2013 Biennial Report

Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs

For Submittal to

Members of the
Connecticut General Assembly,
Office of Policy and Management, and the
Connecticut Alcohol and Drug Policy Council

Prepared by the
Department of Mental Health
and Addiction Services

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Commissioner

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I. Background

Enacted in 1999, Connecticut General Statutes (CGS) Section 17a-451(o) requires the Department of Mental Health and Addiction Services (DMHAS) to establish uniform policies and procedures for collecting, standardizing, managing, and evaluating data related to substance use, abuse, and addiction programs administered by state agencies, state-funded community-based programs, and the Judicial Branch.

Furthermore, it is DMHAS' responsibility to establish and maintain a central data repository of substance abuse services and submit a report to the General Assembly, the Office of Policy and Management (OPM), and the Connecticut Alcohol and Drug Policy Council (ADPC). This report shall include: a) client and patient demographic information; b) trends and risk factors associated with alcohol and drug use, abuse, and addiction; c) effectiveness of services based on outcome measures; and d) a statewide cost analysis.

In 2002, CGS Section 17a-451(o) was amended, changing the submission of the report from annual to biennial. 2013 Legislation (PA 13-26) has eliminated the requirement for future reports, thus this will be the last time this report is published.

Since the enactment of CGS 17a-451(o), the number of collaborating state agencies and scope of data sharing has grown immensely. Today, eleven state departments, the Office of Policy and Management, and the Judicial Branch work together to share data and report the findings presented in the 2013 Biennial Report on the Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs. This broad-based interagency collaboration has resulted in the submission of eight previous reports (February 2000, July 2001, February 2002, December 2003, May 2004, June 2007, December 2009, and August 2010).

In 2004, the first of a series of treatment outcome and effectiveness studies was initiated. Collaborating with the Department of Labor, DMHAS' Research Division and Yale University, conducted a study of earnings two years before and after receiving treatment. The Treatment Effects on Wages Study was the first in Connecticut to directly link employment wage data with substance abuse treatment records. This study of treatment effectiveness was followed by a study of treatment and its effects on recidivism as measured by re-arrest and re-incarceration. Findings from the joint DMHAS and Department of Correction (DOC) Treatment Effects on Criminal Justice Involvement Study were presented in the 2006 Biennial Report. In the 2008 Biennial Report, the most ambitious yet data linkage study was completed—Young Adults Receiving Substance Abuse Treatment with Prior Child Welfare or Judicial Court Involvement -an analysis linking child welfare, juvenile justice, adult substance abuse treatment, adult arrests and mortality records. For the 2010 Biennial Report, DMHAS collaborated with the Department of Consumer Protection to link patients in Connecticut's Prescription Monitoring Program with substance abuse data. The Nonmedical Use of Narcotic Prescriptions and Its Effect on Connecticut's Substance Abuse Treatment System focused on those abusing opiate prescription drugs, particularly young adults, the rate of transitioning to heroin, the rate of treatment access, and the use of Medication Assisted Therapies (e.g., Suboxone).

In 2010, work continued on population overlaps as part of the Data Sharing Project. The Probabilistic Population Estimation or PPE model used in previous years was replaced with a direct linking model. As criminal justice data (i.e., arrests, incarcerations and probationers) has been routinely linked with behavioral health (substance abuse and mental health) records, this was thought to be a good starting point to pilot the new method of analysis. In addition to the 2012 data presented in this report, more comprehensive analyses may soon be performed to better understand the characteristics of those who are criminally involved and receiving care for their behavioral health needs. As confidentiality requirements are addressed, other state agency populations will be included in the population overlap model. This would include child welfare neglect and abuse cases, social services recipients (e.g. Medicaid, Temporary Family Assistance, etc.) and others.

The cross-agency data repository initiative begun in September 2002, known as the Interagency Substance Abuse Treatment Information System (I-SATIS), met with challenges over the years due to confidentiality concerns brought about by the Health Insurance Portability and Accountability Act (HIPAA). Even more stringent HIPAA security and privacy regulations were recently enacted. Also, technological changes in data transfer and sharing require reexamination of how a data repository is conceptualized. In 2010, DMHAS developed a centralized data warehouse that stores state-operated and private not for profit substance abuse SATIS information. This allows DMHAS to report on SATIS outcomes across the state and has allowed for a platform conducive for consistent and accurate reporting and analysis.

Another area of data sharing is the State Epidemiological Outcomes Workgroup (SEOW), first convened in 2005 as part of DMHAS' Strategic Prevention Framework State Incentive Grant funded by the federal Center for Substance Abuse Prevention (CSAP). The primary mission of the SEOW is to contribute to the collection, analysis, and interpretation of state- and community-level epidemiological data, track data trends over time, and produce information to prioritize, focus, and strengthen prevention efforts. For DMHAS, the SEOW provides a broader perspective of trends in substance use and consequences, taps into other state agency areas of expertise and knowledge, works towards more universally accessible information for all stakeholders, and offers the possibility to collaborate on studies of common concern. In 2007, the SEOW was expanded to incorporate some of the reporting objectives under the Biennial Report.

The SEOW has collected and reviewed state level consumption and consequences data from a variety of state and federal sources. These data were used to develop a state epidemiological profile which identified the top six problem substances in the state based on their impact, burden and susceptibility to change. Through the SEOW, data is reviewed and updated triennially, and secondary data sources are made available to regions and municipalities to develop community profiles which are used to plan effective prevention strategies.

The SEOW, managed by the DMHAS Prevention and Health Promotion Unit, continues to work with the Connecticut Data Quality and Access Consortium to pilot a web-based interactive social indicator data repository. The website contains approximately 50 indicators, as well as census data and student survey data collected locally. It allows users to create tables, charts, and maps, displaying data values (numbers, percentages, or rates) for towns, Uniform Service Regions (USR), or statewide, and by population group. The site can be found here: http://ctdata.org

Another important stakeholder body is the state Child Poverty and Prevention Council (CPPC). The Council continues to meet to formulate strategies for action on its priority recommendations. To advance its efforts in reducing poverty among children in Connecticut by 50% over ten years, the Council's work has focused on a process that: built consensus around priority recommendations using national experts, documented research and proven practices; utilized a Results Based Accountability approach to focus resources and strategies; created an economic model to assess which policies would likely reduce child poverty by 50%; developed a community model where selected municipalities worked to decrease child poverty; and promoted interagency collaborations among state agencies to meet the child poverty and prevention goals.

Additionally, the Council continues to develop strategies to lessen the impact of the recession on Connecticut's children. The Council works with other agencies to develop and promote policies, practices and procedures, to mitigate the long-term impact of economic recessions on children; provide appropriate assistance and resources to families to minimize the number of children who enter poverty as a result of the recession; and reduce the human and fiscal costs of recessions, including foreclosures, child hunger, family violence, school failure, youth runaways, homelessness, and child abuse and neglect. Child Poverty and Prevention Council Plans and Reports are available at the Office of Policy and Management web site at:

http:// www.ct.gov/opm/cwp/view.asp?a=2997&q=383356

II. Executive Summary

The 2013 Biennial Report, as in previous reports, looks across the spectrum of state agency services for the prevention, intervention, and treatment of substance use, misuse, and abuse. A range of information is reported using various methods (trend analyses, data sharing and linkage, etc.) to provide the best overview of the current situation. Barriers to implementing a consolidated substance abuse services information system persist but advances in data sharing technology afford an opportunity for expanded collaborations.

The 2013 Biennial Report contains the culmination of years of work on some very important cross-agency projects. Among them are:

1. Adolescent Treatment Service Data

DCF funds a broad mix of substance abuse treatment services including outpatient, intensive in-home services and residential care for adolescents aged 12 and older, and specialized in-home services for caregivers involved with child protective services. DCF has continued its focus on serving youth and families in their communities using evidence-based treatment approaches that integrate treatment for mental health, trauma and victimization, and family therapy. Integrated treatment approaches are supported by comprehensive assessment using the Global Appraisal of Individual Needs (GAIN). Data from the GAIN is used to inform individualized treatment plans, local program evaluation, and statewide program planning by the Department. In SFY09, the Department implemented the Programs and Services Data Collection and Reporting System (PSDCRS) to better monitor the services DCF funds. PSDCRS standardizes the information reported to DCF by providers across programs while retaining the ability to assess program-specific goals. The GAIN and PSDCRS underlie DCF's ability to identify the population served, conduct needs assessments, compare client information across programs, implement systematic monitoring of outcomes and meet its statutory obligation to report on programs to the legislature (see major findings below in the body of the report).

2. Adult Treatment Service Data

Using data collected through DMHAS' substance abuse treatment information systems, a trend analysis was conducted for CYs 2010, 2011 and 2012. This comprehensive data repository contains admission and discharge information from all community-based substance abuse treatment programs licensed by the Department of Public Health (DPH). Additionally, some non-licensed, state-operated programs report to DMHAS as well, including DMHAS operated hospitals and Department of Correction prison-based services. Client-level data are routinely submitted and contain information on each admitted and discharged client.

As in past reports, trends in admissions are analyzed for the primary drug reported at admission, age of first use, demographics, service utilization and other areas of interest.

Major findings in the CY 2010 to 2012 analysis include:

- The percent of primary heroin admissions dropped after years of steady increases, giving rise to alcohol to become, once again, the most frequently reported substance at admission.
- Treatment admissions due to other (prescription) opiates (e.g., OxyContin®, Vicodin®) continued to have the greatest percentage increase continuing a seven-year trend.
- The average age at admission for those with a primary heroin problem **increased** from **CY 2010** to **CY 2012** by **0.5 year (34.7 to 35.2)** and by **0.6 year** for those reporting other opiates.
- The pattern of primary substances reported by race or ethnicity remained similar to those in past years. Whites most frequently present for treatment of other opiates and alcohol followed by heroin and then cocaine. Blacks reported primarily marijuana followed by cocaine. Latinos (Others) reported marijuana followed by heroin as their primary problem substance.

- Injection drug use in **CY 2012** remained similar to past years with about one out of every five persons admitted to treatment having injected drugs.

- Type of care received by primary problem substance followed past patterns with alcohol admissions using outpatient and detoxification; heroin - detoxification and methadone maintenance; cocaine - outpatient followed by residential care; and marijuana predominately outpatient. Overall, utilization of detoxification services dropped while outpatient increased and residential rehabilitation and methadone maintenance remained unchanged.

- Variation in age of first use for primary problem substances reported at admission showed little change and only minor differences between males and females. The greatest variance was seen with clients reporting age of first use for other opiates. In **CY 2010**, the average age of first use was about **26.5** years old. In **CYs 2011 and 2012**, the average age dropped to **22.8 and 22.6 respectively**.

3. Caseload Overlaps

Since 2000, the Data Sharing Project has drawn upon data from seven state agencies and the Judicial Branch. This project has been highly successful in generating statistical information in the past including trends in measuring the overlap of state agency populations receiving treatment.

While PPE was useful to examine general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems, as DMHAS and the state's criminal justice agencies have established consistent and valid methods for linking large administrative databases.

At the June 2010 meeting of the Criminal Justice Policy Advisory Commission (CJPAC), a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. During SFY 2011, DMHAS and the criminal justice partners formed a steering committee responsible for:

- Determining the scope of data sharing.
- Overseeing the creation of essential data documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

The Memorandum of Understanding regarding governance, publication and other pertinent matters was completed in late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probation) and behavioral health data had been linked for the purpose of services research, evaluation, and outcomes. Analysis is pending.

4. Nonmedical Use of Prescription Narcotic Pain Relievers and Treatment

2010-11 National Survey on Drug Use and Health (NSDUH) State Estimates reflects that 3.32% of the Connecticut adult population is using pain relievers for non-medical use. There is evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative. Annual Averages Based on 2008 -2009 NSDUH data reflects that the rate of non-medical use of pain relievers was at 3.8% for the Connecticut adult population. For young adults (18-25), the 2008 – 2009 rate was about two and a half times the general adult population at 10.5%. See the updated link to these data below:

http://oas.samhsa.gov/2k9State/toc.cfm

Recent analyses of DMHAS substance abuse treatment data indicate that the rate of primary heroin admissions is declining. On the other hand, persons entering treatment reporting a primary substance problem for "other synthetic opiates" (e.g., Vicodin®) continues to rise. Over the past decade, treatment options for opiate dependent persons have expanded, particularly with the introduction of buprenorphine (e.g., Subutex, Suboxone). Use of buprenorphine for both detoxification and long-term replacement therapy has been proven to be effective and DMHAS has encouraged the expansion of this treatment approach for opiate dependent persons.

Connecticut's Response to Prescription Drug Overdose:

Prescription drug misuse involves four categories of medications: analgesics (pain killers), tranquilizers, stimulants, and sedatives. By far, analgesics are the most misused. In January 2012, the CDC identified prescription drug overdoses in the United States as an **epidemic** and reported that for every unintentional opioid overdose death, there were an estimated 461 persons using opioid analgesics non-medically. In response to this crisis and to calls from the CDC, the American Medical Association, and the Office of National Drug Control Policy; DMHAS sponsored legislation for Naloxone/Narcan, a prescription medication that reverses an opioid overdose. The law (PA 12 -159 *An Act Concerning Treatment for a Drug Overdose*) became effective October 1, 2012. [Link to PA 12-159 at http://www.cga.ct.gov/2012/ACT/PA/2012PA-00159-R00HB-05063-PA.htm] It allows prescribers to prescribe, dispense or administer Naloxone/Narcan to treat or prevent a drug overdose. In effect, this allows persons other than the individual using opioids access to this life saving medication. This is critical since those overdosing are incapable of self-administering medication and are typically not alone at the time of the overdose.

5. Prevention Services

Over the recent past, the DMHAS Prevention and Health Unit, in collaboration with other state agencies, has leveraged federal funding to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to select effective programs and strategies. The SEOW provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and analyze data, and explore opportunities to collaborate on issues of common concern.
Since 2006, the SEOW has been tracking epidemiological data on six substances (alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine). SEOW data were used to update profiles for each substance, as well as suicide and problem gambling.

