor in actual and reported figures are reconciled.

Fiscal recommendations are intended to bring programs into compliance with CADAC financial requirements and generally accepted accounting procedures. These recommendations typically deal with issues such as inaccurate reporting of budget figures, failure to meet CADAC requirements to report budgetary changes to the commission, and inadequate internal accounting system controls.

The Grants and Contracts Division goal is to visit each grantee twice a year with more frequent site visits to programs having problems meeting CADAC financial requirements. During state FY 84, fiscal auditors performed 88 routine site visits. The frequency of these visits to the 66 grantees is illustrated in Table I-4.

Table I-4. Frequency of CADAC Fiscal Site Visits to Programs--
State FY 84.

Number of Site Visits	Percentage of All Grantees
0	9%
1	52%
2	30%
3	9%
4	0

Source: Legislative Program Review and Investigations Committee.

The commission also conducts technical assistance visits to provide special assistance on proper accounting and financial practices to programs not meeting CADAC standards. During state FY 84 fiscal monitors made 14 technical assistance visits to 9 grantees.

Programmatic Monitoring. Programmatic site visits are conducted by two program management monitors. Prior to a site visit, programmatic monitors review quarterly reports for information on a program's progress in meeting the management and service objectives identified in its funding application. If a grantee offers more than one type of service (e.g., outpatient and residential

treatment), management and service objectives must be reported for each CADAC-funded service component.

Although management and service goals are developed by the grantee for each service component, a standardized set of quantitative activity measures is used for reporting purposes. These measures (e.g., number of persons served, counseling sessions offered) indicate program activity levels and vary with the type of service offered. For example, because their services differ, a shelter and an outpatient treatment program would not report on the same set of activity measures.

When programmatic monitors review quarterly reports, they compare actual achievements with the projections in the funding application. Reported changes in program staffing, organization, and procedures are also analyzed for their effect on the services offered.

During site visits programmatic monitors review client treatment records to determine if client data, medical practices, treatment plans, and treatment procedures meet CADAC requirements. Any violations of these requirements are noted and discussed during the exit conference.

Programmatic recommendations generally require changes in the documentation of client treatment. However, recommendations may also affect treatment services if there is a need for more frequent client contacts or more extensive treatment planning. If program services are being underutilized, the development of a plan to increase utilization may also be required.

The frequency of programmatic site visits is determined by division staff time available and the level of grantee compliance with CADAC requirements. The Program Management Division's goal is to visit each of the 157 prevention, intervention, and treatment programs three times a year. During state FY 84, programmatic monitors conducted 188 site visit reviews--an average of 1.2 per component. The frequency of these visits to the 96 CADAC-funded treatment programs is illustrated in Table I-5.

In FY 84 programmatic monitors participated in research for a report examining the CADAC-funded treatment system, and this reduced the staff time available to conduct site visits. In addition, programmatic monitors made 17 technical assistance visits in which they worked with grantees to improve program operations and/or bring them into compliance with CADAC requirements.

Table I-5. Frequency of Programmatic Site Visits to Treatment Programs--State FY 84.

<u>Number of Site Visits</u>	<u>Percentage of Treatment Programs</u>
0	9%
1	52%
2	35%
3	3%

Source: Legislative Program Review and Investigations Committee.

Programmatic monitors also conduct validation visits to verify the accuracy of client admission and discharge dates reported to the Client Information and Collection System. Twice a year the commission selects one month for which CADAC monitors compare information in the programs' client treatment records with data reported to CICS. The grantee is notified of any inaccuracies in the reported data, and the necessary changes are made in the CICS data base.

Other CADAC Activities

In addition to its basic functions described above, CADAC administers the Pretrial Alcohol Education System (PAES) and the Employee Assistance Program (EAP) for state employees. The commission also provides training for alcohol and drug service providers.

Pretrial Alcohol Education System. CADAC administers the Pretrial Alcohol Education System that allows certain persons charged with driving while under the influence of intoxicating liquor or drugs (DWI) to enter an education or treatment program instead of facing trial for their offense. Persons charged with DWI who apply for the education system have their eligibility for the program evaluated by the Office of Adult Probation. If the court approves an application, the person is assigned to one of the 17 programs that make up the system.

Once assigned to a program, the client is evaluated to determine the severity of his/her drinking problem. If the problem does not appear serious, the client is assigned the Drinking Driver Attitude Reassessment Course. If the person's drinking problem is serious, the client is assigned to Group Interaction.

Attitude reassessment is a 16-hour, 8-session course of lectures and discussion about the use of alcohol as it relates to highway safety. The objective of the course is to teach partici-

pants to recognize the factors that affect their drinking/driving behavior and improve decision-making skills in order to avoid drinking and driving in the future. Group Interaction consists of 10 weeks of group meetings that last an hour and a half. In these sessions, a group therapist leads interaction among people with similar drinking problems.

CADAC contracts with the 17 service providers in the Pretrial Alcohol Education System and pays for the services they provide. Programs are paid \$38.50 for each client evaluation, \$40 for each person assigned to the attitude reassessment course, and \$125 for each group interaction client. Class size for the course is limited to 20 persons while not more than 12 clients can be enrolled in group interaction. Persons who do not successfully complete their program are referred back to the courts to face trial for their offense. PAES activity levels for state FY 84 are reflected in Table I-6.

Table I-6. Pretrial Alcohol Education System Data for State FY 84.

Evaluations	10,753
Participants	7,747
Assigned to Drinking Driver	
Attitude Reassessment Course	2,016 (26%)
Assigned to Group Interaction	5,731 (74%)
<u>% Successful Completion</u>	
Attitude Reassessment Course	96%
Group Interaction	93%
Total PAES	94%

Source: Connecticut Alcohol and Drug Abuse Commission.

State of Connecticut Employee Assistance Program. CADAC runs the Employee Assistance Program for employees of Connecticut state government. This program provides short term counseling and referral services to employees with personal problems (e.g., alcohol or drug abuse; emotional, financial, or family problems). CADAC trains state agency supervisors to recognize employee problems and make referrals to the program. Program counseling and referral services may be provided by qualified staff in an agency or by CADAC personnel. During calendar year 1983, 537 state employees were served through the program.

Training. CADAC provides training to personnel employed in alcohol and drug abuse programs. Training topics range from basic management to clinical supervision; the length of training ranges from a half day to five days. Most of the training is provided by contractors hired by CADAC to meet a specific training need.

During state FY 84 a total of 1,114 participants attended 52 training events conducted by CADAC. Expenditures for training (including the cost of CADAC training staff) for this period totaled \$75,000. In addition to regular training, CADAC also provided 72 scholarships to alcohol studies programs in New Jersey and New Hampshire at a cost of \$22,000.

CHAPTER II

ANALYSIS AND RECOMMENDATIONS

Centralization of Treatment Programs

The appropriate location for substance abuse functions and responsibilities within state government has been an issue since before the creation of the Connecticut Alcohol and Drug Abuse Commission in 1977. At that time community-based programs operated by grantees were removed from the jurisdiction of the Department of Mental Health which continued to operate its own substance abuse programs. CADAC currently has statewide substance abuse planning and coordination responsibilities and administers grants to community-based programs while the Department of Mental Health continues to provide treatment services in state hospitals and community mental health centers.

Department of Mental Health institutional substance abuse treatment programs predominantly serve chronic alcoholics in need of detoxification. The department also operates several rehabilitation programs at its institutions, although it is generally acknowledged that this type of service is best provided in a community setting. A variety of other substance abuse treatment programs are operated by the department at community mental health centers.

The CADAC service system is community-based and provides a wider range of services, including prevention, intervention, and treatment. Community-based services are typically less costly than Department of Mental Health institutional services due to lower salary levels and less of a medical/psychiatric orientation. Data on the two service systems are presented in Table II-1.

While there has been some coordination of services between the Department of Mental Health and CADAC, the division of responsibility between the two agencies has made planning and coordination of substance abuse services more difficult. For example, while the department provides client data to CADAC, not all department programs participate in the automated Client Information Collection System run by CADAC. Although CADAC has responsibility for planning substance abuse services in the state, the department's Plan for Mental Health Services 1982-1987 contains regional objectives for substance abuse services.

Table II-1. CADAC and Department of Mental Health Substance Abuse Services - State FY 84.

	<u>CADAC</u>	<u>DMH</u>
Expenditures ¹	\$14,248,884	\$16,107,294
Admissions ²		
Alcohol	8,301	7,087
Drug	1,008	1,628
Total	<u>9,309</u>	<u>8,715</u>
Patient Days ²		
Alcohol	145,840	95,044
Drug	103,412	41,938
Total	<u>249,252</u>	<u>136,982</u>
Beds ²		
Alcohol	468	275
Drug	355	120
Total	<u>823</u>	<u>395</u>
Average Cost per Bed		
Total	\$15,860	\$40,778
CADAC Share	\$7,649	--
Average Cost Per Patient Day		
Total	\$52.37	\$117.59
CADAC Share	\$25.26	--

¹ Includes estimate of fringe benefit costs for state employees; does not include any DMH indirect costs.

² For residential programs only; does not include shelters.

Source: Legislative Program Review and Investigations Committee.

In testimony before the Legislative Program Review and Investigations Committee, the commissioner of mental health stated that while the department has planned with CADAC, the department has not planned directly with community programs. The commissioner also stated her belief that all treatment services should be based in one agency because the fragmentation of services prevents effective planning for the entire alcohol and drug abuse treatment system. As an example, the commissioner expressed frustration at being responsible for the detoxification of chronic alcoholics

while being unable to plan alternative, community-based care for this population.

In responses to questionnaires developed by the Legislative Program Review and Investigations Committee, CADAC commissioners and executive directors of community-based programs also expressed their dissatisfaction with the current separation of Department of Mental Health and CADAC responsibilities. Eighty-five percent of the 14 commissioners responding to the survey and 72 percent of the 33 executive directors responding did not believe the current separation of activities was appropriate. In addition, 78 percent of the commissioners responding and 89 percent of the executive directors responding said responsibilities for substance abuse should be centralized in CADAC.

The division of alcohol treatment services between CADAC and the Department of Mental Health was analyzed in 1982 by the Office of Policy and Management (OPM) as a program budget issue. Although OPM considers the study an internal working document and has not adopted the resulting recommendations as policy, the report does suggest consolidation of treatment services in CADAC "...to eliminate executive branch fragmentation and overlap to achieve a unified alcohol service policy and service delivery network under the jurisdiction of one state agency." [1]

The program review committee believes substance abuse treatment services should be consolidated within the Connecticut Alcohol and Drug Abuse Commission to:

- centralize responsibility for substance abuse activities, thereby facilitating planning and coordination;
- promote community-based rather than institutional treatment for substance abusers;
- encourage alternative treatment services for chronic alcoholics (e.g., shelters, long-term care); and
- reduce the state's cost of providing substance abuse services.

Accordingly, the Legislative Program Review and Investigations Committee recommends that responsibility for the state's substance abuse treatment programs be centralized by gradually

1 Office of Policy and Management, A Study of the Organization and Delivery of Alcohol Treatment Services in Connecticut, March 1983, unpublished.

replacing institutional programs currently operated by the Department of Mental Health with community-based programs funded by the Connecticut Alcohol and Drug Abuse Commission. A three-year transition plan to accomplish this recommendation shall be developed by a transition group composed of CADAC, Department of Mental Health, Office of Policy and Management, and community-based provider representatives. The House and Senate majority and minority leaders shall each appoint one community-based provider representative to the transition group. The transition plan shall be submitted to the Appropriations and Public Health Committees by February 1, 1986.

It is recognized that the planning and implementation of such a transfer is a complex task; thus, the program review committee recommends that the transition group develop a three-year restructuring plan. This plan should address the following areas:

- the timetable for the phase out and phase in of services over the 36-month period;
- the length of overlap periods needed, if any, to ensure continuity of service;
- the configuration of community-based services needed to replace Department of Mental Health programs;
- the assimilation of department employees providing substance abuse services into other DMH programs;
- the status of noninstitutional departmental services (i.e., whether services provided in community mental health centers should remain in place or be transferred to non-DMH service providers);
- the impact on the state budget for each fiscal year of the transition (i.e., savings realized from DMH program phase out and costs of corresponding community-based services); and
- the revisions in state statutes needed to reflect the new alignment of responsibility.