In SFY 2010, the SEOW began the process of replacing its web-based data repository with a state-of-the-art, interactive site which enables any registered user to access substance abuse prevention and mental health promotion indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. The new site is available here: http://ctdata.org/about

6. Statewide Cost Analysis

For the 2013 Biennial Report most agencies where able to report cost/expenditure data. In past analyses, overall funding for substance abuse services grew from SFY 1999 to SFY 2011. Some of the growth, especially in SFYs 1999 to 2002, reflects more comprehensive expenditure reporting. Particularly, the increase in total expenditures between SFYs 2000 and 2001 was partially due to the identification and inclusion of additional state agencies not previously reporting (e.g., Department of Social Services—Medicaid).

Overall funding for substance abuse services experienced steady growth from SFY 1999 to SFY 2007, but saw a 1.2% decrease (not adjusted for inflation) from SFY 2007 to 2009. Looking at SFY 2009 expenditure categories, the greatest reduction (40.9%) from SFY 2007 was seen in prevention services. The major contributor to this reduction was a $13.6 million dollar loss in State Department of Education discretionary federal grants. Treatment expenditures saw a slight increase (6.7%) due primarily to DSS Medicaid expenditures while deterrence dropped by 19% in SFY 2009 when compared to SFY 2007. Overall total expenditures from fiscal year 2009 to 2012 have increased by 21%.

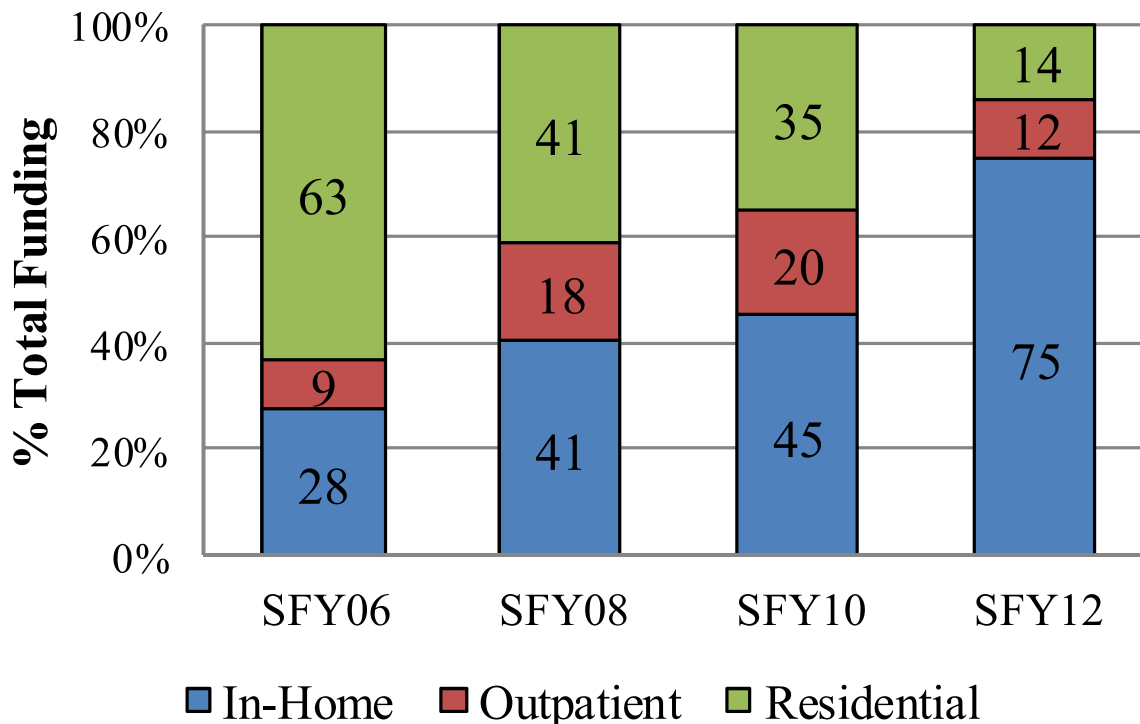
III. Adolescent Substance Abuse Treatment

DCF funds a broad mix of substance abuse treatment services including outpatient, intensive in-home services and residential care for adolescents aged 12 and older, and specialized in-home services for caregivers involved with child protective services. DCF has continued its focus on serving youth and families in their communities using evidence-based treatment approaches that integrate treatment for mental health, trauma and victimization, and family therapy. Integrated treatment approaches are supported by comprehensive assessment using the Global Appraisal of Individual Needs (GAIN). Data from the GAIN is used to inform individualized treatment plans, local program evaluation, and statewide program planning by the Department. In SFY09, the Department implemented the Programs and Services Data Collection and Reporting System (PSDCRS) to better monitor the services DCF funds. PSDCRS standardizes the information reported to DCF by providers across programs while retaining the ability to assess program-specific goals. The GAIN and PSDCRS underlie DCF's ability to identify the population served, conduct needs assessment, compare client information across programs, implement systematic monitoring of outcomes and meet its statutory obligation to report on programs to the legislature.

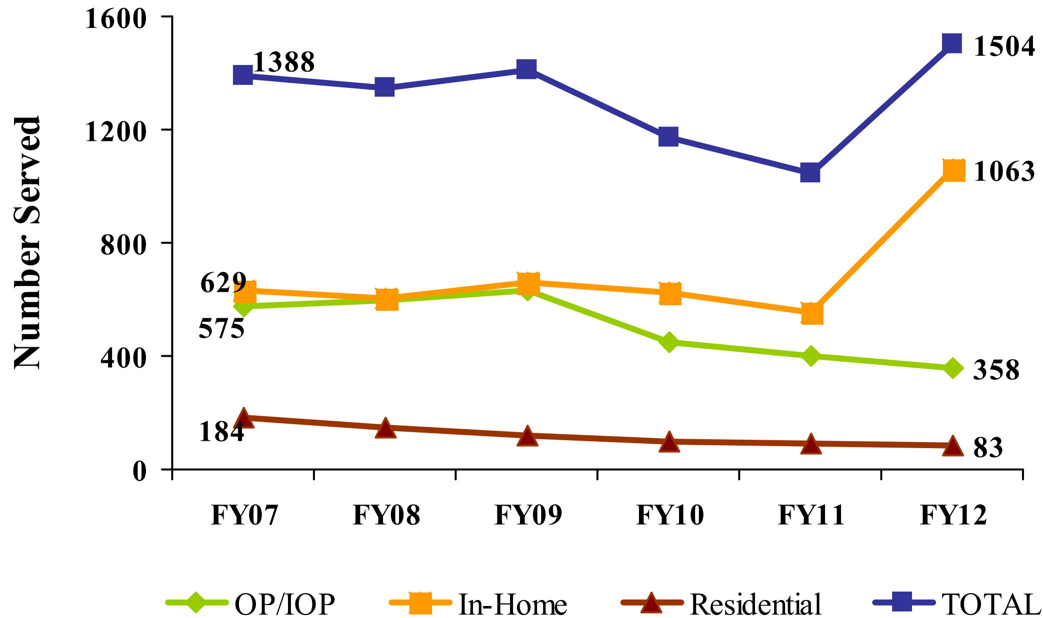
Adolescent Substance Abuse Services

Over the past decade, DCF shifted considerable funding for adolescent substance abuse treatment from residential treatment programs to community based services. Since SFY06, DCF has reduced expenditures for adolescent substance abuse residential treatment 78%, from 63.24% of total expenditures in SFY06 to 13.73% of total expenditures in SFY12. Expenditures for community based services grew 135% during the same period.

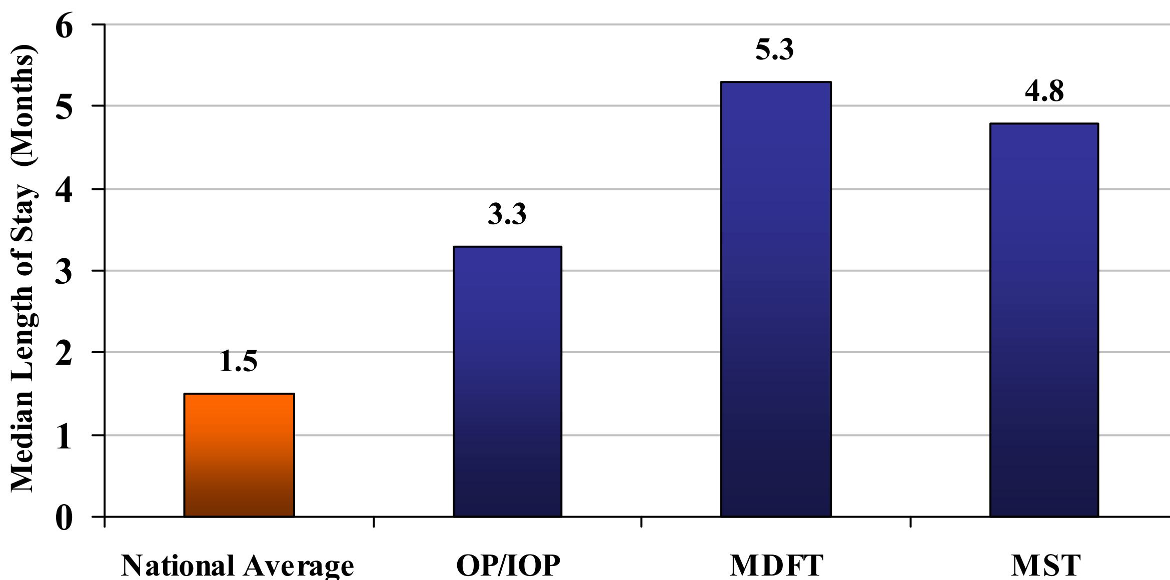
Adolescent Substance Abuse Treatment: Outpatient, Intensive In-home Services and Residential.



Adolescent Substance Abuse Treatment: Outpatient, Intensive In-home Services and Residential. Numbers Served Annually by Program Type. (FY07-FY12). Data from Provider Reports, PSDCRS and the Behavioral Health Partnership.



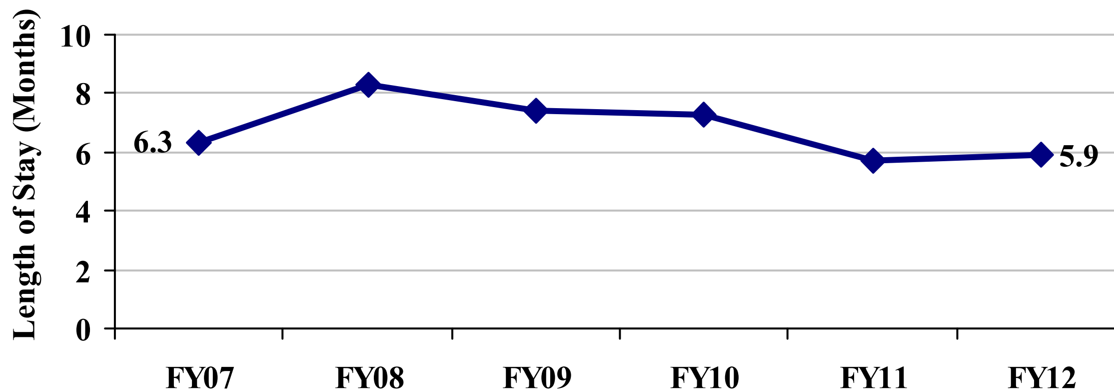
Median Length of Stay for Community Based Adolescent Substance Abuse Treatment Programs (FY12). Data from the GAIN-I and GAIN-Q



MDFT: Multidimensional Family Therapy
MST: Multi-Systemic Therapy

Not only does DCF offer a large array of evidence-based services, but adolescents who enter the publicly funded substance abuse treatment system in Connecticut stay in treatment longer than their peers across the country. Retention in high quality treatment is a significant performance measure that has implications for a greater likelihood of positive long-term outcomes for the adolescents receiving treatment.

Average Length of Stay for Adolescent Residential Substance Abuse Treatment Programs. Data from the Behavioral Health Partnership



In addition to reducing admissions to residential substance abuse treatment for adolescents overall, DCF is committed to quickly transitioning youth back to their communities. Adolescents who receive treatment in a residential facility typically are discharged to community-based services within 6 months of admission.

Adolescent Substance Abuse Treatment: Outpatient, Intensive In-home and Residential. Client Characteristics (SFY12) Data from PSDCRS, the GAIN-I and the GAIN-Q

	Outpatient	Intensive In-Home	Residential
Male	67.7%	61.3%	82.3%
Age of Youth Served			
11-12	0.5%	4.7%	0%
13-14	15.4%	25.4%	5.2%
15-16	51.2%	46.9%	77.1%
17-18	29.4%	22.8%	16.7%
18 +	3.5%	0.3%	1.0%
Median Age	16 years	15 years	16 years
Race/Ethnicity			
African American	22.1%	18.6%	16.7%
Caucasian	38.7%	32.7%	40.6%
Hispanic	19.1%	31.7%	22.9%
Mixed	18.1%	16.0%	18.8%
Minority	61.3%	67.3%	59.4%
Single Parent Household	45.6%	NA	49.5%
Ever Homeless	7.9%	NA	7.5%
Behind More than 1 Grade Level in School	49.2%	NA	53.9%
Current JJ/CJ Involvement	49.7%	56.0%	96.6%

Adolescent Substance Abuse Treatment: Outpatient and Residential. Primary Problem Substance. (FY12) Data from the GAIN-I

	Outpatient	Residential
Marijuana	46.5%	71.9%
Alcohol*	5.5%	7.3%
Heroin & Other Opioids	2.0%	1.0%
Cocaine	0%	3.1%
Sedatives/Tranquilizers	0.5%	0%
Other	1.0%	1.0%

*Includes Alcohol Only and Alcohol with Other Drugs

Consistent with national data, the primary problem substance for youth entering DCF funded substance abuse treatment overwhelmingly is marijuana.

Adolescent Substance Abuse Treatment: Opiate Use Reported at Intake to Outpatient and Residential Treatment. (FY12) Data from the GAIN-I.