An estimate of the cost savings to be realized from the transfer plan must be tentative at this time. The specifics of the final plan (i.e., the configuration of community services; the overlap period needed, if any; attrition of department employees; status of community mental health center programs) will affect the estimate.

However, since community-based services are typically less costly than institutional services, cost savings may be expected as a result of the transfer of services. In addition, treatment alternatives for chronic alcoholics may be less costly than the medical detoxification services provided in Department of Mental Health institutions.

The cost figures presented earlier in Table II-1 illustrate the differences in cost between CADAC and Department of Mental Health services. Since the department has a higher percentage of its beds devoted to the most expensive type of service, detoxification, its average cost per bed greatly exceeds the CADAC cost per bed.

The Office of Policy and Management study cited Department of Mental Health per diem charges for beds ranging from \$124 to \$245; CADAC detoxification bed costs range from \$99 to \$198 per day while rehabilitation bed costs range from \$27 to \$68 per day. Replacement of Department of Mental Health detoxification beds with a combination of detoxification and less costly alternative services (e.g., a shelter) would reduce the total cost of services.

The transfer of programs from institutions to communities is also likely to reduce state costs of transporting alcohol and drug clients to treatment facilities. Department of Mental Health costs for transporting these clients totaled \$776,792 in state FY 84.

A proposed transfer plan developed by CADAC and the Department of Mental Health in 1981 estimated annual savings of \$5 million after the transfer was complete. Program review committee staff updated the figures used in the transfer plan to reflect FY 84 costs, and the estimated annual savings after transfer again totaled \$5 million. The committee believes that even if no cost savings occur, consolidation is worthwhile for administrative integrity, improved planning and coordination, and promotion of community-based substance abuse treatment.

Annual Plan

Current state statutes describe the planning responsibilities of CADAC in terms of the agency's role as the designated single state agency for the receipt of federal funds for alcohol and drug abuse. As the single state agency, the commission is required to prepare a comprehensive plan for the prevention, treatment, and reduction of substance abuse problems based upon the recommendations of the regional mental health boards. The federal requirement for this plan was eliminated in 1981, but the state statutes were not amended to reflect the change.

Since the elimination of the federal planning requirement, CADAC has produced a comprehensive plan for state FY 82 as well as two other planning documents, one that examined substance abuse problems in state and another that analyzed the operation of the CADAC-funded treatment system.

Community-based programs have input into the planning process through a legislative mandate in the appropriations act that provides for joint planning between CADAC and the Connecticut Association of Substance Abuse Agencies, a group of 36 service providers. Since CADAC no longer develops a "plan" as such, joint planning efforts have focused on budget priorities for the expansion or reduction of services.

Responses to the program review committee's questionnaire as well as testimony at the committee's public hearing and staff interviews with program personnel indicate that the joint planning process has not completely satisfied the desire of community-based providers for input. A majority of the program executive directors responding to a committee questionnaire were dissatisfied with the CADAC planning process and the amount of input they had into that process. Fifty-six percent of the 36 respondents disagreed with the statement that the CADAC planning process accurately assesses the need for services in the state. Sixty-five percent of the respondents said they did not have adequate input (direct or indirect) into CADAC's planning and budgeting processes.

This dissatisfaction with the joint planning process may be due to several factors:

- the Connecticut Association of Substance Abuse Agencies represents only about half of the CADAC grantees and thus non-CASAA grantees may believe they do not have adequate input;
- programs that are members of CASAA may not be active in the association and/or the joint planning process; and
- some programs that are active in joint planning believe that it has not been effective.

While the Connecticut Alcohol and Drug Abuse Commission has statutory responsibility to plan for alcohol and drug abuse services in the state, input from community programs is essential to developing a viable plan given the community-based orientation of the CADAC-funded treatment system. Although CADAC has obtained community input informally and through the joint planning process, it is evident that community programs continue to believe that their input is either insufficient or not given adequate consideration.

Therefore, the Legislative Program Review and Investigations Committee recommends C.G.S. Sec. 17-155gg(1), regarding the planning responsibilities of the Connecticut Alcohol and Drug Abuse Commission, be amended to provide for:

- development of an annual alcohol and drug plan with long- and short-range priorities;
- creation of a state plan steering committee composed of CADAC commissioners and representatives of community programs;
- an annual survey of alcohol and drug service providers to elicit planning input; and
- regional hearings on a draft of the annual plan to allow input from the community and the public.

Upon passage of legislation to effect these changes, CADAC should meet with its grantees to develop a method of selecting representatives for the plan steering committee. The selection method chosen should be reported to the Public Health Committee within six months of the effective date of the legislation implementing this recommendation.

While recognizing that community participation is essential to effective planning, the committee also acknowledges the need to integrate data from the community into a coherent document reflecting a statewide focus. Community input may vary in quality and objectivity; therefore, CADAC staff, together with the steering committee should review the providers' responses to the needs survey and examine available data to determine the validity of the reported needs.

Using the survey results and other data, the staff and steering committee should prepare a draft plan and conduct regional hearings on it to gather input from interested parties. A summary of survey results should be included in the annual plan. The plan steering committee, which should have no more than 15 members, should also review CADAC's budget to ensure that plan priorities are reflected accurately. The current joint planning process should be discontinued once the new planning process is in place.

Prevention

One Connecticut Alcohol and Drug Abuse Commission approach to the problem of substance abuse is prevention programs. These programs are designed to reduce the probability that members of the general population will need substance abuse treatment. Prevention is the least expensive approach to substance abuse; it

serves the largest number of clients per dollar and, when effective, reduces the societal costs of alcohol and drug abuse.

Substance abuse studies have shown that the longer a person delays in experimenting with drugs, the less likely that person is to habitually abuse drugs.[2] Nationally, drug use among adolescents is on the increase. From 1975 to 1982, the percentage of high school seniors using drugs rose from approximately 55 percent to 65 percent of the students responding to a national survey. The number of eighth graders experimenting with drugs increased from 8 percent of those surveyed in 1971 to 20 percent of those surveyed in 1978.[3]

A recent Rand Corporation study of adolescent drug use found prevention to be the most promising means of drug abuse control.[4] Research shows that prevention programs based solely on providing drug use information have little effect on preventing abuse. However, the study pointed to the success of programs focusing on social influence and peer group norms in preventing cigarette smoking and recommended the adaptation of these methods in drug abuse prevention.

Elementary and secondary schools are the logical place to concentrate prevention activities. Through the schools nearly all of the state's population between the ages of 5 and 18 can be targeted for prevention efforts, and it is possible to reach children at an early age before they begin using alcohol and drugs.

Local and regional school boards are required by C.G.S. Sec. 10-19 to teach the effect of alcohol, nicotine, tobacco, and drugs to all grade levels each year. C.G.S. Sec. 10-16b requires local and regional school boards to report on their health and safety curriculum, although specific information on substance abuse education is not required.

Under C.G.S. Sec. 10-19, the State Board of Education, in consultation with CADAC and other state agencies, is required to develop substance abuse education programs for elementary and secondary schools and for the training of teachers, guidance personnel, and administrators.

² J. Michael Polich, et al., *Strategies for Controlling Adolescent Drug Use* (Santa Monica, CA: The Rand Corporation, 1984), p. 120.

³ Ibid., p. 2.

⁴ Ibid., P. 117.

Thus, while CADAC funds and coordinates prevention programs in the state, the State Board of Education is responsible for overseeing the required substance abuse education programs in the public schools. Due to limited staffing, the Department of Education has not annually monitored the substance abuse prevention programs in Connecticut's 169 school districts.

As a result, neither the Department of Education nor CADAC have accurate information on the type and scope of current substance abuse prevention activities in the schools. In a preliminary document on school prevention activities completed in January 1984, the commission had information on the prevention programs offered by only 65 percent of Connecticut's 169 towns. To the commission's knowledge, only 25 percent of all towns have fulfilled the statutory mandate to provide substance abuse education at all grade levels.

While the State Board of Education's "Guide to Curriculum Development in Health and Safety" suggests goals for prevention activities at the various grade levels, the department has not developed programs or specific curriculum guidelines for substance abuse prevention. Staffing limitations have also prevented the Department of Education from providing local school districts with information and advice on the development of substance abuse prevention programs. A health consultant position was designed to oversee health and safety curriculum, including substance abuse education, but has never been filled. As a result, schools seeking information on prevention are often referred to the Connecticut Alcohol and Drug Abuse Commission.

To improve the planning, coordination, and monitoring of school-based prevention programs, **the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission and the State Board of Education jointly develop a plan by January 1986 to ensure that substance abuse prevention programs are provided by all local and regional school boards. Upon completion of the plan, CADAC should fund up to one full-time position within the Department of Education to oversee school-based substance abuse programs. The plan shall be available to all private, parochial, and technical schools.**

The issues to be addressed in this plan should include:

- curriculum guidelines and/or minimum standards for substance abuse prevention programs in the schools;
- the grade levels for which substance abuse prevention programs should be required;

- training for teachers, administrators, and guidance personnel, i.e., whether all such personnel should receive training, the content of the training, and the organization responsible for this training;
- a system to regularly collect information on school-based substance abuse prevention programs;
- the penalties for school districts that do not comply with prevention program requirements;
- the staff time required by the Department of Education to oversee the school-based substance abuse prevention programs; and
- statutory changes needed to implement the plan.

Outcome Measures

The Connecticut Alcohol and Drug Abuse Commission monitors grantees to determine if program goals and commission requirements are being met. Programmatic monitoring focuses on the program's policies and procedures, client recordkeeping practices, progress in meeting qualitative management and service goals, and progress in achieving the activity levels specified in the program's grant application. Each program must file quarterly reports with the commission detailing activities such as the numbers of bed days provided, clients in treatment, counseling sessions offered, meals served, and referrals made.

While specific goals vary with the type of program funded, the main goal of all programs is to prevent, reduce, or eliminate a client's abuse of alcohol and/or drugs. Yet, the commission does not evaluate how effective its funded programs are in achieving this goal. Activity levels are monitored to determine whether the volume of services provided by a program matches its funding level. However, the commission has not evaluated service providers on the basis of whether clients are better off as a result of participation in the program.

In a survey of commission-funded programs, the program review committee asked whether the measures used by CADAC to monitor programs were good indicators of program performance. One-third of the 69 respondents said these measures were not good performance indicators. When asked what changes in performance measures are necessary, approximately one-third of the respondents to that question said both service quality and the quantity of services offered should be evaluated.

The Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission,

after seeking input from substance abuse service providers, develop objective outcome measures to evaluate the effectiveness of services offered by commission-funded programs.

The program review committee believes a number of different outcome measures could be used to evaluate the effectiveness of services offered by CADAC-funded programs. Among these are: the client's progress in achieving treatment plan goals; the level of alcohol and drug usage; and any improvement in family, social, financial, and employment status after treatment.

The data generated by these indicators should be used to evaluate individual treatment programs, to analyze the effectiveness of different treatment approaches, and to identify and assist less effective programs in improving treatment quality. Once a system of outcome measures has been established, program quality and the effectiveness of different treatment approaches should be considered in the planning and funding decisions of the commission.

The commission is currently developing a computerized exception reporting system that will use 10 key indicators to identify programs that are not performing within guidelines established by the commission. At present, the effectiveness indicators included in the system will only measure the conditions under which clients are discharged from treatment (e.g., with or without the counselor's approval, etc.). While the program review committee commends CADAC for development of this system, additional outcome measures should be added.

Client Follow-up

The commission's current funding regulations do not require programs to follow-up on the condition of discharged clients. A draft version of CADAC's regulations included a follow-up provision that was later deleted when service providers objected to the requirement.

Commission grantees were uncertain about the expense of follow-up procedures. The cost of conducting client follow-up depends on the number of clients surveyed, the frequency of the contact and the type of follow-up required (e.g., survey by letter, telephone, etc.).

If follow-up was required, service providers were concerned that they could not comply with confidentiality requirements. Federal law requires that the confidentiality of client participation in substance abuse treatment be maintained by the service provider. As a result, programs conducting follow-up must either contact former clients without alerting others that the clients have been in treatment, or the program must request that clients

in treatment sign a release form to allow follow-up after discharge.