	Outpatient	Residential
Never Used	77.9%	67.4%
Past Use	8.2%	16.3%
Current Use (Past Year)	5.1%	8.7%
Any Symptoms of Abuse or Dependence	8.7%	7.6%

While opiates are rarely indicated as the primary problem substance at treatment admission (1-2%), opiate use is more prevalent. Past use of opiates is reported by 16% of adolescents admitted to residential treatment and by 8% of adolescents admitted to outpatient treatment.

Adolescent Substance Abuse Treatment: Severity of Substance Use, Mental Health and Delinquency Reported at Intake to Outpatient and Residential Treatment. (FY12) Data from the GAIN-I

	Outpatient	Residential
Substance Severity		
Use	21.5%	8.6%
Abuse	33.8%	35.5%
Dependence*	42.1%	55.9%
Age of First Use <15 years	73.7%	88.2%
Any Prior Substance Abuse Treatment	24.9%	56.8%
Mental Health Problem Severity		
High Mental Distress	40.0%	32.3%
Traumatic Stress Disorder	26.3%	16.3%
Any Co-occurring Substance & Psychiatric Disorder	56.9%	54.8%
Any Prior Mental Health Treatment	55.3%	60.9%
Victimization		
Ever Victimized	47.6%	59.3%
Ever Abused or Worried About Abuse	48.7%	59.3%
High Severity Victimization	31.4%	33.7%
Victimized in Past Year	28.0%	41.8%
Victimized in Past 90 Days	16.9%	16.5%
Current Worry About Being Victimized	12.1%	10.0%
Delinquency Level		
Unofficial Delinquency	15.5%	0%
Arrest or Police Contact	9.6%	5.6%
Court, Probation or Parole	47.6%	40.0%
Correctional Institution in Past 90 Days	13.9%	54.5%

*Includes Dependence with or without physiological symptoms

Co-occurring disorders and involvement with multiple systems is the norm at all levels of care among adolescents entering publicly-funded substance abuse treatment services. Adolescents who receive DCF funded substance abuse treatment present at admission with multiple complex problems, often have received prior treatment for mental health and/or substance use, and are likely to be involved with the juvenile justice or criminal justice systems. Victimization and traumatic stress are not uncommon and pose an elevated risk for substance use and mental health disorders.

Parole Re-entry Services (FY2012)

DCF's substance abuse division also funds intensive in-home family re-entry services for youthful offenders who are placed in secure facilities and their families. Re-entry services begin with the youth and their family 1-3 months prior to scheduled release and continue after the youth returns to the community. The re-entry programs aim to shorten lengths of stay in secure facilities and admissions to out of home placements, reduce costs associated with out of home placements, stimulate faster re-entry by eliminating or reducing step-down to residential programs, and improve youth outcomes related to substance use, illegal activity, family relationships and educational and vocational engagement.

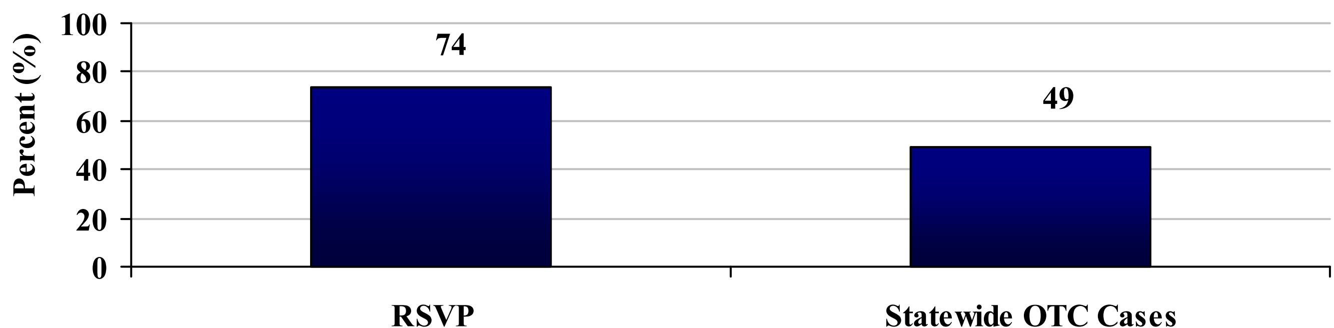
DCF has implemented two re-entry services for youth on parole: Multi-dimensional Family Therapy (MDFT) Re-entry and Family Treatment (RAFT) and Multi-Systemic Therapy-Families in Transition (MST-FIT).

	MDFT	MST-FIT
Enrolled in Treatment	N=49	N=52
Discharged from Treatment	N=57	N=34
Percent Completing Treatment	71%	70%
Living at Home at Discharge	77%	81%
In School or Working at Discharge	92%	70%
No New Arrests During Treatment	71%	81%

Recovery Supports for Caregiver Substance Abuse

Recovery Specialist Voluntary Program (RSVP)
The Recovery Specialist Voluntary Program (RSVP) model is an intensive case management recovery support service for caregivers involved with child protective services who have had a child(ren) removed under an Order of Temporary Custody (OTC), and where substance use was a significant contributing factor. RSVP is modeled after the STARS program in Sacramento, CA which is implemented within a drug-court system and has shown promising results. The aims of RSVP are to facilitate caregiver engagement and retention in treatment; to promote abstinence and recovery from substance use; to better coordinate with treatment providers and the court to improve the time to permanency for children; and to develop a practice model that can be replicated.

12 Month Permanency Rates: RSVP Compared to OTC Cases Statewide
Data from the Judicial Branch (SFY12)



Data from the Judicial Branch show that 74% of children of parents/caretakers in the RSVP program reached permanency through reunification, adoption or transfer of guardianship within 12 months compared to only 49% of OTC cases statewide. This is a significant improvement in a key court performance measure that has implications for a greater likelihood of positive long-term outcomes for the children. Moreover, participants who are compliant with RSVP over time are more likely to be successfully reunited with their children (76% who are fully compliant at 180 days have been reunited with their children compared to 56% who were compliant for 90 days and 27% who had less than full compliance). These rates of reunification exceed those seen in the STARS program after which RSVP was modeled.

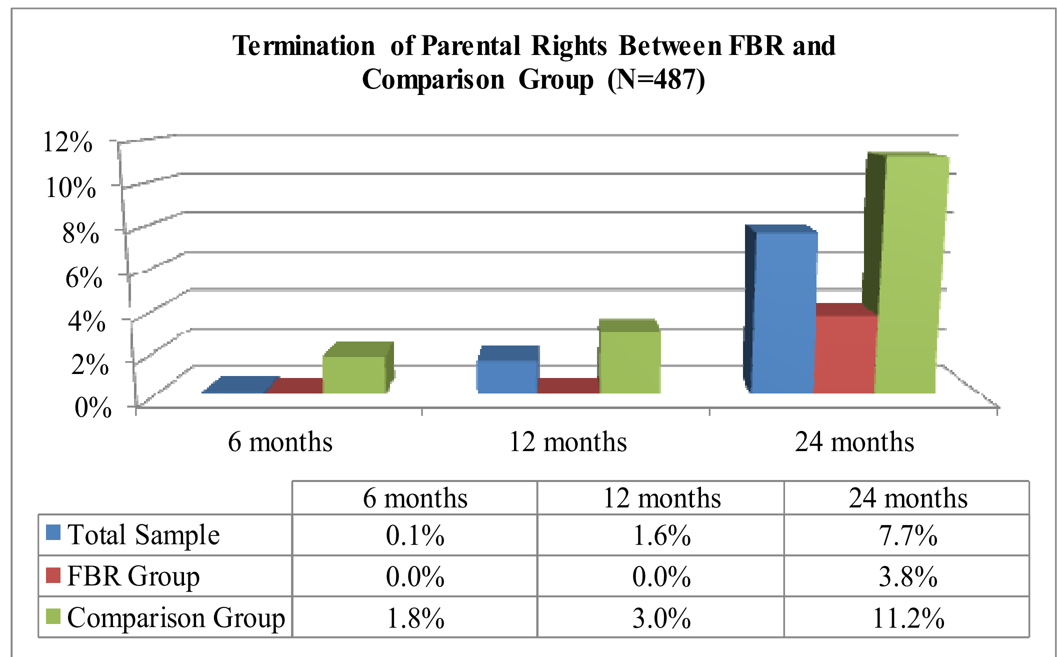
Treatment for Caregiver Substance Abuse and Child Maltreatment

DCF has extended its implementation of evidence-based practices to include intensive in-home services for caregivers with problems related to substance use that also have involvement with child protective services. These services target the Department's most vulnerable children and families, including families with very young children (under the age of 2), families who have had their children removed because of problems related to substance use, and families who are at high risk for removal related to substance use.

Family Based Recovery (FBR)

The Family-based Recovery Model (FBR) is an attachment-based substance abuse treatment model for parents of children under 2 years of age who are involved with DCF child protective services. The model integrates two treatment modalities to focus on attachment, parenting, substance abuse recovery, and psychotherapy: Coordinated Intervention for Women and Infants (CIWI), an attachment-based parent-child therapeutic approach that was developed at the Yale Child Study Center and Reinforcement-Based Treatment (RBT), a contingency management substance abuse treatment model that was developed at Johns Hopkins University. The aims of FBR are to promote safe, secure, drug-free family environments where children can live with their parents; to facilitate parenting skills that promote optimal child development; and to develop an evidence-based practice model that can be replicated.

Preliminary results for FBR are promising. In the first 24 months following referral to treatment, there were differences in the likelihood of the primary caregiver having their parental rights terminated (405 caregivers, 236 in the FBR group and 169 in the Comparison group; Chi square=5.28, df=1, p=.022). Caregivers in the FBR group were much less likely to have their rights terminated than caregivers in the Comparison group within the first two years following referral to treatment.



	6 months	12 months	24 months
Total Sample	0.1%	1.6%	7.7%
FBR Group	0.0%	0.0%	3.8%
Comparison Group	1.8%	3.0%	11.2%

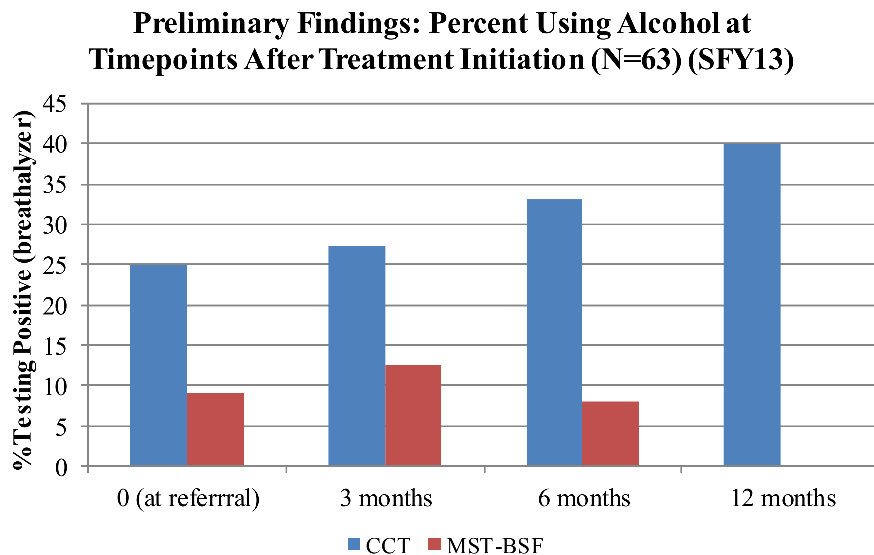
Also,

- There were significantly fewer calls to the DCF Care-line involving FBR caregivers than caregivers in the Comparison group (6.0% of FBR and 14.2% Comparison caregivers; Chi square=9.28, df=1, p=.002). Similarly, the rates of substantiated allegations were lower for the FBR caregivers (4.1% of FBR and 10.1% Comparison caregivers; Chi square=9.28, df=1, p=.002).
- The FBR children were less likely to be removed from the home in the first six months or 12 months following the caregiver's referral to treatment than children in the Comparison group; at 6 months, 8.8% or N=28 of FBR children versus 20.1% or N=34 of Comparison group children were removed from the caregiver's home (Chi square=14.06, df=2, p=.001), and at 12 months, 15.4% or N= 49 of the FBR children versus 26.0% or N=44 children in the Comparison group were removed from the caregiver's home (Chi square=8.37, df=2, p=.015).

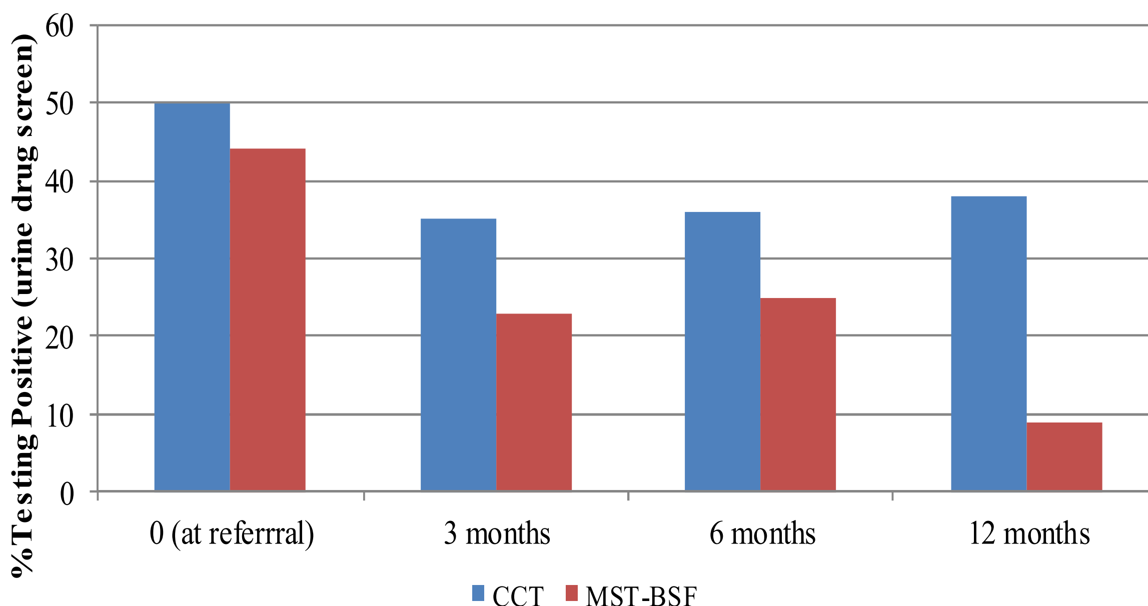
These findings suggest that families who participate in FBR have more favorable child permanency outcomes compared to families who receive community-based substance use treatments.

Multisystemic Therapy-Building Stronger Families (MST-BSF)

Multisystemic Therapy-Building Stronger Families (MST-BSF) was developed through a collaboration between DCF, Wheeler Clinic and Johns Hopkins University with support from the Annie E. Casey Foundation to address the problem of co-occurring parental substance abuse and child maltreatment. This program integrates an innovative evidence-based treatment for adult substance abuse (i.e., Reinforcement-Based Therapy [RBT]) with an evidence-based treatment of child abuse and neglect (i.e., Multisystemic Therapy for Child Abuse and Neglect [MST-CAN]). MST-BSF is a comprehensive integrated treatment intervention that addresses the individual, family, peer, school, and community-level problems that brought the family to the attention of child protective services. MST-BSF works closely with a family's natural support systems to achieve abstinence, reduce risk to children, and sustain treatment gains without ongoing child welfare involvement. MST-BSF targets families with children between the ages of 6-17 years of age. The aims of MST-BSF are to promote safe, secure, drug-free family environments where children can live with their parents or be quickly reunified.



CCT = Comprehensive Community Treatment (i.e., treatment as usual in CT)



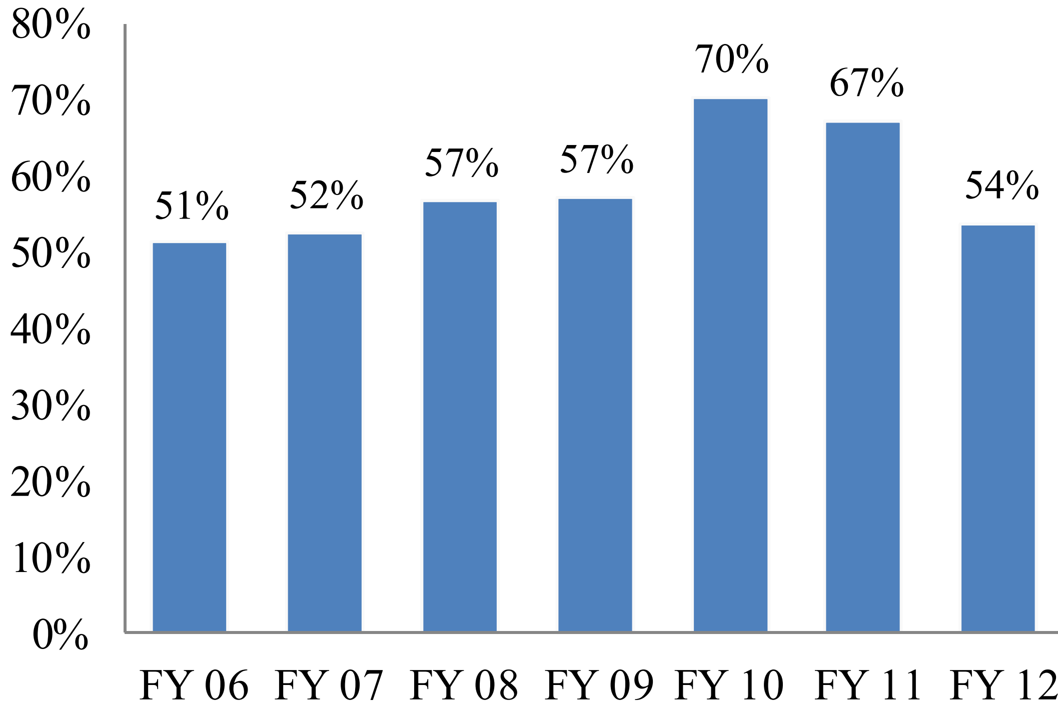
Project SAFE

Project SAFE (Substance Abuse Family Evaluation) is an interagency collaboration between DMHAS and DCF that funds evaluations and direct care services for families identified with substance abuse treatment needs. Advanced Behavioral Health, the Administrative Services Organization, manages all referrals to Project SAFE, collects screening information, and manages utilization of treatment services. Over the past several years, DCF has implemented a standardized screening tool, the GAIN Short Screener (GAIN-SS), to improve identification of substance use among caregivers.

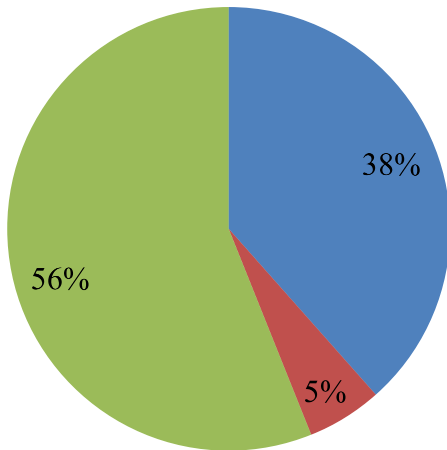
Most Project SAFE clients have no insurance (56%), while the remainder have mostly public entitlement coverage. Please find below the referral and insurance data for the Project Safe program:

	# Referred for Treatment	# of Referrals Receiving Treatment	Percent of Referrals Receiving Treatment
2006	2,437	1,244	51.05%
2007	2,559	1,342	52.44%
2008	2,554	1,447	56.66%
2009	2,480	1,417	57.14%
2010	2,217	1,558	70.28%
2011	2,347	1,577	67.19%
2012	2,605	1,399	53.70%

Project SAFE Percent of Referred Clients Receiving Treatment Services (2006 – 2012):



**Health Insurance Statusat Intake to Project SAFE: SFY 2012
(Total Referrals = 6297)**



Most Project SAFE clients have no insurance (56%) while the remainder have mostly public entitlement coverage.

IV. Adult Substance Abuse Treatment

Trend Analysis of Admissions for Calendar Years (CY) 2010, 2011, 2012

Most Connecticut substance abuse treatment programs report client information, for persons 18 and older, to DMHAS through its data collection system. Data are electronically submitted to DMHAS monthly and contain information on each admitted and discharged client. The range of client information collected at admission includes: demographics, employment status, education level, type of drug use, frequency of drug use, living arrangements, arrests, and other pertinent data.

All substance abuse treatment programs licensed by the Department of Public Health (DPH) are required, by state statute, to report to DMHAS. Additionally, some non-licensed, state-operated programs report as well, including DMHAS state hospitals and DOC prison-based services. These mandatory reporting systems ensure that all publicly supported clients, i.e., those whose treatment is paid for out of public entitlement programs such as Medicaid or who have no insurance, are included in the department's database. Excluded from the DMHAS information system are those persons who receive services through the Veterans' Administration, general hospitals or private practitioners.

DMHAS routinely checks the data for quality, completeness and internal consistency. On-line reports are available to treatment providers and DMHAS monitoring, evaluation and planning staff. The department has developed comprehensive "report cards" to represent individual service providers as well as overall system performance. Specific trends over the three-year period include:

Client Demographics:

Whites comprised about two-thirds of all admissions while blacks accounted for almost one in five admissions, and Hispanics about one in four.

White: 63%, African American: 17%, Hispanic: 20% in 2012

Males represented the vast majority of admissions **(71%) in 2012**.

The average age at admission **increased** slightly between **CY 2010** and **2012 (35.9 vs. 36.6)**.

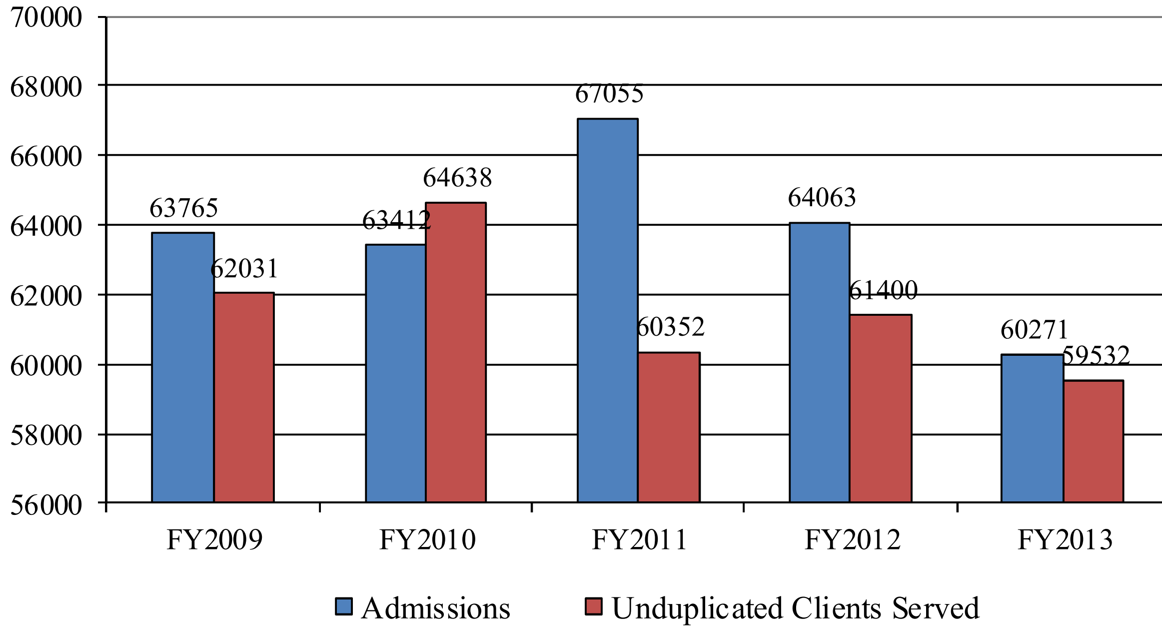
The pattern of primary substances reported by race and ethnicity remained similar to those in past years. Whites most frequently presented for treatment of other opiates and alcohol followed by heroin and then cocaine. Blacks reported primarily marijuana followed by cocaine. Latinos (Others) reported marijuana followed by heroin as their primary problem substance.

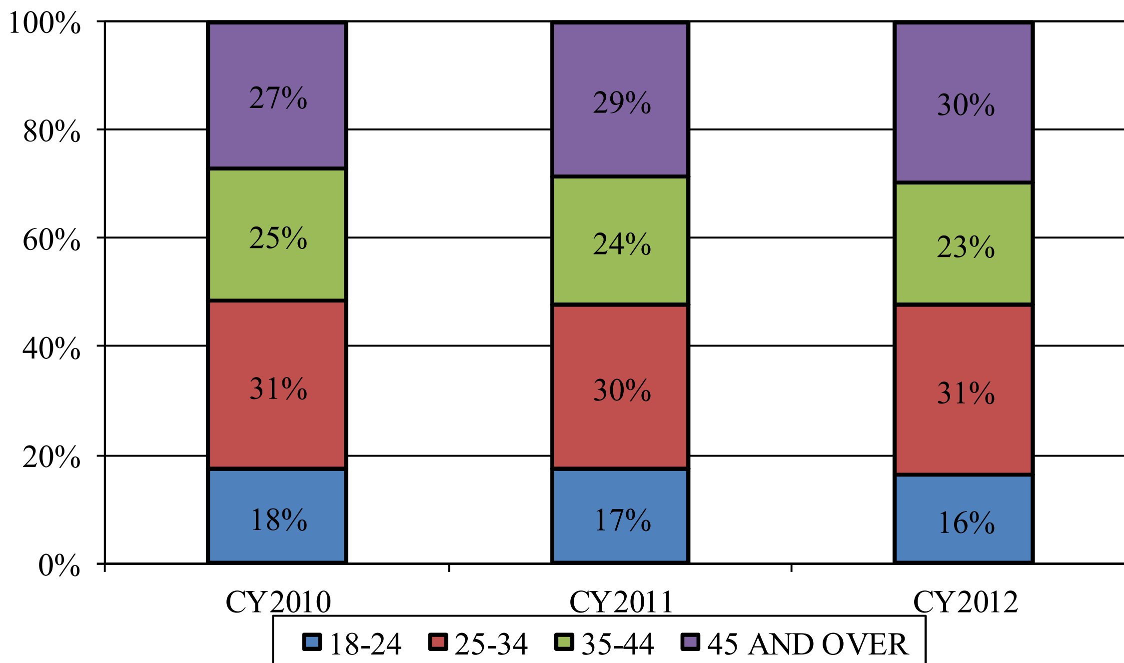
- The average age at admission for those with a primary heroin problem **increased** from **CY 2010** to **CY 2012** by **0.5 year (34.7 to 35.2)** and by **0.6 year** for those reporting other opiates.