Despite the difficulties involved, some substance abuse programs have developed client follow-up procedures. In a program review committee survey of commission-funded program directors 44 percent of the 63 respondents stated that they had some form of formal or informal follow-up. In addition, one CADAC grantee is currently receiving \$4,000 in commission funding to conduct a follow-up study of alcoholic clients.

Follow-up procedures, in conjunction with the development of outcome measures, would enable the commission to analyze the effectiveness of programs in improving the functioning of clients over a period of time. **Therefore, the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission staff investigate the merits of requiring CADAC-funded programs to follow-up on discharged clients.**

Among the issues that should be examined in this investigation are: the type of follow-up procedures currently in use by CADAC grantees; the effectiveness of various follow-up approaches and their relative costs; the criteria and methods to be used in reporting follow-up results to the commission; and the need for additional funding to finance follow-up costs.

Unique Client Identifier

All licensed substance abuse treatment programs in the state of Connecticut are required by statute to report treatment statistics to the Connecticut Alcohol and Drug Abuse Commission. The information reported includes data on admission and discharge dates, type of substance abused, educational level, employment status, referrals made, type of discharge (whether treatment terminated with or without program approval), and the client's condition at the time of discharge (improved, no change, worse).

To report this information to the commission's Client Information Collection System, the treatment programs assign each patient a client number to ensure the confidentiality of medical information. If a patient is readmitted to the same program, the previously assigned client number is used to report this information. Thus, the commission can monitor a patient's activity within a single program. However, if a client is admitted to a different program, a new client number is assigned, and the patient's participation in more than one treatment program cannot be traced.

A system of unique client identifiers can be established to track patient participation in multiple treatment programs. In a

survey of nine states, the program review committee found that three (Massachusetts, Rhode Island, and Delaware) have developed unique client identifiers. With a unique identifier, a patient is assigned the same client number regardless of the program entered. The client number may be assigned on the basis of a standard formula used by all programs (e.g., the person's initials, birth-date, and the first four digits of his/her social security number), or through a central registry that matches client names and numbers. In either case, it is possible to monitor clients if they transfer from one treatment program to another.

The Connecticut Alcohol and Drug Abuse Commission identified the development of a unique client number as one option in its "Long Range Data Processing Plan" of November 1983. In the commission's plan, use of the unique client identifier would be limited to the alcohol detoxification programs where there is a high rate of recidivism and clients are most likely to use multiple programs. It was estimated that implementation would cost approximately \$700 and require one and a half person-months.

In 1984 CADAC estimated that it would cost \$5,000 to require all programs to report on the Client Information Collection System using unique client identifiers. However, the commission has placed a higher priority on developing other data processing capabilities and does not currently plan to implement a system of unique client identifiers.

The program review committee believes that the development of a unique identifier would significantly improve the commission's planning and evaluating capabilities. **Therefore, the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission develop unique client identifiers for all commission-funded treatment programs.**

If applied to all programs, information provided by the unique client identifier can be used to evaluate the performance of individual service providers. The identifier would provide data on:

- program success in treating clients as measured by the percentage of discharged clients re-entering the system, the level of treatment utilized upon re-entry, and the client's condition upon re-entry;
- program success in motivating discharged clients to seek further treatment as measured by the percentage of clients discharged with referral who seek further treatment; and

- the way in which clients use the treatment system as measured by the number and type of clients re-entering the system and the type of program re-entered.

Data on client utilization patterns would assist the commission in planning statewide service needs. The movement of clients through the treatment system could be monitored to determine whether patients progress from more to less intensive treatment programs. For example, a large number of clients leaving the system when additional treatment is recommended could indicate the need for modifications of existing services, improvements in the referral system, or the development of alternate modes of treatment.

With a unique identifier the actual number of clients treated by CADAC programs could be determined and the rate of recidivism analyzed for each treatment modality. In the case of alcohol detoxification, where there is a large recidivist population in need of long term care, the commission could more accurately predict the needed capacity for long term care facilities.

Budgeted Capacity

The Connecticut Alcohol and Drug Abuse Commission requires its grantees to report on their utilization rates. The units used to calculate utilization rate vary with the type of service provided. For a residential program the utilization rate is the number of bed days provided compared to the total number of CADAC-funded bed days available; for outpatient programs the number of clients in treatment is compared to the program's capacity to treat clients (represented by "slots" for clients).

To calculate the number of available client slots in state FY 85, the commission developed a formula to determine the budgeted capacity of outpatient programs. This formula is based on the assumption that each counselor can handle a case load of a certain size (e.g., 20 to 25 clients). The outpatient program's total capacity is computed by multiplying the number of counselors available by the expected case load.

In theory, utilization rate is the most objective activity measure available to the commission for monitoring performance because it is based on a program's actual capacity to treat clients rather than on a projected activity level. Other activity measures used by CADAC (e.g., number of meals served, counseling sessions offered) are compared to the grantee's projections of the total service units that will be provided during the year. These estimates of annual activity level are primarily based on past experience. Data on utilization rate are also more reliable than other activity measures because the commission periodically validates program admission and discharge information.

However, the program review committee found that the way in which the commission sets budgeted capacity has diminished the reliability of utilization rate data. The budgeted capacities of 10 of the 43 CADAC-funded outpatient programs were changed as a result of negotiations between commission staff and the service providers when state FY 85 funds were allocated. There was no procedure to document the reasons for these changes or the methods used to determine the new capacity levels. In some cases, correspondence between program personnel and the commission discuss changes in capacity level, but in other cases no explanation of the change is documented.

Program review committee staff found that consistent standards have not been used to determine capacity levels for outpatient programs. For FY 85, a variety of client/counselor ratios were used to determine budgeted capacities for outpatient programs. On the basis of interviews with commission staff it was determined that in two cases a client/counselor ratio of 25:1 was used, in one case a ratio of 20:1 was used, and for the other seven programs combinations of various client/counselor ratios and historic data were used.

Furthermore, capacity figures are not always reliable because the commission has not made timely changes in the recorded budgeted capacities of some programs. When a formula was used to compute total capacity for FY 85, the budgeted capacities of two outpatient programs were reduced to less than one-third of their FY 83 and 84 levels. As a result, these programs' utilization rates for the past two years have not been meaningful measures of service activity.

A utilization rate must accurately measure program activity level before it can be used to evaluate program performance. **Therefore, the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission revise its procedures for determining the budgeted capacity of substance abuse treatment programs by:**

- developing written guidelines;
- documenting the standards applied to determine budgeted capacity and the reasons for any changes; and
- reviewing annually the budgeted capacity of individual programs to ensure that written guidelines are consistently applied and the reasons for change are clearly documented.

Underutilized Programs

CADAC requires programs to maintain the following minimum utilization rates: 85 percent of capacity for residential programs and 80 percent for outpatient programs. Before any funding sanctions for underutilization are applied, however, it is commission policy to work with programs and provide technical assistance to increase utilization.

In reviewing utilization rate data, the committee noted a significant number of programs with utilization rates below CADAC standards. For state FY 84, 47 percent of the 96 treatment programs had annual utilization rates below CADAC standards. One-third of these programs were within 10 percent of the CADAC utilization standard.

Program review committee staff undertook a closer analysis of 8 programs with utilization rates below 70 percent for state fiscal years 1983 and 1984 to determine what efforts had been made to increase utilization and how commission funding of these programs was affected by low utilization. The data presented in Table II-2 on the utilization and funding of these programs indicate that low utilization has had little or no effect on the funding programs receive from CADAC. Reviews of monitoring files for these programs revealed that five of the eight programs had either been provided CADAC technical assistance to improve their utilization or had been required to develop a plan to increase utilization.

As discussed in the previous recommendation, CADAC has not applied a consistent, well-documented method of determining budgeted capacity. As a result, utilization rates are not always reliable as an accurate indicator of program activity. **The Legislative Program Review and Investigations Committee recommends that once CADAC standardizes programs' budgeted capacities, programs that are consistently underutilized should receive reduced funding as provided in their letter of award.**

CADAC should be commended for providing assistance in increasing utilization rates, and the committee believes this assistance should continue. However, programs that are unable to increase utilization to an acceptable level after receiving assistance should have their funding adjusted to a level appropriate to the number of clients actually served.

Frequency of Site Visits

The goal of the CADAC Program Management Division has been to make three site visits a year to each commission-funded service component. These visits provide programmatic monitors with the

Table II-2. Utilization and Funding Levels for Selected CADAC Programs.

	Fiscal Year 1983		Fiscal Year 1984		FY 83	FY 84	FY 85
	Budgeted Capacity	Utilization Rate	Budgeted Capacity	Utilization Rate	Funding Allocation	Funding Allocation	Funding Allocation
<u>Residential Programs</u> ¹							
Program A	25	41.3%	25	46.7%	\$270,535 ²	\$245,000	\$254,739
Program B	21	62.0%	16	66.6%	157,409	143,554	164,767
<u>Outpatient Programs</u> ¹							
Program C	100	32.9%	55	68.9%	125,960	171,893	154,589 ³
Program D	80	25.7%	33	55.0%	65,000	66,527	70,053
Program E ⁴	150	28.7%	150	51.7%	185,000	189,347	199,382
Program F	17.5	48.1%	20	68.7%	28,000	49,472	38,598
Program G	30	23.1%	30	63.3%	15,000	15,352	16,166
Program H	160	22.7%	45	51.1%	26,238	20,670	20,670

¹ Programs may provide other services (e.g., outreach, information and referral) in addition to their primary service.

² Includes funding for outpatient services not included in FY 84 and 85 allocation.

³ Indirect costs paid in previous fiscal years not funded in FY 85 due to program's high cost per slot.

⁴ Program began operation in November 1982.

Source: Legislative Program Review & Investigations Committee.

opportunity to assess program compliance with commission requirements. The commission also receives information on program activities from:

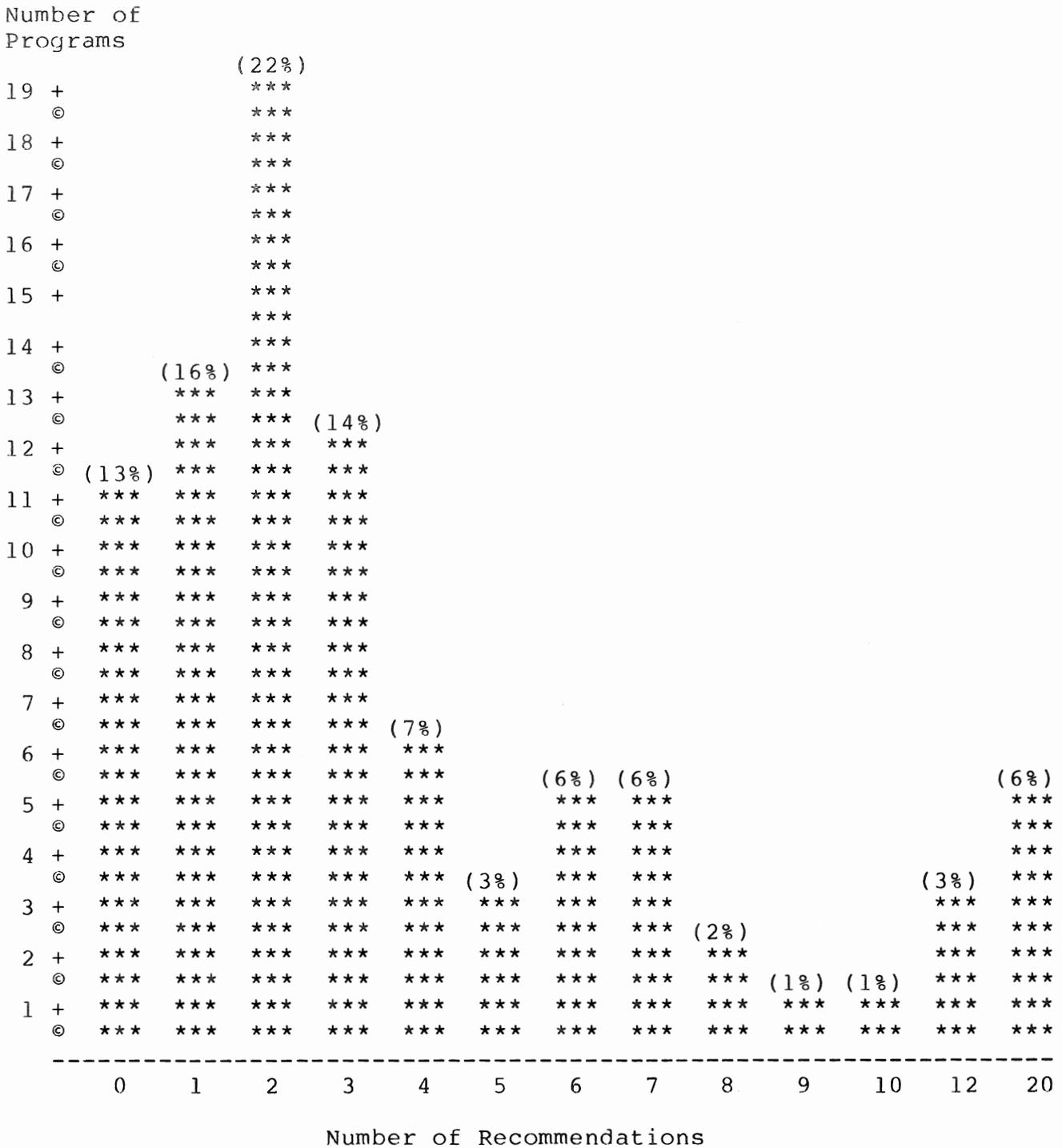
- annual grant applications;
- correspondence with grantees;
- monthly reports on client admission and discharge data;
- quarterly reports on progress in meeting service goals;
- semiannual validation visits, which may be concurrent with regularly scheduled site visits, to check the accuracy of admission and discharge data; and
- license inspection reports from the Department of Health Services, which monitors all treatment programs at least once a year in areas such as staffing policies, record-keeping practices, and client treatment procedures.