Characteristics of Substance Abuse Treatment Clients by Primary Problem Substance at Admission—CY2012

	Alcohol	Heroin	Other Opiates	Cocaine	Marijuana
% Female	27.8	29.2	37.3	36.6	22.2
Mean age (years)	40.4	35.2	33.0	39.5	28.4
Race					
% White	69.8	66.9	81.6	48.3	37.2
% Black	14.0	8.9	3.4	27.8	38.1
% Other	16.2	24.2	15.0	23.8	24.7
Ethnicity					
% Hispanic	14.5	23.8	9.6	22.2	32.2
% Non-Hispanic	85.5	76.2	90.4	77.8	67.8

Total Substance Abuse Treatment Program Admissions for FY2009 through FY2013



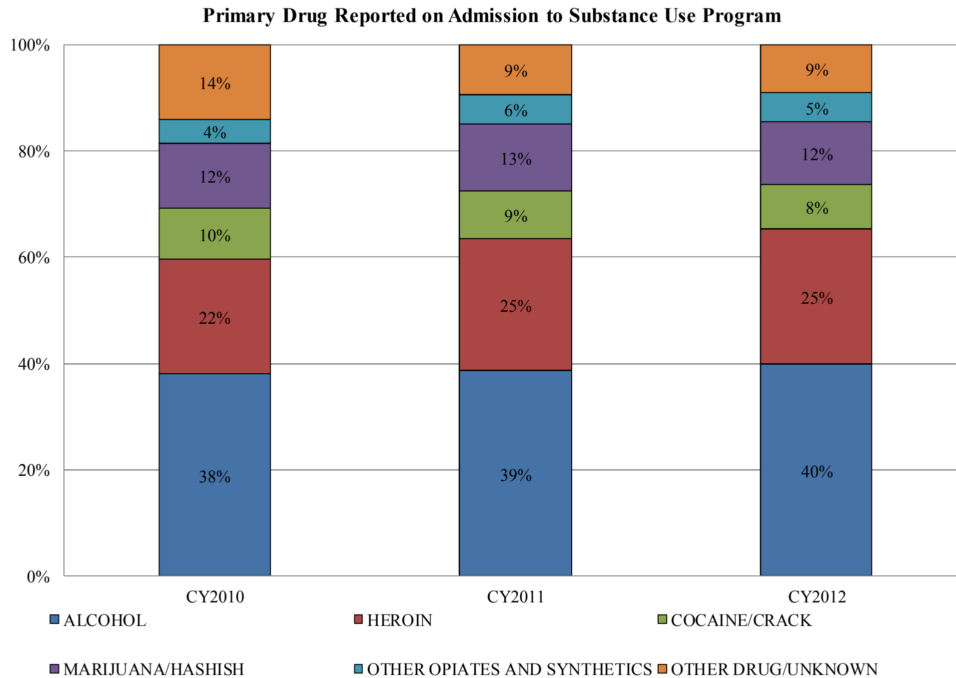


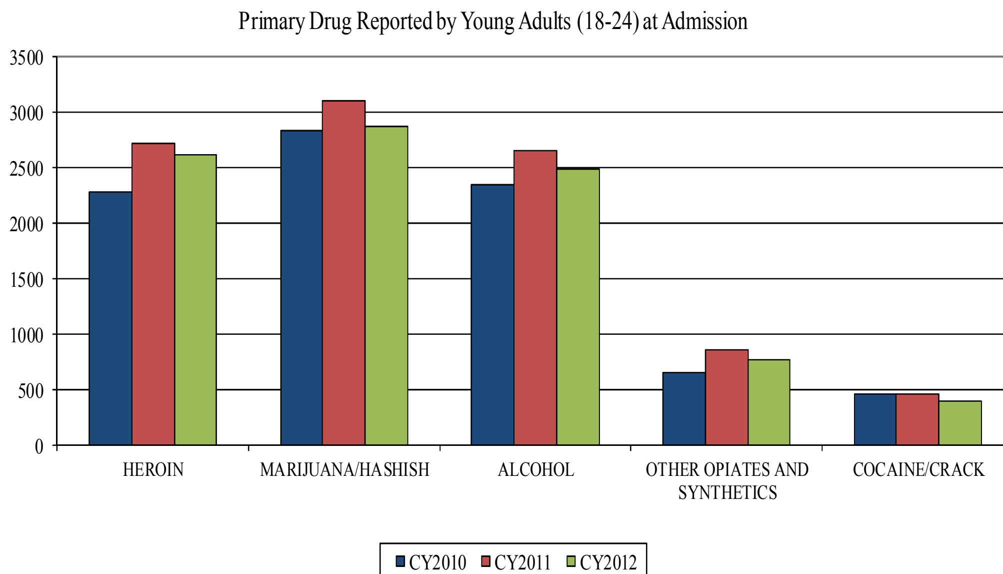
Rates of admissions grew slightly for those ages **45 and over** while those age **18 to 24 and 25 to 44** dropped over the **three**-year period. NSDUH has reported an increase in substance abuse by older adults as "baby boomers" age.

Patterns and Trends of Primary Problem Substance:

The percent of primary heroin admissions dropped after years of steady increases giving rise to alcohol to become, once again, the most frequently reported substance at admission.

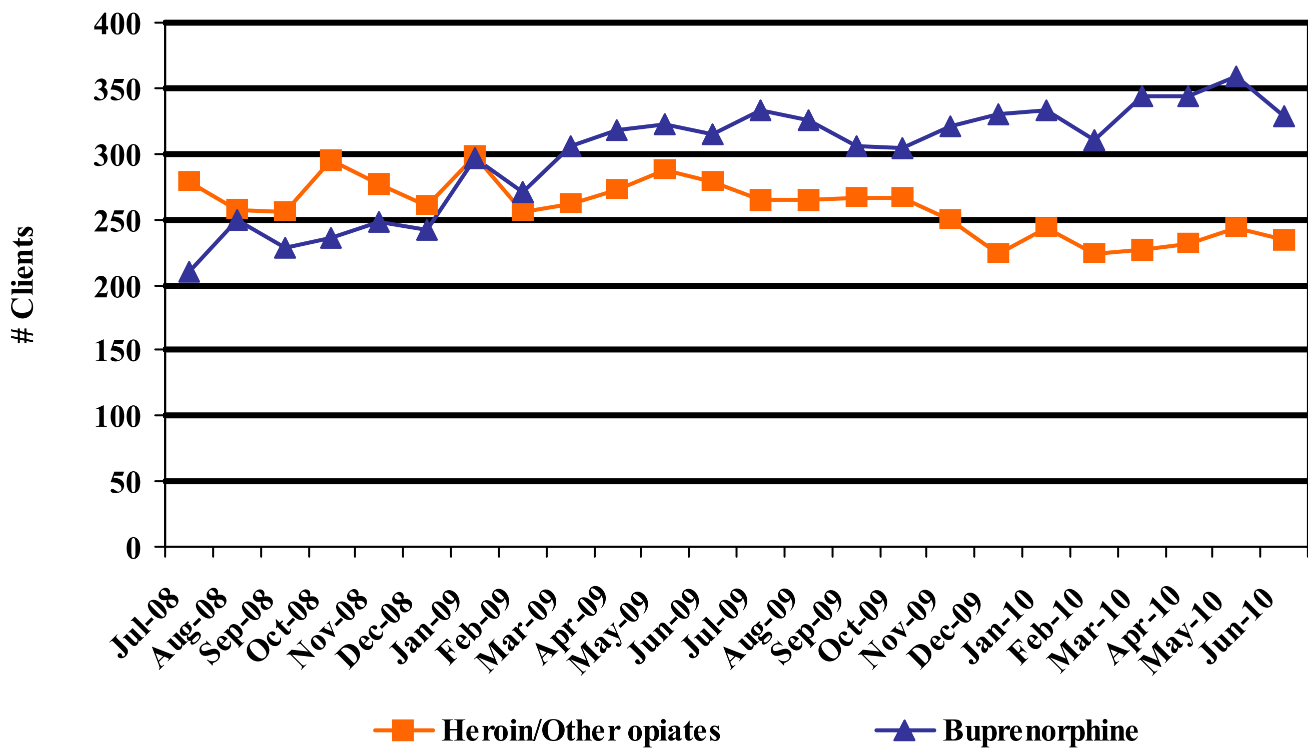
Treatment admissions due to other (prescription) opiates (e.g., OxyContin®, Vicodin®) continued to have the greatest percentage increase continuing a seven-year trend. Injection drug use in **CY 2012** remained similar to past years with about one out of every five persons admitted to treatment having injected drugs.
Variation in age of first use for primary problem substances reported at admission showed little change and only minor differences between males and females. The greatest variance was seen with clients reporting age of first use for other opiates. In **CY 2010**, the average age of first use was about **26.5** years old. In **CYs 2011 and 2012**, the average age dropped to **22.8 and 22.6 respectively**.





Type of care received by primary problem substance followed past patterns with alcohol admissions using outpatient and detoxification; heroin - detoxification and methadone maintenance; cocaine - outpatient followed by residential care; and marijuana predominately outpatient. Overall, utilization of detoxification services dropped while outpatient increased, and residential rehabilitation and methadone maintenance remained unchanged.

The monthly number of persons prescribed buprenorphine adjusted based upon the one year prevalence rate (NSDUH) of persons age 18-24 estimated to be using narcotic pain relievers for nonmedical purposes (CY2012)



Connecticut's Response to Prescription Drug Overdose:

Prescription drug misuse involves four categories of medications: analgesics (pain killers), tranquilizers, stimulants, and sedatives. By far, analgesics are the most misused. In January 2012, the CDC identified prescription drug overdoses in the United States as an **epidemic** and reported that for every unintentional opioid overdose death, there were an estimated 461 persons using opioid analgesics non-medically. Data collected in 2006/7 by Professor Traci Green from Brown University found that, on average, one person in Connecticut was dying every day from an opioid overdose. These deaths exceeded the number of deaths due to motor vehicle accidents, fires, and firearms combined. In response to this crisis and to calls from the CDC, the American Medical Association, and the Office of National Drug Control Policy; DMHAS sponsored legislation for Naloxone/Narcan, a prescription medication that reverses an opioid overdose. The law (PA 12 -159, *An Act Concerning Treatment for a Drug Overdose*) became effective October 1, 2012. View PA 12-159 at http://www.cga.ct.gov/2012/ACT/PA/2012PA-00159-R00HB-05063-PA.htm

The law allows prescribers to prescribe, dispense or administer Naloxone/Narcan to treat or prevent a drug overdose. In effect, this allows persons other than the individual using opioids access to this life saving medication. This is critical since those overdosing are incapable of self-administering medication and are typically not alone at the time of the overdose. Research conducted by Yale University in 2008, found that with minimal training, anyone could learn to recognize a drug overdose and respond with Naloxone/Narcan as effectively as a medical professional.

As part of this recent legislation, DMHAS was responsible for reporting to the joint standing committee of the General Assembly by January 15, 2013 concerning the number of prescriptions written by DMHAS providers for Naloxone/Narcan. Informing and supporting DMHAS providers in this effort was accomplished by conducting multiple training events across the state as well as offering presentations on this initiative at two conferences, one sponsored by DMHAS and the other by DPH. The report submitted in January 2013 reflected the 120 prescriptions written in the initial quarter (October – December 2012). By the end of the second quarter following implementation, DMHAS has been informed of three cases (each at a different program) of successful opioid overdose reversal using narcan.

The enactment of PA 12 – 159, in concert with Connecticut's "Good Samaritan" law (PA 11 -210, *An Act Concerning Emergency Medical Assistance for Person's Experiencing an Overdose and the Designation of Certain Synthetic Stimulants as Controlled Substances*) which provides protection from prosecution for drug possession to persons calling 911 in the event of a drug overdose; reinforces Connecticut's position as a leader in prevention efforts.

V. Substance Abuse Treatment and Caseload Overlaps

The Data Sharing Project, initiated in December 2000, originally drew upon data from seven state agencies and the Judicial Branch. The project had been highly successful in generating statistical information including trends over the years regarding shared caseloads. Analyses conducted using a statistical model called Probabilistic Population Estimation or PPE was instrumental in measuring the "population or caseload overlap" of Connecticut's substance abuse treatment system with criminal justice, and health and human service systems. Over that 10-year period, a series of reports were produced which included an unduplicated count of persons in each state agency population, the percent and number of overlap (i.e., those receiving treatment who were also arrested, incarcerated, on probation, receiving welfare benefits, involved in child protective services, etc.) and demographics such as age, race and gender.

While PPE was useful in examining general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems as DMHAS and the state's criminal justice agencies had established consistent and valid methods for linking large administrative databases.

At the June 2010 meeting of the Criminal Justice Policy Advisory Commission (CJPAC), a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. Essentially, the concept was to match individual records across separate databases using person identifiers such as first/last name, Social Security number, date of birth and gender. Once linked, all person identifiers were be removed although a random identifier for each person was assigned so that analyses could be conducted at the person level. This random unique identifier was not tied to any person identifiers and therefore posed no risk for re-disclosure.

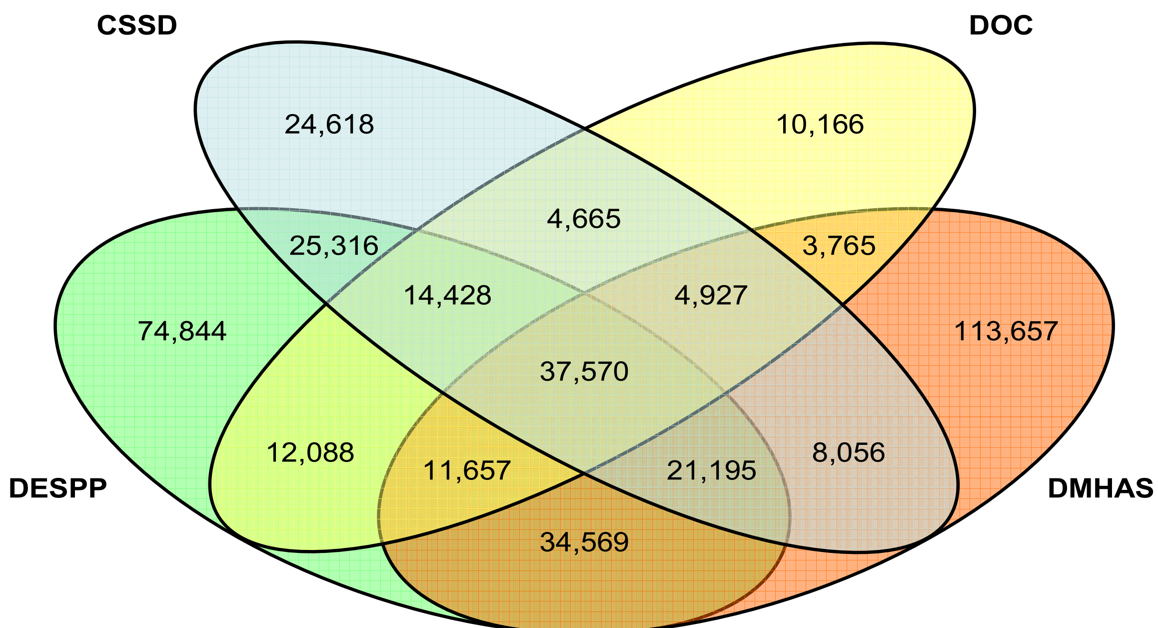
This linking method was exhaustively scrutinized by a number of state agency review boards and academic human subject committees, and was validated as complying with state and federal confidentiality laws and regulations.
During SFY 2011, DMHAS and its criminal justice partners (DOC, DPS and JB-CSSD) formed a steering committee responsible for the following components of the data linking project:

- Determining the scope of data sharing (i.e., which data elements to be included, frequency of updates, etc.).
- Overseeing the creation of data dictionaries and other essential documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

The Memorandum of Understanding regarding governance, publication and other pertinent matters was completed in late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probationer) and behavioral health data were linked for the purpose of services research, evaluation and outcomes analysis.