Some of the information gathered during site visits is available from other sources. For example, information on significant program changes and compliance with commission recommendations from previous site visits is provided in quarterly reports and program correspondence with the commission.

Unless the program has a significant turnover in management staff, many of the activities monitored in site visits are unlikely to change radically over the course of a year. In a program with stable management, the policy and procedures manual, staff training requirements, and methods of preparing and reviewing client treatment plans are unlikely to change unless the commission recommends modifications during site visits.

To determine the extent to which the commission recommends changes in CADAC-funded programs, the number of recommendations made in programmatic site visits to 96 treatment programs during state FY 84 was analyzed. Eighty-seven programs were visited at least once during the year. Figure II-I illustrates the number of commission recommendations made to each of the 87 programs during their first site visit of FY 84. In 51 percent of the programs, the commission suggested less than three modifications in program procedures.

Figure II-1. Recommendation Frequency--First Site Visit By CADAC Monitors.



Source: Legislative Program Review and Investigations Committee.

In addition, based on commission ratings for a nine-month period, a majority of the CADAC-funded treatment programs were meeting or exceeding CADAC performance requirements during FY 84. An analysis of the performance ratings assigned by the commission to the 96 treatment programs shows that, when program ratings in five categories are averaged, 69 percent of the programs were meeting or exceeding commission requirements for satisfactory performance.

A reduction in the commission's goal to conduct three site visits a year to programs that are meeting CADAC requirements would minimize commission intrusion into the operations of these programs and allow monitoring staff to concentrate their efforts on assisting programs that are having difficulty meeting commission standards. **Therefore, the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission conduct one programmatic site visit per year to each commission-funded service component; additional visits should be scheduled as needed to programs having difficulty meeting CADAC standards.**

In order to direct monitoring efforts toward those programs that are not meeting CADAC standards, the program review committee believes that the commission must improve its methods for scheduling site visits. A statistical test was performed to compare utilization rates, and commission performance rating, with the number of site visits per treatment program during FY 84. This analysis showed that the number of site visits made to a program was not related to the level of program performance. In other words, a site visit was no more likely to be made to a poorly performing program than to a program that was meeting commission requirements.

Since January 1984, the Program Management Division has improved its scheduling of site visits by establishing a log of completed visits, centralizing responsibility for scheduling visits, and developing an exception reporting system that will identify programs not meeting CADAC performance standards. The program review committee commends the commission for making these improvements and believes that CADAC's Program Management Division should establish a procedure to regularly review its site visit scheduling to ensure that multiple site visits are targeted to programs having difficulty meeting commission standards.

Consistency of Regulation

C.G.S. Sec. 19a-491(a) requires all alcohol and drug treatment programs in the state of Connecticut that treat clients over the age of 17 to be licensed by the Department of Health Services. This license must be renewed annually, and the department makes at

least one site visit per year to each licensed program to monitor compliance with department regulations.

According to CADAC statistics there are 55 licensed alcohol or drug treatment programs in the state, 84 percent of which are funded by the commission. CADAC monitors the programs it funds to ensure that commission requirements are met. As a result, 84 percent of all licensed substance abuse treatment programs in the state are monitored by both the Department of Health Services and the Connecticut Alcohol and Drug Abuse Commission.

Each of these state agencies has developed its own set of standards and requirements for monitoring programs. The CADAC funding regulations, approved in October 1984, are used to monitor commissionfunded programs. The Department of Health Services has two separate sets of licensing regulations, one for alcohol and one for drug treatment programs. The department is in the process of developing a new set of regulations that will govern both alcohol and drug treatment facilities. CADAC and the Connecticut Association of Substance Abuse Agencies are participating in the development of those new regulations.

In a survey of commission-funded program directors, the program review committee asked if there was any duplication or overlap in the monitoring activities of state agencies. Of the 29 respondents who believed overlap existed, 69 percent specified that the monitoring activities of CADAC and the Department of Health Services were duplicative. The area of duplication cited most often was the monitoring of client records (10 comments).

In an analysis of CADAC and DOHS current and proposed regulations, the program review committee found that both agencies monitor client treatment records, employee qualifications, staffing levels, program governing authorities, and program policies and procedures for various types of treatment (e.g., alcohol detoxification, methadone maintenance, etc.). In some areas, CADAC and the Department of Health Services review the same documents but with slightly different requirements. For example, both agencies review client treatment records for the inclusion of treatment plans, progress notes, and treatment plan reviews. However, the commission's regulations are more specific about the content of these documents and require more frequent treatment plan reviews.

Review of program records by two state agencies for similar purposes creates a duplication of effort. **The Legislative Program Review and Investigations Committee recommends that the coordination between the regulatory functions of the Connecticut Alcohol and Drug Abuse Commission and the Department of Health Services be improved by:**

- requiring by statute that CADAC and DOHS substance abuse regulations be consistent; and
- requiring the Department of Health Services, once consistent substance abuse regulations are developed, to provide detailed reports of licensing inspections to CADAC for use in its program evaluations.

The license inspection reports should include information on the number of client records reviewed, the areas reviewed, and the areas and number of incidents of noncompliance with licensing regulations. The use of consistent standards will enable the commission to incorporate the results of DOHS reviews into CADAC program evaluations. This will reduce the number of commission staff hours necessary to monitor program compliance with documentation requirements and allow CADAC monitors to focus on commission standards that are not monitored by the Department of Health Services.

The Connecticut Alcohol and Drug Abuse Commission and the Department of Health Services have different regulatory philosophies, with the department more medically oriented in its requirements than the commission. Some CADAC-funded service providers have expressed concern that the philosophical differences of the two agencies will lead to inconsistent regulations. In testimony before the Legislative Program Review and Investigations Committee, one program director objected to the lack of coordination in the types of service categories recognized in current CADAC and draft DOHS regulations. For example, one of the service categories recognized by CADAC for funding purposes is non-medical detoxification; this category is not included in the services eligible for licensing under the draft DOHS regulations. As a result, service providers could be caught in the middle of a dispute between the two agencies with CADAC requiring one set of services for funding and DOHS requiring a different set of services for licensure.

It is uncertain whether the inconsistencies in the current CADAC and the new DOHS regulations will be resolved during the public comment period required prior to the adoption of the DOHS regulations. Therefore, the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission and the Department of Health Services be required to meet to resolve any inconsistencies between the final draft of the proposed DOHS substance abuse licensing regulations and the current CADAC regulations. If these conflicts have not been resolved by the time DOHS regulations are submitted to the legislature for final approval, both agencies should submit reports addressing the inconsistencies to the Regulations Review Committee.

Changes in the Composition and Operation of the Commission

The executive director of the Connecticut Alcohol and Drug Abuse Commission by statute is also a voting member of the commission. Thus, the executive director as a commissioner sets policy for the agency, and then as executive director, is responsible for implementing that policy. These two functions should be separated to clearly define the role of the executive director and eliminate possible conflicts of interest. **The Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission statutes be amended to remove the executive director from membership on the commission.**

Currently, a double standard exists for commissioners voting on programs with which they are affiliated. State agency representatives can vote on matters specifically affecting the substance abuse programs operated by their agency while appointed commissioners associated with a community-based program abstain from voting on their own programs.

A 1983 letter from the attorney general indicated that state agency representatives on CADAC did not have a conflict of interest in voting on matters affecting their own agency because the officials did not stand to benefit in an individual or personal capacity. However, a 1980 advisory opinion from the State Ethics Commission recommended that appointed CADAC commissioners who were also members of the board of directors of community programs resign one of the two positions since the programs they represent could directly benefit from their official actions as CADAC commissioners.

Since the ethics commission opinion was not binding, CADAC adopted a practice whereby appointed commissioners may retain their directorships but must abstain from voting on their own programs; there are two commissioners who currently serve as directors of community programs. State agency representatives, while not required to do so, also frequently abstain from voting on their own programs.

The program review committee believes the expertise possessed by representatives of community programs is essential to the operation of an informed commission. Therefore, in order to resolve the double standard issue, **the Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission statutes be amended to allow representatives of community-based programs to serve as commissioners, but prohibit all commissioners from voting on matters that specifically affect a program with which they are affiliated.**

Although CADAC usually has a quorum at its monthly meetings, a review of individual commissioners' attendance indicated that a few of the commissioners are not active. **The Legislative Program Review and Investigations Committee recommends that the Connecticut Alcohol and Drug Abuse Commission statutes be amended to implement model sunset recommendations on commissioners' attendance and number of terms.** Under the model provisions, appointed commissioners who fail to attend three consecutive meetings or who fail to attend 50 percent of all meetings during any calendar year shall be deemed resigned from office. In addition, appointed commissioners shall be limited to two consecutive full terms to ensure the introduction of a fresh perspective to the commission.

Several changes in CADAC's bylaws are needed to ensure that they conform to the spirit and the letter of the statutes. C.G.S. Sec. 17-155ff states that a majority of the commission shall constitute a quorum. Two CADAC bylaws, however, state that commission action may be taken without a quorum. Under Section III(b) of the bylaws, the membership attending a duly called meeting at which a quorum is present may continue to do business despite the later withdrawal of enough members to leave less than a quorum. Section XIII(c) states that CADAC's Executive Committee (consisting of the officers of CADAC, the executive director, and the chairpersons of the standing committees) may act on behalf of the commission between regular meetings.

Section IV(a) of the bylaws states the chairperson of the commission shall be appointed by the governor, although C.G.S. Sec. 17-155ff provides for the election of the chairperson and other officers by the commission. To eliminate these conflicts, **the Legislative Program Review and Investigations Committee recommends the Connecticut Alcohol and Drug Abuse Commission amend its bylaws to conform with state statutes.**

Statutory Mandate

State statutes prescribing CADAC's powers and duties enumerate 15 activities the commission is required to perform and charge the executive director with seven areas of responsibility. While all of the activities currently listed in statute are desirable, the inclusion of some of these items as statutory duties is not appropriate. For example, four statutory duties require CADAC to "encourage" or "foster" activities related to substance abuse. CADAC's compliance with such statutory mandates cannot be accurately determined. Several statutory duties are obsolete such as the approval of Department of Mental Health substance abuse contracts, while others like research and job development for substance abusers are not performed due to lack of funding. Several statutory responsibilities of the executive director also overlap or duplicate the duties of the commission.