The following CJPAC FY 2007 through FY2011 data shows the overlapping patterns for 4 agencies (DOC, DMHAS, DESPP, and CSSD) revealing the extent to which common clients are served by multiple state agencies.

Data Sources Overview:



Percentages of Shared Clients Across State Agencies
(2007-2011)

	DMHAS	DOC	DESPP	CSSD
DMHAS (N=235,396)	--	24.6%	44.6%	30.5%
DOC (N=99,076)	58.5%	--	76.3%	62.0%
DESPP (N=231,477)	45.4%	32.6%	--	42.5%
CSSD (N=140,585)	51.0%	43.7%	69.9%	--

VI. Prevention Data:

Statewide Epidemiological Outcomes Workgroup Behavioral Health Indicators Portal (SEOW BHIP)

Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to be able to select effective programs and strategies. The SEOW also provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and use data, and explore opportunities to collaborate on issues of common concern.

In SFY 2010, DMHAS provided funding to the Connecticut Data Collaborative to develop and maintain a user-friendly web-based prevention epidemiological data repository for the SEOW. Called the SEOW Behavioral Health Indicators Portal (BHIP), the web-based data repository with a state-of-the-art, interactive site enabled registered users to access behavioral health indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.) that can be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. DMHAS provided the initial data to populate the site in 2010 including:

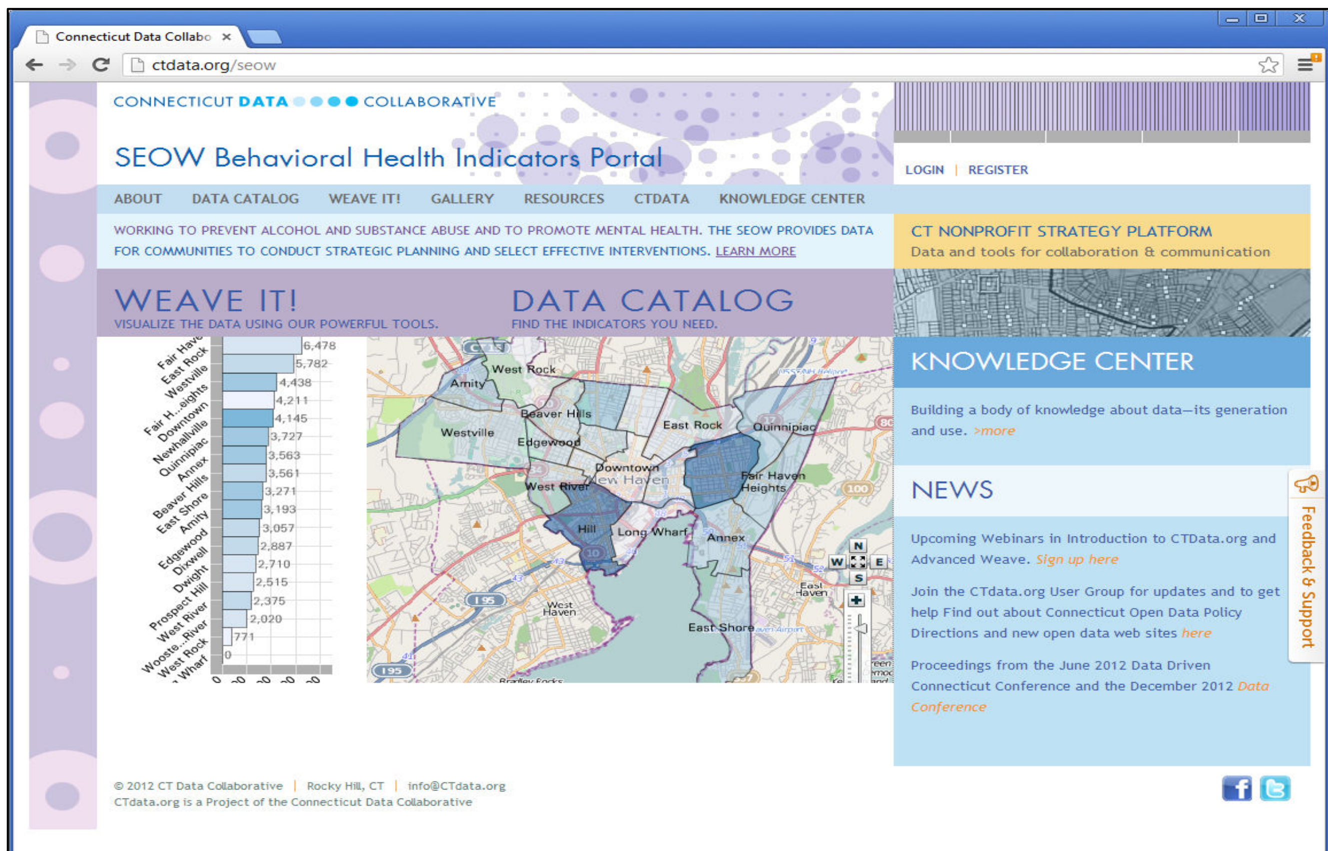
- Current use
- Past month use
- Current binge drinking
- Past month binge drinking
- Past year use
- Lifetime use
- Perception of risk of harm from use
- Early onset (first use < age 13)
- School Attendance
- School suspensions/expulsions
- Drove after drinking
- Rode in car when driver had been drinking
- Alcohol-related fatal motor vehicle crashes
- Alcohol-related motor vehicle accidents
- Alcohol-related motor vehicle deaths
- Driving under the influence arrests
- Liquor law violations
- Drug law violations
- Alcohol Seller Violation Rate
- Tobacco Retailer Violation Rate
- Abuse or dependence past year
- Calls to gambling helpline
- Needing but not receiving treatment
- Treatment admissions
- Deaths from lung cancer
- Alcohol-related suicide deaths
- So sad or hopeless stopped usual activities
- Suicide seriously considered past 12 months
- Suicide plan past 12 months
- Suicide attempt(s) past 12 months
- Self-injury treated by a doctor or nurse

Other crime, education, health, nutrition, housing, Medicaid, poverty, employment and several other indicators were also available on the SEOW BHIP for analysis purposes.

The Web Site functionality developed with DMHAS included the following main features:

- About Us—description of project developed with DMHAS Project Contact
- Registration – ability to create an account in which to save one's work on the site to come back to or share
- Data Catalog – searchable database for selecting indicators to display or download with multiple filtering options
- Weave It –Data visualization tools, including access to Advanced Weave to create one's own visualizations. Default visualizations include a bar chart of all towns, a map of all towns, and a data table with the ability to filter towns, select and create subsets in any tool, download selected data and create images for download of any visualization for use in reports
- Gallery –ability to save and share one's work
- Knowledge Center – Semantic Wiki-based knowledge center for documenting all indicators as well as creating pages of resources related to any topic that can be semantically linked including the above referenced indicators not collected by DMHAS.

SEOW Behavioral Health Portal Main Page http://ctdata.org/seow



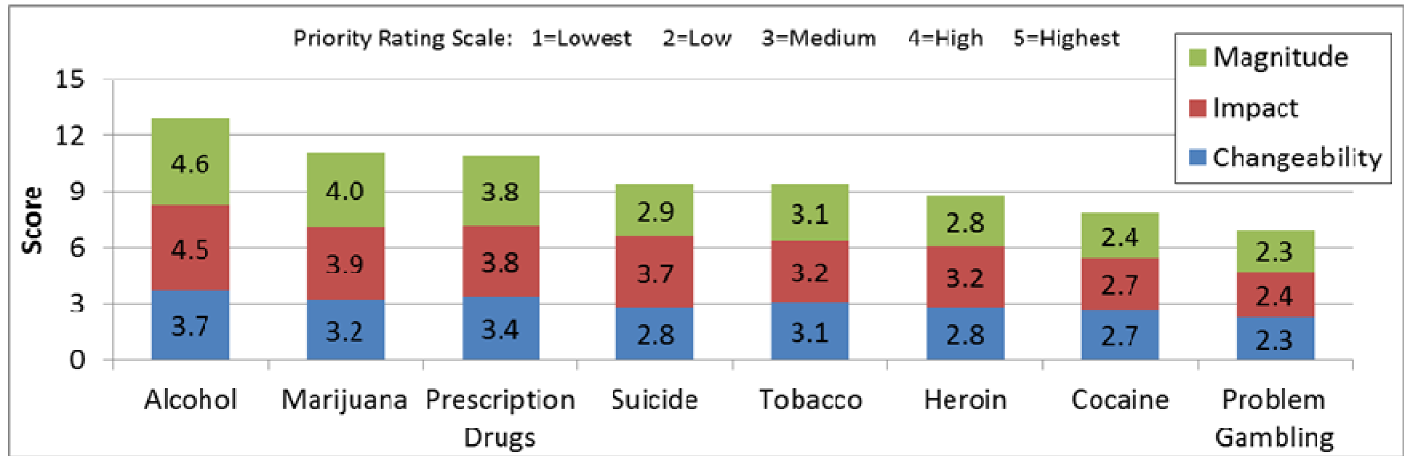
DMHAS data and other indicators were posted online so that users can access a wide range of data available on the site. CT Data Collaborative conducted training sessions, including for Regional Action Council staff, for use in their regional profile development.

During Phase II of the project starting July 1, 2013, CT Data Collaborative will update and upload the data sets, update the data visualization, train and provide technical assistance to DMHAS staff, SEOW members, Regional Action Councils and other community members identified by the Prevention staff.

2012 Behavioral Health Priorities

In 2012, the *Epidemiological Profiles of Substance Use Problem Gambling and Suicide In Connecticut* was updated. The document describes the six priority substances (alcohol, tobacco, marijuana, heroin, prescription drug use, and cocaine), and two additional behavioral health priorities – problem gambling and suicide added in 2010. In addition, the Regional Action Councils (RACs) for the third time, conducted a data-driven needs and response capacity assessment concerning six substances as well as problem gambling and suicide. Each RAC convened a Community Needs Assessment Workgroup (CNAW) to use quantitative and qualitative data to describe and rank each problem according to magnitude, impact and changeability. These problem areas were ranked in the following order: alcohol, marijuana, prescription drugs, suicide, tobacco, heroin, cocaine and problem gambling.

2012 Regional Priorities: Ranking Results



At the state, regional and sub regional levels, alcohol misuse and abuse, especially underage drinking, continued to be the highest prevention priority. Marijuana is the illicit drug of choice in CT and was ranked second overall by the CNAWs. Sub regional CNAW members ranked prescription drugs as the third highest priority after alcohol and marijuana. Prescription Drug Abuse is defined by the NSDUH as nonmedical use of prescription-type pain relievers without a prescription or use simply for the experience or feeling the drug caused. Over-the-counter (OTC) use and legitimate use of prescription-type pain relievers were not included. Suicide contemplation and completion was ranked number four owing to the recent rise across the state. Ranked fifth was tobacco use which has steadily declined within the state over the last 6 years. There is little prevention-related data on heroin use and consequences. However, treatment data reflect a drop in treatment admissions putting it at number 6 in the ranking. Cocaine was ranked number seven and problem gambling was ranked last.

Subsequent profiles describe current prevalence, trend patterns, socio-demographic differences (e.g., age, gender and race/ethnicity), Connecticut's status compared to the nation, and specific health and social consequences associated with the substance use or behavior. A variety of tables and graphs reveal the state and region-specific rates over time in consumption and consequence indicators from a wide variety of sources, as well as updated data to show population subgroup differences in substance use and behaviors and their related problems.

Partnership for Success Initiative

In September 2009, DMHAS was awarded a Partnership For Success grant from CSAP. The goal of this grant program was to achieve a quantifiable decline in statewide substance abuse rates, particularly those related to underage drinking, incorporating a $500,000 incentive award to grantees that reached or exceeded their prevention performance targets. The CSAP-approved performance target was a reduction in past 30-day alcohol use among youth 12 to 17 years of age from 19.6% to 18.1% (7.7%) within three years as measured by the Connecticut state estimates from the National Survey of Drug Use & Health.

The target performance indicator for Connecticut's PFS project was exceeded and in March 2013, Connecticut was informed that it would be awarded the incentive bonus. Past month alcohol use among 12 to 17 year olds dropped from 19.6% in the 2006-2007 baseline year to 17.8% in 2009-2010 as measured by the NSDUH, surpassing Connecticut's CSAP-approved performance target of 18.1%. According to the NSDUH, underage drinking among the state's population ages 12 to 17 decreased 9.2% in the three-year period.

These positive results were due in large part to concerted efforts at the state and community levels. The table below summarizes the performance indicators monitored and measured at the state level.

Table 2: PFS Indicators Monitored & Measured

Connecticut's PFS	Year 1 Baseline	Year 3 Performance Target	Improved Outcomes
Performance Targets			
Past 30 day use 12-17	19.6	17.8	√
Past 30 day use 12-20	32.8	31.9	√
Past 30-day use HS students	43.5	41.5	√
Past month binge use 12-20	23.5	22.3	√
Past month binge use HS students	24.2	22.3	√
Source: NSDUH 2006/07 & 2009/10; YRBS 2009 &2011			
Level of community readiness for substance abuse prevention	4.3	5.1	√
Source: CT Community Readiness Survey 2006 & 2012			
Other State Measures			
Alcohol related motor vehicle crashes (per 10,000 persons) *Source: CT Department of Transportation*	6.91	6.29	√
Underage DUI arrests per 10,000 persons *Source: CT State Police*	18	14	√
Underage Liquor Law Violations (per 10,000 persons) *Source: CT Dept. Consumer Protection*	24.4	17.8	√

Community Readiness Assessment Survey

The evaluation of the CT PFS was designed to assess changes in community capacity and readiness to implement effective substance abuse prevention strategies as measured by the Community Readiness Assessment Survey (CRS). Community readiness for prevention was conceptualized as an intermediate variable leading to greater community effectiveness in reducing and preventing underage drinking and its consequences. First developed to measure the impact of the CT SPF-SIG, the CRS has been administered biannually since 2006 to key informants in every town and municipality in the state.