The presence of vague and obsolete items as statutory duties muddles the basic mission of CADAC and may unduly raise expectations of what the commission can do. The overlap of duties between the executive director and the commission needs to be eliminated to provide clear lines of responsibility. **Therefore, the Legislative Program Review and Investigations Committee recommends that the statutory mandate of the Connecticut Alcohol and Drug Abuse Commission be revised to focus on the agency's basic mission of planning, coordinating, funding, and monitoring substance abuse activities in the state. The proposed revision should be included in their legislative proposals for the 1986 session of the General Assembly.**

PAES Data

Since 1982 CADAC has tried to obtain driving while intoxicated conviction data for Pretrial Alcohol Education System (PAES) participants from the Department of Motor Vehicles. To date, technical problems and concerns about the confidentiality of records have prevented development of a system to produce this information. These problems have now been resolved and recidivist data should be available to the commission by March 1985.

With this data, CADAC and the legislature can gauge the effectiveness of PAES in reducing drinking and driving behavior. Recidivist data will also allow CADAC to compare the relative performance of the 17 contractors who operate PAES programs. **The Legislative Program Review and Investigations Committee recommends that recidivism data for Pretrial Alcohol Education System participants be analyzed to evaluate the effectiveness of the program and determine if changes in its structure are needed.**

Information about recidivists should be analyzed to determine if program design changes are needed. If, for example, a high percentage of recidivists are found to have had a very high blood alcohol content, it may indicate that the current program is not effective for these persons, and a new approach may be needed for this population.

Restrictions on PAES Participation

The Pretrial Alcohol Education System was designed to enable DWI first offenders to re-evaluate and change their drinking and driving behaviors. However, certain statutory changes are needed to ensure that second offenders and persons violating program rules are not allowed to participate in the system. The current wording of the PAES statutes provide that applicants must state under oath in court that they have never had PAES invoked on their behalf and have not been convicted of driving while intoxicated, in order to have the information or complaint against them sealed to the public.

This statutory language does not, however, prevent a prior PAES participant or second offender from entering PAES; it just prevents sealing of the complaint or information. C.G.S. Sec. 54-56g also provides that if the defendant does not successfully complete the PAES program, the court shall unseal the information or complaint, and the case shall be brought to trial.

Discussions with CADAC staff and PAES contractors as well as testimony at the program review committee's public hearing indicated that courts sometimes allow defendants who have violated program rules (e.g., failing to attend, disrupting sessions, showing up intoxicated) to return to the program. This practice creates two difficulties for the programs: the integrity of program rules is compromised, and programs are undercompensated since they are paid only once for a defendant who takes up a slot in two different PAES groups.

Although accurate data on the number of returned "violators" are not currently available, CADAC staff estimates that 16 percent of the individuals who violated program rules were returned to the program by the courts in state FY 84. To correct these problems, **the Legislative Program Review and Investigations Committee recommends C.G.S. Sec. 54-56g be amended to ensure that second-time driving while intoxicated offenders, prior Pretrial Alcohol Education System participants, and persons dismissed from that program are not allowed to enter or reenter the Pretrial Alcohol Education System.**

APPENDICES

APPENDIX A

PERFORMANCE AUDIT METHODOLOGY

The Legislative Program Review and Investigations Committee examined data from a variety of sources in its performance audit of the Connecticut Alcohol and Drug Abuse Commission. The sections of the Connecticut General Statutes governing CADAC operations as well as the commission's funding regulations were reviewed. Committee staff also examined a variety of CADAC funding and monitoring documents including grant applications, quarterly progress reports, site visit reports, CADAC ratings of program performance, and utilization rate reports. The planning documents examined included the commission's FY 82 State Plan Update, a 1984 analysis of the CADAC-funded substance abuse treatment system, and a 1984 report describing the operations of the statewide substance abuse system.

Program review committee staff interviewed six CADAC commissioners, including the chairpersons of the full commission and its two committees. The commission's operations were discussed with staff members from each CADAC division and with representatives of the Connecticut Association of Substance Abuse Agencies and other community-based programs. Program review committee staff also met with representatives from the Departments of Children and Youth Services, Education, Health Services, Mental Health, and Motor Vehicles regarding their roles in the substance abuse system.

National substance abuse organizations (e.g., the Alcohol, Drug Abuse and Mental Health Administration, the National Institute on Alcohol Abuse and Alcoholism, and the National Association of State Alcohol and Drug Abuse Directors) were contacted for information on the administration of substance abuse services in other states, new approaches to providing these services, and confidentiality problems entailed in tracking patients through multiple treatment programs.

Program review committee staff attended meetings of the CADAC community planning, policy and planning, and budget and operations committees as well as full commission meetings. A meeting sponsored by the Connecticut Association of Substance Abuse Agencies at which the commissioner of mental health and the executive director of CADAC discussed their roles in the state substance abuse system was also observed by program review committee staff. In addition, committee staff accompanied CADAC monitors on six site visits to treatment, prevention, and Pretrial Alcohol Education System programs.

To obtain information on the commission's operations and effectiveness in performing its duties, surveys were sent to the 22 CADAC commissioners, the 66 CADAC grantees, and 106 of the grantees' individual service components. In addition, a telephone survey of nine states was conducted regarding the administration and organization of substance abuse services in those states.

The Legislative Program Review and Investigations Committee also held a public hearing on CADAC operations, focusing on its effectiveness in planning, funding, monitoring, and coordinating state substance abuse services. Among those testifying at the hearing were CADAC commissioners, the commissioner of mental health, and representatives from the Connecticut Association of Substance Abuse Agencies and community-based substance abuse programs.

APPENDIX B

HISTORY OF THE CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION

Until the late 19th century alcohol abuse was treated primarily as a legal offense in the state of Connecticut. In the 1870s the Connecticut General Assembly became concerned with the care and treatment of alcoholics. A legislative study commission found that intemperance was a disease and recommended medical care for curable alcoholics. As a result, legislation was adopted in 1874 to allow alcoholics and drug addicts to be taken to an inebriate asylum for treatment, care, and custody. In 1915 the State Farm for Inebriates was established at Norwich State Hospital for the Insane to treat male inebriates.

Board of Trustees of the State Fund for Inebriates

In the mid 1900s the state began to take a more active role in the study, planning, and coordination of alcohol treatment programs. In 1945, a five-member board of trustees of the State Fund for Inebriates was established. The board was responsible for studying the problem of alcoholism, promoting discussion of the problems involved in the treatment of alcoholics, and disseminating information on alcoholism.

Care and treatment for alcoholics was provided by clinics operated by the board of trustees. Individuals with alcohol abuse problems could seek the assistance of the board on a voluntary basis or could be committed to the board's care by the courts.

Commission on Alcoholism

In 1947, Public Act 157 changed the name of the board of trustees to the Commission on Alcoholism. In 1959 the commission was statutorily placed within the Department of Mental Health for fiscal and budgetary purposes. The commission was financed from the General Fund, and the Department of Mental Health was responsible for supervising its operations. Under the same act, the commission and the department were required to submit legislation to the General Assembly in 1961 to eliminate the commission and transfer its functions to the department.

In 1961, Public Act 527 dissolved the Commission on Alcoholism and established an Alcoholism Division within the Department of Mental Health. The duties of the Alcoholism Division, which were similar to those of the commission, were to study the problems of alcoholism, disseminate information on the subject, and train personnel to work in the field of alcoholism. The division could also provide treatment and assistance to individuals with alcohol abuse problems.

In 1967, Public Act 555 changed the division's name to the Alcohol and Drug Dependence Division. The division's duties were expanded to include the treatment of drug-dependent individuals and the study and dissemination of information on the topic of drug addiction. Subsequent to a reorganization of the Department of Mental Health in 1972, the division was eliminated as a separate administrative unit, but its duties were retained within the department.

State Councils and Commissions

Between 1967 and 1984, six different councils and commissions were established to deal with state alcohol and drug abuse policy. The major duties of these groups were the development of state plans, the coordination of state programs, and the administration of state and federal funds for drug and alcohol abuse. While the statutes consistently authorized the councils to perform the planning and coordination functions, the responsibility for program funding was transferred back and forth between the Department of Mental Health and the various councils. The trend in recent years has been to reduce the number of councils and consolidate the planning, coordinating, and funding functions within the Connecticut Alcohol and Drug Abuse Commission (CADAC).

Drug and alcohol councils. In 1972, the federal government adopted Public Law 92-255 requiring the designation of a single state agency to develop and administer a comprehensive drug prevention and treatment plan. To comply with this federal requirement, Public Act 73-208 was adopted in 1973 to establish a 12-member Drug Council as the single state agency for drug abuse programs.

The Drug Council was responsible for the development of the state comprehensive plan for drug abuse prevention and for the coordination of all drug abuse programs in the state. To carry out these responsibilities, the Drug Council studied state laws and treatment facilities concerned with drug abuse, and recommended changes in drug abuse policies and programs.

The commissioner of mental health was the Drug Council chairperson, and funding for the council was provided by the Department of Mental Health. The council was required to meet at least quarterly. Council members served three-year terms without compensation.

The Connecticut State Alcohol Council was established in 1974 by Public Act 74-280 as the single state agency to administer federal funds for alcohol abuse programs. The alcohol council was required to develop and supervise the implementation of the state comprehensive plan for the prevention, treatment, and reduction of alcohol problems. It was also responsible for coordinating all

state activities related to alcohol problems. State agencies dealing with alcohol abuse problems were required to report changes in their policies and regulations to the alcohol council.

The commissioner of mental health was the council chairperson, and the vice chairman was elected by the council members. Council members served without compensation. The 14-member alcohol council was required to meet at least quarterly. Funding for outside experts employed by the council was provided by the Department of Mental Health.

In 1975, Public Act 75-523 designated the Department of Mental Health as the single state agency for the distribution of federal funding for drug and alcohol programs. The two councils were placed within the Department of Mental Health for fiscal and budgetary purposes but each retained their responsibilities for state planning. In 1977, Public Act 77-544 eliminated both councils and transferred their responsibilities to the Connecticut Alcohol and Drug Abuse Council.

Connecticut State Drug Advisory Council. In 1967, the Drug Advisory Council was established by Public Act 555. The advisory council was responsible for studying both the laws related to controlled drugs and drug addiction, and the facilities available for the treatment of drug dependent persons.

The advisory council was also responsible for coordinating the drug-related activities of state agencies. Departments concerned with controlled drugs were to report to the council annually and to notify the council of any changes in drug policies and regulations. In addition, the council was to establish a task force to coordinate the state's educational programs dealing with drug and alcohol abuse.

The commissioner of health was the council chairperson and any fiscal or clerical services required by the council were to be provided by the Department of Health. The 21-member council was required to meet at least quarterly. Council members served without compensation for three-year terms.

In 1973, Public Act 73-208 transferred most of the Drug Advisory Council's duties to the Drug Council. After the adoption of this act, the Drug Advisory Council's primary responsibility was to advise the Drug Council on the development of the state comprehensive plan for drug abuse prevention.

In 1977, Public Act 77-544 changed the name of the Drug Advisory Council to the Connecticut State Drug Advisory Council. The council was also given the responsibility to advise on the establishment of standards for licensing treatment facilities. The council continued to advise on the development of the comprehensive plan

for drug abuse prevention, but was no longer responsible for advising on the plan's implementation.

Connecticut State Alcohol Advisory Council. The alcohol advisory council was established in 1974 by Public Act 74-280. The primary duties of the advisory council were to work with the alcohol council in establishing a task force on alcohol education programs and to advise the alcohol council on the development of the state comprehensive plan for alcohol problems.

The chairperson of the 13-member advisory council was appointed by the governor. Advisory council members served three-year terms without compensation. The advisory council was required to meet periodically, and the Department of Mental Health provided the council with fiscal and clerical services.

Connecticut State Alcohol and Drug Advisory Council. In 1981, Public Act 81-473 combined the alcohol and drug advisory councils to form a 22-member Connecticut State Alcohol and Drug Advisory Council. The primary duty of the alcohol and drug advisory council was to advise in the development of comprehensive plans for the prevention, treatment, and reduction of alcohol and drug abuse problems. The council was also permitted to advise on funding decisions and other matters before the Connecticut Alcohol and Drug Abuse Commission.

The federal law requiring the existence of an advisory council was repealed in 1981, and the council did not meet after that time. As a result, in 1983, Public Act 83-160 abolished the State Alcohol and Drug Advisory Council.