The CRS measures perceived community capacity and readiness to implement data-driven planning and evidence-based practices and programs at the community level. The community-level implementation of the CT SPF planning process is expected to lead to greater implementation of evidence-based practices, especially environmental strategies, which would in turn result in reductions in underage drinking. More specifically, as a result of the CT SPF-SIG and PFS initiatives, it was hypothesized that the following improvements in substance abuse prevention infrastructure and community readiness would occur: increased community concern about alcohol and other drug use; increased community support for substance abuse prevention; increased availability of environmental strategies; fewer perceived barriers to substance abuse prevention; greater use of data for prevention; fewer barriers to data-driven prevention; and, an increased stage of community readiness for substance abuse prevention.

The CRS data analysis, as displayed in the table and figure below, shows that there has been steady and statistically significant improvements in community readiness for prevention in Connecticut since the CT SPF-SIG was first initiated (p = 0.0001). In 2008, 21% of key informants reported that their communities had taken steps to implement programs and strategies in their town or municipality to address substance abuse problems; by 2010, 31% of key informants reported active prevention programs and practices in their communities. These results are consistent with the hypothesized intermediate outcomes expected from both the SPF-SIG and PFS initiatives, and as the PFS moves forward, community readiness is expected to continue to increase over time.

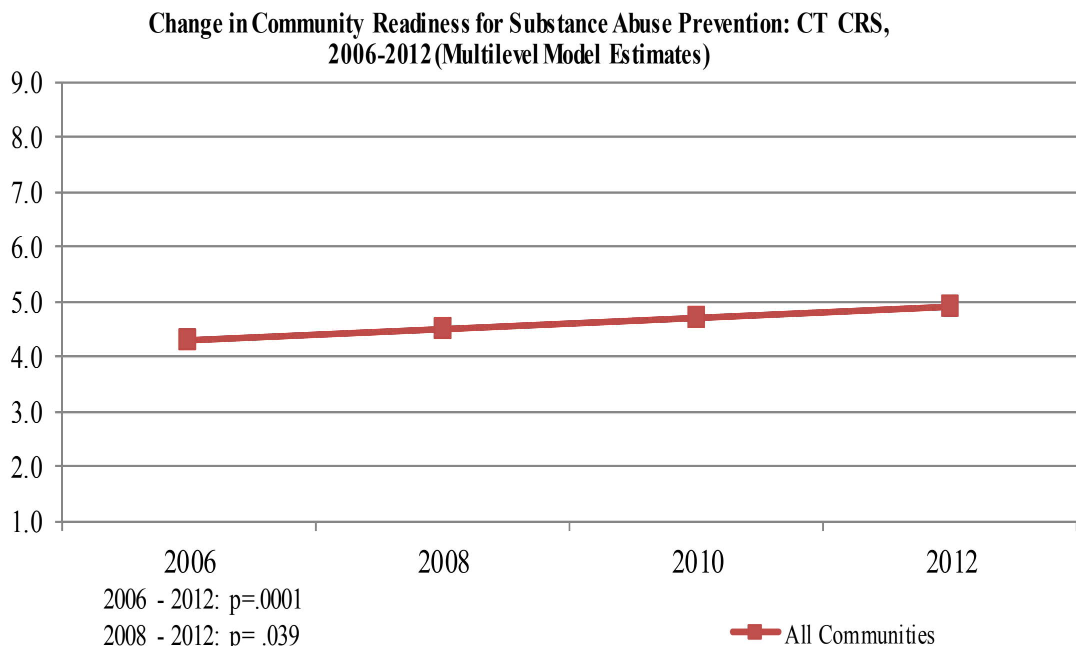


Table 3: Key Informant Ratings of the Community Stage of Readiness for Substance Abuse Prevention: CRS, Connecticut, 2008 and 2012.

Stage of Readiness	2008	2012
Tolerates or encourages substance abuse	1%	1%
Has little or no recognition of substance abuse problems	11%	11%
Believes a substance abuse problem exists, but awareness is only linked to one or two incidents involving substance abuse	17%	13%
Recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors	24%	23%
Planning for substance abuse prevention is focused on practical details, including seeking funding for prevention	17%	15%
Has enough information to justify a substance abuse prevention program and has great enthusiasm for the initiative	5%	6%
Has created policies and/or more than one substance abuse prevention program is running with financial support and trained staff	9%	10%
Views substance abuse programs as valuable, new programs are being developed for at-risk populations and there is ongoing evaluation	7%	13%
Has detailed knowledge of prevalence, risk factors and program effectiveness, and programs are tailored by trained staff to address community risk factors	5%	8%

Reducing Youth Tobacco Use

In July 1992, Congress enacted the Synar Amendment as part of the Alcohol and Drug Abuse and Mental Health Administration Reorganization Act (P.L.103-321). The Synar Amendment is aimed at decreasing access to tobacco products among individuals under the age of 18 by requiring states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18. The ultimate goal of the amendment is to reduce the number of tobacco outlets selling to minors to no more than 20 percent in each state.

The Synar Amendment further defined state requirements for conducting unannounced inspections of a random sample of tobacco vendors, to assess their compliance with the state's access laws. Each state must submit an annual report to the Secretary of Health and Human Services describing that year's enforcement activities, the extent to which the state reduced the availability of tobacco to minors, and a strategy and timeframe for achieving and maintaining a retailer violation rate (RVR) of no greater than 20 percent. Synar regulation requires that the sample be "scientific", providing an accurate depiction of the state's RVR from the base year, and each year thereafter. A state that does not meet its targeted reduction is penalized 1 percent of its federal Substance Abuse Prevention and Treatment (SAPT) block grant funds for each percent it is over the 20 percent minimum threshold. The following table details Connecticut's retailer violation rates over the past seventeen years.

Table 4: Connecticut's Tobacco Retailer Violation Rate: 1996-2012 (Synar)

Year	Target Percentage	Actual Percentage (weighted)
Base Year 1996	70%	69.7%
1997	60%	58.8%
1998	45%	35.0%
1999	30%	17.3%
2000	25%	18.1%
2001	20%	13.1%
2002	At or below 20%	12.0%
2003	At or below 20%	18.9%
2004	At or below 20%	18.0%
2005	At or below 20%	10.6%
2006	At or below 20%	11.4%
2007	At or below 20%	14.0%
2008	At or below 20%	13.7%
2009	At or below 20%	9.7%
2010	At or below 20%	13.3%
2011	At or below 20%	11.3%
2012	At or below 20%	12.1%

The FFY 2012 annual Synar retailer violation rate inspections were conducted in the months of July and August. The results presented are based on the analysis of 525 randomly chosen licensed tobacco vendors. There were 518 over the counter (OTC) and 7 vending machine (VM) locations selected. Of these sites 454 locations were inspected. The remaining locations were identified as either out of business, no longer selling tobacco, inaccessible by youth, temporarily closed, private club or private residence, and therefore; could not be inspected.

From the 454 inspections completed a total of 55 purchase attempts were successful. After statistical weighting, Connecticut's 2012 retailer violation was calculated at 12.1% percent maintaining the federal minimum standard of no greater than 20 percent. This represented a decrease of 57.6 percentage points from the 1996 benchmark rate of 69.7 percent and an increase of 0.8 percentage points from the FFY 2011 rate of 11.3%.

In addition to the Synar mandate, in June 2011, DMHAS contracted with the federal Food and Drug Administration (FDA) to conduct inspections for compliance with provisions of the FDA 2010 Tobacco Control Act pertaining to: 1) restriction on selling tobacco to anyone younger than 18 years old; and, 2) restrictions on advertising, marketing and promoting cigarettes and smokeless tobacco (e.g. no coupons, free samples, open packages, etc.). Data from this program will be available in 2013.

Connecticut's overall success in reducing underage youth access to tobacco can be credited to several factors: the enforcement of State tobacco laws by the Department of Revenue Services (DRS) and DMHAS; the enactment of key legislation such as Connecticut General Statute Section 12-295a and 53-344 that provides meaningful, yet rational penalties for non-compliance with Connecticut's tobacco laws; the Attorneys' General Office and their efforts to encourage large chain stores to sign Assurances of Voluntary Compliance to curtail their tobacco signage placement regarding schools, playgrounds and products popular with minors; the Department of Public Health's (DPH) provision of quality trainings through their Tobacco Education and Training Institute; a comprehensive merchant and community education campaign; and, the dedication of merchants who are invested in the health and wellness of their communities by not selling tobacco products to youth.

VII. Statewide Cost Analysis: 2009, 2011, and 2012

Information regarding the funding, directly or indirectly, of substance abuse services was gathered from ten state agencies and the Judicial Branch, the Office of Policy Management (OPM) and the Board of Pardons and Paroles. Expenditures reported include all funding sources – state, federal, and other. Clearly, the most easily defined service is substance abuse treatment. Treatment dollars, for the most part, are readily identified and reported. Less clearly defined are intervention activities, as the range of services in this category often overlap into prevention services. Therefore, intervention funds are included within prevention expenditures. While CGS Section 17a-451(o) speaks to prevention and education services separately, for purposes of expenditure reporting, these two activities have been combined, as education is one segment of the prevention continuum. The category "deterrence", also a component of prevention services, was added in the 2001 Annual Report but is reported separately as law enforcement activities. Substance Abuse service expenditures by agency for SFY 2012 are included in the Table seen below. Overall total expenditures from fiscal year 2009 to 2012 have increased by 21%.

Agency (FY 12 data)	Prevention	Deterrence	Treatment	Total
DMHAS[1]	$10,852,240	$0	$192,647,818	$203,500,058
JUDICIAL-CSSD	$9,172,397	$0	$19,930,360	$29,102757
DCF	$1,516,721	$0	$17,235,195	$18,751,916
DMV[2]	$0	$0	$0	$0
DOC	$0	$0	$14,264,425	$14,264,425
DOT[3]	$1,346,449	$3,263,131	$0	$4,609,580
DPH	$1,587,033	$0	$0	$1,587,033
DPS	$80,167	$2,851,222	$0	$2,931,389
DSS[4]	$0	$0	$77,654,280	$77,654,280
DVA	$0	$0	$273,221	$273,221
OPM[5]	$393,983	$0	$60,500	$454,483
PAROLE	$0	$0	$0	0
SDE	0	$0	$0	0
FY2012 TOTALS	$24,948,990	$6,114,353	$322,065,799	$353,129,142

[1]Note that expenditures do not include administration dollars.
[2]Clients pay directly for retraining, education and required substance abuse treatment programs.
[3]All figures are based upon a Federal Fiscal Year (i.e., October 1 through September 30). Prevention costs from the State Highway Safety Office include staff salaries, public information and education initiatives and media. Deterrence costs reflect law enforcement initiatives.
[4]Expenditures include claims paid for Inpatient and Outpatient substance abuse treatment. Excludes pharmacy, transportation and crossover claims.
[5]FY12 Residential Substance Abuse program may also be reported by the Department of Corrections. OPM sub-grants these funds to DOC, which provides the treatment services to inmates.

VIII. Update on DMHAS Three-Year Strategic Substance Abuse Treatment Plan:

Background

On June 29, 2009 the Connecticut state legislature passed, and the governor signed, Public Act 09-149 which required DMHAS, to address in its three-year strategic substance abuse treatment plan, a number of specific elements for consideration, such as data management, continuum of care and use of evidence based practices. This was offered as part of observations and recommendations provided by the Program Review and Investigation Committee's report entitled *State Substance Abuse Treatment for Adults* published in December 2008.

Strategy #1

Assure the availability of adequate residential and case management supports to eligible individuals in the network of Supported Recovery Housing Services.

Supported Recovery Housing Services (SRHS) provide safe, sober housing and case management to support residents in securing treatment and other community based recovery supports. In FY2012 there were a total of 176 SRHS beds (106 for men and 70 for women). These bed locations were at 26 locations and provided by 10 SRHS providers. At the time of this report in 2013 there are currently 15 providers in 42 locations providing 243 beds with supports. DMHAS is currently assessing gaps in need for a potential re-procurement, pending resource availability.

Strategy #2

Analyze the impact, opportunities, and potential challenges of the Patient Protection and Affordable Care Act (ACA).

DMHAS, in partnership with Department of Social Services (DSS), converted the State Administered General Assistance program to the Medicaid Low Income Adult program in April 2010, taking advantage of provisions within the health reform act that afford broader coverage. DMHAS and DSS are now preparing for 2014 as more people will become eligible for this coverage. DMHAS, jointly with DCF and DSS, comprise the Connecticut Behavioral Health Partnership, working collaboratively on behalf of our clients to implement the ACA.

There are a number of initiatives exploring the integration of behavioral and primary health care to meet the triple aim of the ACA. DMHAS, in collaboration with DSS and the Department of Children and Families (DCF) is developing a Behavioral Health Home (BHH) model, in which primary care services will be integrated into the Department's behavioral health system of care. Moreover, DMHAS plans to submit an Innovation Round Two application for funding to the Centers for Medicare and Medicaid Services (CMS) to enhance our BHH model for individuals with serious behavioral health conditions. DMHAS is also collaborating with DSS on another integration model for individuals dually eligible for Medicare and Medicaid. And, finally, DMHAS is participating in the State Innovation Model (SIM) planning process with other state agencies, insurance companies, and stakeholders which would allow for the implementation of payment reform over multiple payers.

The DMHAS Commissioner was an active participant in the development of CT's Health Insurance Exchange and choosing of our state's benchmark plan. Access Health CT is CT's Health Insurance Marketplace to help more people get insured, improve health care quality and lower health insurance costs. See the web link below:
http://www.ct.gov/hix/site/default.asp

Strategy #3

Examine the ability to expand provision of case management, life coaching, employment, education, community affiliation and wellness supports, including the provision of these services by peer providers (continuum of care), by capitalizing on opportunities created by federal reforms to address desires of the recovery community and service providers.