Connecticut Alcohol and Drug Abuse Commission. In 1977, Public Act 77-544 established the Connecticut Alcohol and Drug Abuse Council. The comprehensive plans for both alcohol and drug abuse were to be developed by the council based upon the recommendations of the alcohol and drug advisory councils. Employee assistance, occupational, and job development programs for alcohol and drug dependent persons were also to be encouraged by CADAC.

The council was further required to provide information on the effects of alcohol and drug abuse and to develop and foster programs to reduce the incidence of this abuse. The council was also responsible for disseminating educational material and encouraging research on the topic of alcohol and drug abuse.

Public Act 77-544 gave the council the authority to make grants to or contract with certain state agencies that deal with alcohol and drug abuse problems. CADAC could require quarterly reports from all state departments dealing with alcohol and drug abuse problems for the purpose of evaluating the implementation of the state alcohol and drug abuse plans. Each year, CADAC was required to report

its findings and recommendations to the governor and the General Assembly. When necessary to fulfill its functions, the council was also authorized to make grants and contracts with outside agencies.

The 22-member Connecticut Alcohol and Drug Abuse Council was required to meet at least quarterly, and a majority of its members constituted a quorum. The commissioner of mental health was the council's chairperson, and the council was placed within the Department of Mental Health for fiscal and budgetary purposes. The governor was required to appoint an executive director of the council.

Public Act 77-544 was ambiguous as to whether CADAC or the Department of Mental Health was the lead agency for distributing alcohol and drug abuse funds. To clarify the council's authority, Public Act 78-127, adopted in 1978, designated CADAC as the single state agency for alcohol and drug abuse. As a result, CADAC was responsible for distributing all federal funds received by the council for alcohol and drug abuse programs. The council administered and supervised both federal and state grants and contracts for alcohol and drug abuse community services, except for those services designated to be carried out by agencies other than the Department of Mental Health.

Public Act 78-127 required programs requesting CADAC funds to provide the council with a definition of the area to be served by the program, a plan for coordinating the program's activities with other organizations providing such services, a description of the services to be provided, and an explanation of the methods used to encourage local initiative and participation. In addition, with the adoption of this act, employees of organizations benefiting from CADAC grants were no longer prohibited by statute from serving on the council, the chairperson of the council was elected by its members, and the council was placed within the Department of Mental Health for administrative purposes only.

The name of the council was causing some confusion because of its similarity to the titles of alcohol and drug advisory councils then in existence. As a result, Public Act 80-92 was adopted in 1980 to change the name of the council to the Connecticut Alcohol and Drug Abuse Commission.

Public Act 81-96 was adopted in 1981 to mandate that CADAC require all licensed alcohol and drug treatment facilities to keep and make available statistics that included the number of persons treated, the frequency of admission and readmission, and the frequency and duration of treatment. This act was adopted to ensure that statistical information would be available to CADAC from both state and privately funded treatment programs.

A 1981 sunset review of the alcohol and drug advisory councils recommended that two of CADAC's appointed members be former alcohol

abusers and that two be former drug abusers. Public Act 81-473 was adopted in 1981 to make this change in the council's membership.

In 1981, Public Act 81-446 was adopted requiring the Office of Adult Probation to contract with CADAC to oversee alcohol education and treatment programs for the Pretrial Alcohol Education System (PAES). The commission was also required to draft regulations to establish standards for these programs. In 1982, Public Act 82-408 removed the Office of Adult Probation from the contracting process for PAES. Thus, CADAC was solely responsible for contracting with PAES service providers. In addition, the commission was given the authority to administer the alcohol and education treatment fund for the purpose of financing these services.

As a result of the State Alcohol and Drug Advisory Council's termination in 1983, CADAC assumed the council's duties in developing drug and alcohol education programs. Under the provisions of Public Act 83-160, the State Board of Education was required to consult with the commission in developing training and health education programs for elementary and secondary schools on the effects of alcohol and drugs.

In 1983, Public Act 83-508 eliminated the alcohol education and treatment fund, and provided for the transfer of the fund's balance to the General Fund. Thus, after state FY 1983 CADAC was no longer responsible for administering this fund, but the commission's authority to oversee PAES remained unchanged.

Public Act 83-557 was adopted in 1983 to require CADAC to certify and register alcoholism counselors. The act required CADAC to adopt regulations specifying experience and training criteria for certification, and the necessary procedures to suspend or revoke a certificate. The commission was required to maintain a current registry of all certified alcoholism counselors.

APPENDIX C

CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION (CADAC)

STATUTORY REFERENCE: C.G.S. Sections 17-155ff through 17-155ii

ESTABLISHED: 1977 (P.A. 77-544)

LOCATION: Department of Mental Health for administrative purposes only

PURPOSE: To plan, coordinate, and fund activities in order to establish comprehensive, community-based systems for preventing and treating alcohol and drug abuse

POWERS AND DUTIES:

The Connecticut Alcohol and Drug Abuse Commission shall:

- Serve as the single state agency for alcohol and drug abuse as required for receipt of federal funds; specifically:
 - prepare, develop, and approve a comprehensive plan for the prevention, treatment, and reduction of alcohol and drug abuse problems;
 - allocate federal funds for alcohol and drug programs and state grants for community alcohol and drug programs;
 - administer and supervise federal and state funds for community alcohol and drug services carried out by the Department of Mental Health; and
 - solicit and accept gifts and grants from all public and private sources.
- Coordinate all state alcohol and drug abuse activities.
- Insure effective coordination among state departments' activities related to alcohol and drug abuse.
- Approve copies of grants and contracts by the Department of Mental Health to agencies for the delivery of alcohol and drug services prior to execution.
- Prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and drugs.

- Develop and foster educational and prevention programs to reduce the incidence of substance abuse.
- Organize, foster and participate in training programs for persons engaged in alcohol and drug treatment.
- Sponsor and encourage research into the cause, nature, and treatment of alcoholism and drug dependence.
- Specify uniform methods for keeping statistics; require all licensed facilities to implement these methods; and collect and make available relevant statistics.
- Foster the development of public and private sector employees' assistance and occupational alcoholism and drug abuse programs.
- Foster and encourage job development programs for alcoholics and drug-dependent persons.
- Utilize persons in the community to encourage alcohol and drug dependent persons to seek help voluntarily.
- Encourage all appropriate facilities to admit without discrimination alcoholics and intoxicated and drug dependent persons seeking help for their problems.
- Encourage all health and disability insurance programs to include alcoholism and drug dependence as covered illnesses.
- Make grants, contracts, and other joint or cooperative agreements with the Department of Mental Health and other individuals, organizations, and agencies for problems related to alcohol and drug abuse.

The Connecticut Alcohol and Drug Abuse Commission may:

- Require quarterly reports from funding recipients and from all state agencies whose activities are alcohol and drug related for the purpose of evaluating implementation of state plans. If quarterly reports are required, the commission shall report findings and recommendations for executive and legislative action to the governor and General Assembly annually.

- Hold hearings, issue subpoenas, administer oaths, compel testimony, and order production of books, papers, and records in the performance of duties.
- Make grants and contracts with public or private agencies as may be necessary to perform duties and execute powers.

STAFF: 54 full-time positions

The statutory duties of the executive director who is appointed by the governor with the advice of the commission, are to:

- employ a deputy director and necessary staff;
- prepare reports to the commission;
- evaluate and plan for alcohol and drug abuse programs; and
- assist the commission by:
 - identifying alcohol and drug abuse needs,
 - establishing priorities for substance abuse programs and projects,
 - supervising limited research related to state needs and problems,
 - conducting information and technology transfer operations,
 - formulating state guidelines,
 - reviewing and coordinating federal grant applications for substance abuse programs and projects,
 - coordinating regulatory functions of the entities represented on the commission, and
 - performing other functions and duties as necessary.

APPENDIX D

CONN. STATE AGENCIES INVOLVED IN SUBSTANCE ABUSE ACTIVITIES

- Department on Aging--administers preventive education program for elderly on proper usage of medications; investigates cases of alcohol and drug abuse among the elderly and refers individuals for treatment.
- Department of Children and Youth Services*--responsible for licensing substance abuse treatment programs for clients less than 18 years of age.
- Department of Correction*--the Addiction Services Division provides identification, screening, and treatment services for substance abusers during their incarceration and at the time of their re-entry into the community.
- Department of Education*--the State Board of Education in consultation with CADAC and other state agencies must develop substance abuse education programs for primary and secondary schools on the effects of alcohol and drugs.
- Department of Health Services*--provides data utilized by CADAC on drug-related deaths, develops the state health plan that includes a section on substance abuse, and licenses community-based substance abuse treatment programs.
- Department of Human Resources--administers the Social Services Block Grant, a portion of which is allocated to CADAC to fund substance abuse services.
- Department of Income Maintenance--reimburses certain intensive residential treatment and methadone maintenance programs; determines the reimbursement rate for eligible treatment programs based on the level of program expenses.
- Department of Mental Health*--provides inpatient treatment for substance abuse problems at department facilities. Services provided include detoxification, intensive treatment, and rehabilitation with the majority of clients receiving alcohol detoxification services.
- Department of Motor Vehicles*--provides driver improvement courses for individuals convicted of driving while intoxicated; refers repeat offenders to alcohol treatment programs.
- Office of Adult Probation*--identifies probationers in need of substance abuse services and refers them to experts for further screening and treatment.

* Represented on CADAC board.

APPENDIX E

TYPES OF ALCOHOL AND DRUG ABUSE SERVICES

1. Detoxification (Alcohol and Drug)-Management of clients withdrawing from the effects of alcohol and/or drug abuse/misuse through medical or nonmedical means under the supervision of trained personnel. Treatment is most often provided on an inpatient basis in order to ensure the safety and well being of clients who are experiencing potentially life threatening withdrawal symptoms.
2. Intensive treatment (14 to 30 day Rehabilitation) - Residential rehabilitation of substance abusers providing 24 hour supervised care and treatment under the direction of professional staff.
3. Residential Drug Free Treatment (6 to 18 months Rehabilitation) - Live in facilities where planned treatment and rehabilitation programs are offered to individuals in need of a 24 hour a day supportive environment.
4. Intermediate Treatment (Halfway House) - Community-based, peer group oriented, residential facility for persons in transition from inpatient rehabilitation to the community. Clients are assisted with the various aspects of re-entry including vocational rehabilitation and resocialization.
5. Long Term Care (3 months to 1 year) - Long term residential program providing a supportive environment for the chronic relapsing alcoholic, for whom the established health and mental health system has proven ineffective.
6. Shelter Care - An overnight program which provides basic care for intoxicated persons in need of a protected, supportive environment.
7. Day Care - Treatment provided by a unit where the client resides outside of the unit. The client participates in a drug/alcohol abuse treatment program, with or without medication, in accordance with a prescribed attendance schedule (typically 5 hours/day, 5 days/week).
8. Outpatient Treatment - Treatment provided by a unit where the client resides outside the facility. The client participates in a drug/alcohol abuse treatment program, with (e.g., methadone maintenance) or without medication, and attends the treatment unit according to a prescribed schedule for services that include individual, group, and family therapy as well as supportive services.

9. Education, Information, and Referral - Collection and dissemination of knowledge or material relating to alcohol and/or drug abuse. Services include the maintenance of a speakers bureau, school-based prevention services, mass media campaigns, preparation of brochures, and referrals to other community-based substance abuse services.
10. Primary Prevention - Programs focus on the development of life skills that are useful in coping with life stresses. The goal of this type of program is to diminish the probability of substance abuse in the target population by equipping persons with such skills as: self-esteem building, decision making, problem solving, handling feelings, handling peer pressure, financial management, life planning, etc. Prevention programs usually focus on high risk groups such as youth, elderly and women.
11. Early Intervention - Programs focus on short term counseling and/or diagnostic assessment, referral to ongoing treatment, hotlines and support groups. Early intervention in a problem such as substance abuse often precludes development of the more serious and debilitating consequences of addiction. Employee Assistance Programs are designed to intervene in personal and family problems that interfere with job performance.

APPENDIX F

N=14 (67% response rate)

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

SURVEY OF COMMISSIONERS
CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION (CADAC)

This questionnaire has been constructed to elicit information about the commission. Please follow the directions for each question as the results will not be valid unless you do so. The questionnaire may be completed by a commissioner's designated representative to the commission, if he/she regularly attends commission meetings.

Please feel free to provide additional comment on any specific question, the commission's operations, or the substance abuse field in general. Any such comment may be included directly on the questionnaire or in a separate attachment.

1. In your opinion, what percentage of the commissioners' collective time is devoted to each of the following duties? (Total should equal 100 percent.) See end of questionnaire for results.

- _____ a) Prepare, develop, and approve or disapprove the Connecticut comprehensive plan for prevention, treatment, and reduction of alcohol and drug abuse problems
- _____ b) Allocate state and federal grants and contract funds for community alcohol and drug programs
- _____ c) Administer and supervise all federal and state grant and contract funds for alcohol and drug abuse community services
- _____ d) Coordinate all activities in the state relating to alcohol and drug abuse problems
- _____ e) Insure effective coordination among state departments in their activities relating to alcohol and drug abuse problems
- _____ f) Approve copies of grants and contracts by the Department of Mental Health to agencies for the delivery of alcohol and drug services prior to execution
- _____ g) Prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and drugs
- _____ h) Develop and foster educational and prevention programs to reduce the incidence of alcoholism and drug abuse

- _____ i) Organize, foster, and participate in training programs for persons engaged in treatment of alcoholics and intoxicated and drug-dependent persons
 - _____ j) Sponsor and encourage research into the cause, nature, and treatment of alcoholism and drug dependence
 - _____ k) Specify uniform methods for keeping statistical information and collect and make available relevant statistical information
 - _____ l) Foster the development of employees' assistance and occupational alcoholism and drug abuse programs in the public and private sectors
 - _____ m) Foster and encourage job development programs for alcoholics and drug-dependent persons
 - _____ n) Utilize the support and assistance of persons in the community to encourage alcoholics and drug-dependent persons to seek help for their problems
 - _____ o) Encourage all appropriate facilities to admit without discrimination alcoholics and intoxicated and drug dependent persons seeking help for their problems
 - _____ p) Encourage all health and disability insurance programs to include alcoholism and drug dependence as covered illnesses
 - _____ q) Other (specify) _____
-

2. What do you think are the five most important duties of the commission as a whole (i.e., commissioners and staff)? (Please list in order of importance.)

- 1) Planning in general and development of state plan
- 2) Allocation of state and federal funds
- 3) Monitoring
- 4) Education and prevention activities
- 5) Coordinate drug and alcohol treatment statewide

3. Which three commission duties do you feel are least important?

1) Job Development _____

2) _____

3) _____

No answer and None = 43%

4. Using the scale below, please rate the performance of CADAC staff in each of the following areas.

1 = excellent 3 = fair
2 = good 4 = poor

2	3	4	No Ans.	
50%	21%	0%	0%	a) Planning for alcohol and drug abuse services in the state
36	14	7	0	b) Administering and supervising grant and contract funds
29	50	0	0	c) Coordinating alcohol and drug abuse services
43	36	7	0	d) Developing educational material dealing with the nature and effects of alcohol and drugs
36	36	14	0	e) Developing educational programs
21	43	7	0	f) Developing prevention programs
50	21	14	0	g) Providing training programs for persons engaged in treatment of alcoholics and intoxicated and drug-dependent persons
43	21	0	0	h) Gathering statistical information on funded programs and substance abuse in general
36	36	0	0	i) Analyzing statistical information
50	14	7	7	j) Evaluating alcohol and drug abuse programs
57	21	0	0	k) Identifying the need for alcohol and drug abuse services
36	21	0	14	l) Administering the state's Employee Assistance Program
36	14	0	14	m) Administering the Pretrial Alcohol Education System
				n) Other (please specify) _____

5. Please indicate the commission's role in each of the following areas by circling the appropriate number.

<u>Initiate Action</u>	<u>React to Staff Proposals</u>	<u>Not Involved</u>	<u>No Ans.</u>	
				Error in wording of question. Developing disapprove the Connecticut comprehensive plan for prevention, treatment, and reduction of alcohol and drug abuse problems
36%	64%	0%	0%	Allocating state and federal grants and contract funds for community alcohol and drug programs
14	71	14	0	Administering all federal and state grant and contract funds for alcohol and drug abuse community services
14	57	29	0	Coordinating all activities in the state relating to alcohol and drug abuse problems
21	50	29	0	Insuring effective coordination among state departments in their activities relating to alcohol and drug abuse problems
7	14	64	14	Approving copies of grants and contracts by the Department of Mental Health to agencies for the delivery of alcohol and drug services prior to execution
0	50	43	7	Developing educational material dealing with the nature and effects of alcohol and drugs
14	64	21	0	Developing educational programs to reduce the incidence of alcoholism and drug abuse
14	71	14	0	Developing prevention programs to reduce the incidence of alcoholism and drug abuse
7	57	36	0	Providing training programs for persons engaged in treatment of alcoholics and intoxicated and drug-dependent persons
14	21	64	0	Sponsoring research into the cause, nature, and treatment of alcoholism and drug dependence
21	43	36	0	Collecting statistical information

<u>Initiate</u>	<u>React to</u>	<u>Not</u>	<u>No</u>	
<u>tion</u>	<u>Staff</u>	<u>Involved</u>	<u>Ans.</u>	
	<u>Proposals</u>			
14	64	21	0	Developing employees' assistance and occupational alcoholism and drug abuse programs in the public and private sectors
0	36	64	0	Encouraging job development programs for alcoholics and drug-dependent persons
21	36	43	0	Employing the support and assistance of persons in the community to encourage alcoholics and drug-dependent persons to seek help for their problems
50	29	21	0	Encouraging all appropriate facilities to admit without discrimination alcoholics and intoxicated and drug-dependent persons seeking help for their problems
43	43	14	0	Encouraging all health and disability insurance programs to include alcoholism and drug dependence as covered illnesses
43	36	21	0	Evaluating alcohol and drug abuse programs
43	57	0	0	Identifying the need for alcohol and drug abuse services
64	29	7	0	Establishing priorities for alcohol and drug-related projects and programs
7	57	36	0	Supervising the conduct of limited research directly related to the state's own needs and problems
7	86	7	0	Formulating state guidelines
0	36	64	0	Conducting information and technology transfer operations
21	64	14	0	Coordinating all federal grants for alcohol and drug-related projects and programs
21	57	21	0	Coordinating alcohol and drug regulatory functions that are administered by the departments, boards, commissioners, and agencies represented on CADAC

6. Using the scale below, please rate the performance of the commission as a whole (i.e., commissioners and staff) in each of the following areas. If you feel the commission is not involved in a particular activity, mark N/A (not applicable).

1 = excellent 3 = fair
2 = good 4 = poor

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>N/A</u>	
36%	50%	7%	7%	0%	a) Developing the Connecticut comprehensive plan for prevention, treatment, and reduction of alcohol and drug abuse problems
50	43	7	0	0	b) Allocating state and federal grants and contract funds for community alcohol and drug programs
43	50	0	0	7	c) Administering all federal and state grant and contract funds for alcohol and drug abuse community services
0	43	43	14	0	d) Coordinating all activities in the state relating to alcohol and drug abuse problems
0	21	43	29	7	e) Insuring effective coordination among state departments in their activities relating to alcohol and drug abuse problems
7	14	7	0	64	f) Approving copies of grants and contracts by the Department of Mental Health to agencies for the delivery of alcohol and drug services prior to execution (no ans. = 7)
21	29	43	7	0	g) Developing educational material dealing with the nature and effects of alcohol and drugs
21	29	43	0	0	h) Disseminating educational material (no ans. = 7)
21	29	36	14	0	i) Developing educational programs to reduce the incidence of alcoholism and drug abuse
21	29	43	7	0	j) Developing prevention programs to reduce the incidence of alcoholism and drug abuse
21	43	21	14	0	k) Providing training programs for persons engaged in treatment of alcoholics and intoxicated and drug-dependent persons
0	14	43	21	14	l) Sponsoring research into the cause, nature, and treatment of alcoholism and drug dependence (No ans. = 7)
21	57	21	0	0	m) Collecting statistical information
29	43	29	0	0	n) Making relevant statistical information available
36	36	21	0	7	o) Developing employees' assistance and occupational alcoholism and drug abuse programs in the public and private sectors

Key: 1 = excellent; 2 = good; 3 = fair; 4 = poor;
 N/A = not applicable

2	3	4	N/A	
21	36	14	29	p) Encouraging job development programs for alcoholics and drug-dependent persons
29	36	14	14	q) Employing the support and assistance of persons in the community to encourage alcoholics and drug-dependent persons to seek help for their problem
29	36	7	0	r) Encouraging all appropriate facilities to admit without discrimination alcoholics and intoxicated and drug dependent persons seeking help for their problems
36	36	7	0	s) Encouraging all health and disability insurance programs to include alcoholism and drug dependence as covered illnesses
50	14	0	7	t) Evaluating alcohol and drug abuse programs
50	21	0	0	u) Identifying the need for alcohol and drug abuse services
36	21	0	0	v) Establishing priorities for alcohol and drug-related projects and programs
36	29	21	14	w) Supervising the conduct of limited research directly related to the state's own needs and problems
36	29	0	0	x) Formulating state guidelines
21	21	7	43	y) Conducting information and technology transfer operations
43	36	0	0	z) Coordinating all federal grants for alcohol and drug-related projects and programs
14	64	7	14	aa) Coordinating alcohol and drug regulatory functions that are administered by the departments, boards, commissions, and agencies represented on CADAC

7. In your opinion, is the current composition of the Connecticut Alcohol and Drug Abuse Commission appropriate or should the membership be changed? (Composition includes type of representation and size of membership.)

43% Composition is appropriate

57% Composition should be changed

If you feel the composition should be changed, please indicate the change(s) you feel should be made.

a) Size of commission should be increased as follows:

b) Size of commission should be decreased as follows:

c) Representation on commission should be changed as follows:

8. For each of the following statements, please indicate the degree to which you agree or disagree.

	<u>Strongly</u> <u>Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>	<u>No</u> <u>Ans.</u>
a) All state alcohol and drug abuse activities should be centralized in the Department of Mental Health.	0%	7%	21%	71%	0%
b) All state alcohol and drug abuse activities should be centralized in CADAC.	57	21	14	0	7
c) The current organization of alcohol and drug abuse activities between CADAC and the Department of Mental Health is appropriate.	7	7	64	21	0
d) The CADAC planning process accurately assesses the need for alcohol and drug abuse services in Connecticut.	21	57	14	7	0
e) The needs identified in the CADAC planning process are being met through the existing system of alcohol and drug abuse services.	7	36	57	0	0

9. Do you feel that having the CADAC executive director as a voting member of the commission is appropriate?

43% Yes 57% No

10. Do you feel that the statutory duties assigned to the commission are appropriate?

71% Yes 29% No

If no, what changes do you feel are needed in the commission's statutory duties?

11. Do you feel that the commission has adequate authority to perform the duties assigned to it by statute?

71% Yes 29% No

If no, what additional authority is needed?

12. Do you feel that any changes are needed in the division of responsibilities between CADAC and the Department of Mental Health?

71% Yes 29% No

If yes, please describe the changes you think are needed.

13. If there are any other areas related to CADAC where you feel changes or improvements are needed, please describe them below. (Use additional paper if needed.)

1. Percentage of commissioner's collective time devoted to specific duties.

	0%, N/A or No Answer	1-5%	6-10%	11-20%	21-40%	41-100%
a.	7%	21%	36%	14%	21%	0%
b.	7	0	0	14	43	36
c.	36	21	21	14	7	0
d.	21	57	7	14	0	0
e.	29	57	14	0	0	0
f.	86	14	0	0	0	0
g.	36	64	0	0	0	0
h.	21	71	7	0	0	0
i.	36	64	0	0	0	0
j.	36	64	0	0	0	0
k.	29	57	14	0	0	0
l.	7	93	0	0	0	0
m.	43	57	0	0	0	0
n.	50	50	0	0	0	0
o.	36	57	7	0	0	0
p.	14	71	14	0	0	0
q.	64	29	7	0	0	0

(Answers may not total 100% due to rounding.)

APPENDIX G

Total N=73 (69% response rate)

Legislative Program Review and Investigations Committee

SURVEY OF PROGRAMS FUNDED BY THE
CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION (CADAC)

This questionnaire has been constructed to elicit information on individual programs and their relationship with the CADAC commission and staff. Please follow the directions for each question to ensure the validity of the results.

CADAC grantees with more than one program component will be provided with multiple copies of this questionnaire to allow the director of each program component to complete a survey. In addition, one copy of a general questionnaire will be sent to the executive director of each CADAC grantee.

Please feel free to provide additional comments on any specific question, CADAC's operations, or the substance abuse field in general. Any such comment may be included directly on the questionnaire or in a separate attachment.

1. Please indicate if your program deals with:

N=73 31% 1) Alcoholism/Alcohol Abuse 10% 2) Drug Abuse 59% 3) Both

2. Please indicate the type of service your program provides.

N=73

<u>3%</u>	1) Shelter	<u>44%</u>	7) Outpatient
<u>1%</u>	2) Long Term Care	<u>3%</u>	8) Methodone Treatment
<u>6%</u>	3) Medical Detox	<u>15%</u>	9) Primary Prevention
<u>-</u>	4) Social Detox	<u>10%</u>	10) Early Intervention
<u>25%</u>	5) Residential Intensive or Intermediate	<u>15%</u>	11) Community Awareness/ Information and Referral
<u>1%</u>	6) Prison Program		

3. Do you think that monthly reporting for the Client Information Collection System (CICS) is:

N=60 8% 1) Too frequent 92% 2) About right - 3) Not frequent enough

4. Do you think that quarterly performance reporting to CADAC is:

N=72 25% 1) Too frequent 75% 2) About right - 3) Not frequent enough

5. Do you feel that the types of measures used in the quarterly performance reports (e.g., bed-days, number of counseling sessions, etc.) are good indicators of your program's performance?

68% 1) Yes 32% 2) No

5a. If no, what changes or improvements do you feel are needed?

6. How often does CADAC visit your program to verify CICS data?

22% 1) Once a year 9% 3) Three times a year
47% 2) Twice a year 16% 4) Four times a year
6% 5) Other (please specify) _____

7. Do you feel these visits are:

11% 1) Too frequent 89% 2) About right - 3) Not frequent enough

8. How often does CADAC visit your program to conduct programmatic reviews?

18% 1) Once a year 16% 3) Three times a year
46% 2) Twice a year 18% 4) Four times a year
1% 5) Other (please specify) _____

9. Do you feel these visits are:

22% 1) Too frequent 74% 2) About right 4% 3) Not frequent enough

10. Are the criteria that CADAC has used to evaluate programmatic compliance during site visits clear?

70% 1) Yes 30% 2) No

10a. If no, what areas are unclear? _____

11. Do you think that CADAC's criteria for evaluating programmatic compliance have been:

11% 1) Too stringent 86% 2) Appropriate 3% 3) Too lenient

11a. Please indicate any specific changes you would like to see in CADAC's criteria for evaluating programmatic compliance.

12. During programmatic reviews, has CADAC ever recommended changes in your program's operations? 82% Yes 18% No
N=72

12a. If yes, which of the following areas did these recommendations address?
N=59
36% 1) Administrative procedures
10% 2) Client treatment methodologies
78% 3) Client treatment records
34% 4) Data records for CICS
20% 5) Increasing program utilization rate
12% 6) Other (please specify) _____

13. How effective were these recommendations in improving your program's operations ?
N=67
10% 1) Very effective
49% 2) Somewhat effective
24% 3) Made no difference
- 4) Detrimental
16% 5) Not applicable

14. Do any other government agencies make field visits to your program?
N=70
64% 1) Yes 36% 2) No

14a. If yes, please list the name of each agency and the purpose and frequency of their visits (e.g., Department of Health Services visits once a year to verify compliance with licensure requirements).

15. Do any of the agencies visiting your program coordinate their monitoring efforts?
N=64 14% 1) Yes 48% 2) No 28% 3) Don't know 9% 3) Not applicable

15a. If yes, please describe the coordination. _____

16. Do you feel that any overlap or duplication of effort occurs because of multiple monitoring activities?
N=63 46% 1) Yes 32% 2) No 22% 3) Not applicable

16a. If yes, please identify specific areas of overlap or duplication and the monitoring agencies involved.

17. Has your program received technical assistance from CADAC?

54% 1) Yes 46% 2) No

17a. If yes, please indicate the quality of help provided for each type of technical assistance your program has received.

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Not Applicable</u>
28 Financial	32%	36%	11%	-	21%
29 Programmatic	17%	55%	14%	7%	7%
15 Other (please specify type of assistance) _____	40%	40%	7%	-	13%

18. Have personnel from your program participated in any CADAC-sponsored training?

95% 1) Yes 5% 2) No

18a. If no, why not?

- 25% 1) Training not relevant to our program
- 50% 2) Level of training not appropriate for our staff
- 75% 3) Location or time of training inconvenient
- 25% 4) Lack of staff to cover for trainees
- 25% 5) Other (please specify) _____

19. If your staff has participated in CADAC-sponsored training, please evaluate the overall quality of the training.

29% 1) Excellent 57% 2) Good 13% 3) Fair
- 4) Poor 1% 5) Not Applicable

20. Do you feel that CADAC training meets the needs of your program?

71% 1) Yes 29% 2) No

20a. If no, please indicate any training needs that have not been met by CADAC-sponsored training.

21. Does your program have a system to follow-up on discharged clients to evaluate their status?

N=63

44% 1) Yes

56% 2) No

21a. If no, please indicate any reasons why follow-up is not conducted (check as many as apply).

N=35

- Never considered it
20% Too difficult
29% Too expensive

80% No resources available to do it
26% Other (please specify)

22. If your program does follow-up on discharged clients, please describe the procedures used (e.g., frequency and method of follow-up).

23. If there are any other areas where you feel changes or improvements are needed in CADAC or its operations, please describe them below. (Use additional paper if needed.)

APPENDIX H

N=38 (58% response rate)

Legislative Program Review and Investigations Committee

SURVEY OF GRANTEES FUNDED BY THE
CONNECTICUT ALCOHOL AND DRUG ABUSE COMMISSION (CADAC)

This questionnaire has been constructed to elicit information from grantees on their relationship with the the CADAC commission and staff. Please follow the directions for each question to ensure the validity of the results.

CADAC grantees with more than one program component are being provided with one copy of this general questionnaire and multiple copies of a questionnaire to be completed for each program component by each program director. Grantees operating a single program component will be provided with one copy of each survey.

Please feel free to provide additional comments on any specific question, CADAC's operations, or the substance abuse field in general. Any such comment may be included directly on the questionnaire or in a separate attachment.

1. Please indicate the HSA region and subregion where your program is located.

2. Is your organization a member of the Connecticut Association of Substance Abuse Agencies?

58% 1) Yes 42% 2) No

3. How long has your organization received funding (state and/or federal) through CADAC?

Average 6.4 Years

4. Please indicate the approximate amount of funding your program received from CADAC during state fiscal year 1984.

Average \$ 127,800

5. Approximately what percent of your total budget is funded through CADAC?

Average 35.5 Percent

6. Do you feel that the CADAC funding application process is:

21% 1) Overly Burdensome 79% 2) Reasonable - 3) Too Simple

6a. Please indicate any changes you would like to see in the CADAC funding application process.

7. Do you feel that your funding applications have been processed by CADAC in a timely manner?

N=38 95% 1) Yes 5% 2) No

8. Do you feel that CADAC's method of allocating funds to community programs is equitable?

N=33 42% 1) Yes 58% 2) No

8a. If no, in what ways do you feel the allocation method is inequitable?

N=38 9. Do you think that quarterly financial reporting to CADAC is:

18% 1) Too frequent 82% 2) About right - 3) Not frequent enough

10. Are the data required in the reports to CADAC listed below used by your program for internal management purposes?

N=34	Client Information		
	Collection System	<u>59%</u> 1) Yes	<u>41%</u> 2) No
N=36	Financial Reports	<u>72%</u> 1) Yes	<u>28%</u> 2) No
N=38	Performance Reports	<u>84%</u> 1) Yes	<u>16%</u> 2) No

11. How does your organization develop projected program performance measures (e.g., number of counseling sessions, bed-days) for the CADAC performance monitoring system?

- 18% 1) Projection based on data for a past week/month
89% 2) Projection based on data for prior year
3% 3) Compare with similar programs
21% 4) Educated guess
29% 5) Based on documented service needs of the community
13% 6) Other (please specify)
-
-

N=38

12. How often does CADAC visit your program to review financial records?

- 29% 1) Once a year 10% 3) Three times a year
50% 2) Twice a year 8% 4) Four times a year
3% 5) Other (please specify) _____

N=38

13. Do you feel these visits are:

- 11% 1) Too frequent 89% 2) About right - 3) Not frequent enough

N=38

14. Are the criteria CADAC uses to evaluate your organization's financial management clear?

- 79% 1) Yes 21% 2) No

N=38

14a. If no, what areas are unclear? _____

15. Do you think the criteria used by CADAC to evaluate financial management are:

- 11% 1) Too stringent 89% 2) Appropriate - 3) Too lenient

N=37

15a. Please indicate any specific changes you would like to see in CADAC's criteria for financial management.

16. For the following statements, please indicate the degree to which you agree or disagree.

	<u>Strongly Agree</u>	<u>Agree</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
a) All state alcohol and drug abuse activities should be centralized in the Department of Mental Health. N=35	-	3%	29%	68%
b) All state alcohol and drug abuse activities should be centralized in CADAC. N=36	47%	42%	3%	8%
c) The current organization of alcohol and drug abuse activities between CADAC and the Department of Mental Health is appropriate. N=33	9%	18%	39%	33%
d) The CADAC planning process accurately assesses the need for alcohol and drug abuse services in Connecticut. N=36	3%	41%	39%	17%
e) The needs identified in the CADAC planning process are being met through the existing system of alcohol and drug abuse services. N=35	3%	31%	51%	14%
f) "Deficit funding" (i.e., supplemental CADAC funds for programs projecting a deficit) is a good use of CADAC funds. N=36	11%	33%	25%	31%
g) Your program has adequate input (direct or indirect) into CADAC's planning and budgeting processes. N=37	3%	32%	46%	19%
h) There is good cooperation among the alcohol and drug abuse programs in your community. N=37	19%	62%	19%	-
i) There is good coordination between the alcohol and drug abuse programs in your community. N=37	16%	54%	24%	6%

17. If there are any other areas where you feel changes or improvements are needed in CADAC or its operations, please describe them below. (Use additional paper if needed.)

APPENDIX I

Legislative Changes Needed to Implement the Legislative Program Review and Investigations Committee's Recommendations

- Mandate the submission of a three-year transition plan to replace institutional programs currently operated by the Department of Mental Health with community-based programs funded by CADAC. The plan, to be submitted to the Appropriations and Public Health Committees by February 1, 1986, shall be developed by a transition group composed of CADAC, Department of Mental Health, Office of Policy and Management, and community-based provider representatives. The Senate and House majority and minority leaders shall each appoint one of the community representatives.
- Amend C.G.S. Sec. 17-155gg(1) to require:
 - an annual alcohol and drug plan with long- and short-range priorities;
 - a state plan steering committee composed of CADAC commissioners and representatives of community programs;
 - an annual survey of alcohol and drug service providers to elicit planning input; and
 - regional hearings on a draft of the annual plan to allow input from the community and the public.
- Require CADAC and the State Board of Education to jointly develop a plan by January 1986 to ensure that substance abuse prevention programs are provided by all local and regional school boards.
- Require that substance abuse regulations developed by CADAC and the Department of Health Services be consistent.
- Amend C.G.S. Sec. 17-155ff to:
 - remove the executive director of CADAC from membership on the commission;
 - prohibit all commissioners from voting on matters that specifically affect a program with which they are affiliated;
 - provide that appointed commissioners who fail to attend three consecutive meetings or who fail to attend 50 percent of all meetings during any calendar year shall be deemed resigned from office; and
 - limit appointed commissioners to serving only two consecutive full terms.
- Amend C.G.S. Sec. 54-56g to ensure that second-time "driving while intoxicated" offenders, prior Pretrial Alcohol Education System participants, and persons dismissed from that program are not allowed to enter or re-enter the Pretrial Alcohol Education System.