These services, which are detailed below, are available through the CT Behavioral Health Partnership, the Behavioral Health Recovery Program and the federally funded Access to Recovery Program. The ability to expand provision of these services will be addressed by opportunities allowed by the ACA as described in Strategy #2. Shifting resources in support of these efforts may be a consideration as greater numbers of the population obtain coverage for Medicaid covered services through the ACA.

Case Management Services

Case management services are available throughout the state funded by the federal Center on Substance Abuse Treatment grant program known as, *Access to Recovery III*. The ability to expand provision of these services will be addressed by the Commissioner's Executive Group described in Strategy #2. Shifting resources in support of these efforts may be a consideration as greater numbers of the population obtain coverage for clinical services through the Patient Protection and Affordable Care Act.

In addition, DMHAS funds statewide intensive case management services for identified populations through Advanced Behavioral Health, Inc. It also funds regional case management services in the more rural areas in Regions 3 and 5.

Employment Services

DMHAS has implemented the following employment services specifically targeting people with substance use disorders. They are:

Direct Individual Placement – Two agencies are funded to assist people recovering from substance use issues reentering the workforce through vocational assessment and evaluation; work adjustment; vocational counseling; job development; and support groups.

***Recovery Oriented Employment Services* (ROES)–** This unique program, a collaboration between a treatment provider and a community recovery organization, provides employment services to adults who are currently participating in addiction treatment and who desire to assess their readiness and options for employment and/or education. Participants attend a seven module curriculum developed to address a variety of topics from resume writing to managing a paycheck. Additionally, participants have the option of receiving telephone recovery support from the recovery community organization and receiving a volunteer certificate for hours spent donating time to this organization. These certificates can be used as part of a resume package when participants begin the job application process.

In addition to the employment services above, interactive on-line classes were created for job seekers with visible/hidden disabilities and the people who support them.

These free on-line courses are the newest resource for job seekers with barriers to employment. There is an Employability Course that contains eight (8) modules, a Soft Skills Course that contains six (6) modules and fourteen (14) simulations or interactive vignettes that teach a range of skills related to finding and retaining a job. These courses are available here https://elearning.connect-ability.com/

Peer Provided Services

DMHAS funds the Connecticut Community for Addiction Recovery (CCAR), which is a consumer/peer operated agency dedicated to organizing the recovery community state-wide to put a face on recovery, and to provide direct recovery support services. CCAR strives to end discrimination surrounding addiction and recovery, remove barriers to recovery, provide supports to help sustain recovery while ensuring that all people in recovery are treated with dignity and respect.

Some of the funded peer recovery support services provided by CCAR are:

Telephone Recovery Support (TRS) helps people in recovery stay in recovery. A person new in recovery can enroll to receive a weekly call from a trained person who checks in to see how their recovery is progressing. On average, people receive calls for fourteen weeks, though they can stay enrolled longer. In 2011, CCAR enrolled 1,945 new recoverees, and volunteers made more than 35,000 outbound calls and had more than 8,200 conversations about recovery. People enrolled continue to receive recovery calls even if they relapse and are no longer in recovery.

Outcome data supports that telephone recovery support is highly effective, especially when it comes to relapse. In a recent sample of 483 individuals who received calls for 12 weeks, only 58 people self-reported they were no longer in recovery. Of these 58, 42 later reported they were back in recovery (72%).

This initiative began in 2005 as a DMHAS Centers of Excellence project with calls to 22 recoverees. Since then, CCAR's trained volunteers have made over 125,000 telephone calls resulting in 36,000 conversations with about 4,500 recoverees!

The ***Recovery Coach Academy*** is a five-day training designed to develop peer recovery coaches. A Recovery Coach can be anyone interested in promoting recovery by removing barriers and obstacles to recovery and serving as a personal guide and mentor for people seeking or already in recovery. The training provides a comprehensive overview of the purpose and tasks of a recovery coach, and explains the roles played by a recovery coach. The training provides tools and resources useful in providing recovery supports and emphasizes the skills needed to link people in recovery to needed supports within the community that promote recovery.

A ***Recovery Community Center (RCC)*** provides a recovery oriented environment set in the heart of a community. It serves as a physical location where CCAR can organize the local community's recovery resources and helps put a face on recovery by integrating people in recovery in their communities. Recovery Centers are not a treatment agency, a 12 Step club, or a drop-in center, although aspects of all of these are present. A RCC will deliver peer-to-peer recovery support services using its volunteer force as the providers of these services and will host specific recovery social events. A structured schedule provides recovery-related workshops, trainings, meetings, services and social events, and targets people in recovery, family members and friends to serve as volunteers. A RCC exists as a recovery resource for the local community.

CO-OCCURRING DIAGNOSIS

The Department has also been involved in a statewide initiative that enhances the delivery of case management services and seeks to expand access to case management services and increase efficiency. Through a conversion of case management services to a Community Support/ Recovery Support Program model, additional case management capacity was created. In addition, each of these reengineered programs provided support services by identified peer recovery specialist staff. Service standards and expectations have been set. Outcomes and conformity to the service model are being monitored.

Strategy #4
Promote the provision of comprehensive assessments.

DMHAS completed the Assessment Guidance document as of July 2013. The Community Services Division has posted the Guidelines document on the web at the following link:

http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335022

Dissemination of the Guidelines will take place at on-site monitoring visits conducted by Community Services Division staff and at various Learning Communities DMHAS regularly convenes. These Learning Communities or collaboratives include program managers and directors. Agencies will be asked to review their bio-psychosocial assessment documents and compare them to the DMHAS Assessment Guidance document with the understanding that due to Electronic Health records already implemented in a number of agencies, immediate changes in their data gathering may not be possible. Changes to assessment forms may be needed so that they are more consistent with DMHAS' assessment expectations.

Strategy # 5
Promote the adoption of evidence based and best practices and models.

DMHAS created an Evidence-Based and Best Practices Governance Committee, chaired by the DMHAS Commissioner in 2010 which continues to meet quarterly. This Governance Group consists of 17 members in addition to the Commissioner and includes other executive staff and Office of the Commissioner Division Directors. Also at that time, DMHAS designated a new position in the Office of the Commissioner's Community Services Division: Manager of Evidence-Based and Best Practices Implementation. This manager provides staff support to the Governance Group as described above along with other functions that promote the adoption of evidence-based and best practices. A behavioral health specialist was reassigned to work for this manager, and more recently a behavioral health program manager was assigned to this unit as well, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system.

The first product from this Governance Committee was the DMHAS Catalog of Evidence-Based & Best Practices. This catalog includes twenty practices that are currently being implemented in various ways through the DMHAS system of care, across six Divisions. The catalog describes each practice, the number of programs involved, the implementation process being used, training and technical assistance currently available, a summary of fidelity measurement being used, and a summary of how client outcomes are being measured. Over the past year a new DMHAS webpage was created that summarizes the evidence-based and best practices DMHAS supports and/or is actively working to more fully implement: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912

Specific to the addiction treatment system, the following progress is important to note:

•The DMHAS ***Co-Occurring Disorders*** *Practice Improvement Collaborative* continues with several components:

* The Co-Occurring Practice Improvement Collaborative continues with 40+ agencies and contracted training/technical assistance from the Yale Program on Supervision. Pre-post fidelity reviews are done for agencies as they go through the year-long change process to implement integrated mental health and addiction treatment services for individuals with co-occurring disorders. For the addiction treatment agencies, a fidelity scale is used to conduct reviews which was developed and validated by Dartmouth Medical School: Dual Diagnosis Capability in Addiction Treatment (DDCAT).
* The programs in the Collaborative come together every-other-month, in three regional meetings, facilitated by DMHAS, to exchange lessons learned and problem solve full implementation of integrated services.
* Two co-occurring enhanced residential treatment programs continue to be monitored closely using the DDCAT fidelity scale and remain high quality integrated programs.

•DMHAS implemented a pilot project in 2012, tailoring the evidence-based practice of Dialectical Behavior Therapy (DBT), originally developed for treating Borderline Personality Disorders, for use with an addiction treatment population. The high rate of co-occurring psychiatric conditions in addiction clients can make these clients not only challenging to treat, but increases the likelihood of treatment non-completion. Consequently, the pilot project focuses not only on skill development, but on strategies for approaching and engaging the client. Evaluation results from the first pilot agency were very positive and a second agency is now being trained in this 6-month program.

•The ***Trauma Initiative*** continues through a partnership and contractual relationship with the CT Women's Consortium. Most individuals in addiction treatment services have a history of experiencing some kind of trauma, sometimes resulting in a diagnosis of post-traumatic stress disorder (PTSD). Some activities of the Trauma Initiative include:

* A new fidelity scale has been developed to measure a program's adherence to trauma-informed, trauma-specific and gender-responsive care – all best practices. Five programs have been assessed so far and the measure will be refined. The addition of this fidelity tool holds much promise for measurably expanding this best practice across the system of care.
* Each year, a cohort of four DMHAS agencies is selected through Request for Qualifications (RFQ) process and are trained and coached over a two year change process by national experts in the trauma and gender field.
* The Consortium provides many ongoing trainings on several trauma-specific models for DMHAS addiction treatment providers, including one on Advanced Motivational Interviewing (MI), which is another evidence-based practice that is used throughout the system of care, however booster sessions and help with full adherence to MI is always needed. DMHAS and the Consortium have partnered with another non-profit agency in CT to provide trainings on the evidence-based practice called Eye Movement Desensitization and Reprocessing (EMDR). This practice is very effective in helping individuals with trauma-related flashbacks, nightmares and other symptoms.
* A quarterly newsletter, *Trauma Matters*, developed by the Consortium and DMHAS, is disseminated system-wide to further inform system development.

The DMHAS ***Women Services Practice Improvement Collaborative*** (WSPIC) continues, again through a partnership with the Connecticut Women's Consortium. DMHAS funds seventeen women's specialty programs for addiction treatment and co-occurring disorders, including seven women and children's addiction treatment residential programs. DMHAS and the Consortium are currently underway in developing a fidelity tool for these gender-responsive services that will yield measurable data on an ongoing basis about how well these programs are delivering best practices. These programs, DMHAS and the Consortium meet on a quarterly basis to exchange lessons learned and problem solve full implementation of the DMHAS gender-responsive programs guidelines.

Strategy #6

Improve access to treatment for young adults, criminal justice populations, and other adults

YOUNG ADULTS

DMHAS continues to support prescribed Suboxone as an alternative to methadone for individuals ineligible for, uncomfortable with or unable to attend a licensed Chemical Maintenance Treatment Facility (i.e., a methadone clinic) for daily dispensing and receipt of methadone, including for young adults. In order to allow for greater access to Suboxone, DMHAS collaborated with the Department of Public Health (DPH) to enact changes in Connecticut's licensing regulations which would allow for the prescribing of Suboxone in licensed substance abuse outpatient clinics (other than Chemical Maintenance Treatment Facilities) while final licensing regulations are codified. This allows individuals with opiate dependence, whether to heroin or prescription opioids, to be able to receive treatment within their own communities. Most persons, including young adults, find receiving treatment from an outpatient program rather than a methadone clinic, more palatable. DMHAS is monitoring the implementation of this practice in outpatient substance abuse clinics in order to effectively refer individuals seeking Suboxone for opiate dependence.

In addition, the DMHAS Community Services Division and the DMHAS Prevention Unit are currently brainstorming possible collaborations/partnerships that would maximize the resources available for prevention and treatment initiatives for young adults.

DMHAS, in partnership with Department of Social Services (DSS), converted the State Administered General Assistance program to the Medicaid Low Income Adult program in April 2010, taking advantage of provisions within the health reform act that afford broader coverage. This included coverage for services provided to young adults (ages 18 to 26) and enhanced service access for this population. DMHAS and DSS are now preparing for 2014 as more people will become eligible for this coverage.

Regarding criminal justice populations, the Department continues to collaborate with the CT Department of Correction (DOC) and the Judicial Branch Court Support Services Division (JB-CSSD) around treatment of our mutual clients. As a result of the collaborative contracting process, meetings occur on a quarterly basis between the departments addressing issues critical to these populations and to the Memoranda of Understanding between the Departments. In addition, DMHAS is co-sponsoring a methadone maintenance pilot project matching a New Haven clinic with the New Haven jail enabling individuals currently receiving methadone to continue to do so in the event that they are incarcerated. The goal is to continue to discuss the use of Medication Assisted Treatment with a variety of inmate populations. The Director of the DMHAS Community Services Division is a member of the Recidivism Reduction Sub-Committee of the CT Sentencing Commission.

Finally, the Community Services Division (CSD) pays constant attention to the issue of access to treatment. Through the Community Call Line, callers seeking services are provided assistance specific to their needs in accessing an appointment for care as quickly as possible. CSD Regional staff also assists individuals with making that same connection to treatment. A Daily Census of all Detoxification and Residential treatment beds assists with identifying available slots on a statewide and daily basis.

TREATMENT AVAILABILITY FOR PUBLIC INFORMATION

Through the DMHAS website, a consumer or interested member of the public can now be linked directly to a specific provider website, once the geographic preference has been indicated. By accessing the provider's web site through a hyperlink, an interested individual will be able to develop his/her own impression of the treatment provider and perhaps be motivated to make that first contact to enter treatment. The website is under constant review and revision to ensure the most up to date information possible.

Also, the CT Behavioral Health Partnership has information and referral resources for Medicaid covered individuals both through their customer service center and via their website.

DMHAS website users are given the opportunity to offer feedback about the use of the website though the "Contact Us" link:

"Do you have questions, inquiries or feedback regarding the DMHAS Website?"

Please contact: DMHAS Webmaster@po.state.ct.us"

For those individuals interested in more than just provider website information and seeking actual "performance" information, DMHAS continues to finalize provider performance reports. These reports are intended for use by consumers, providers and other interested parties for assessing treatment effectiveness as well as customer satisfaction. Although customer satisfaction reports are currently available, provider performance reports are in the final stage of being completed. DMHAS will make performance reports available on its provider locator website likely before November 30, 2013.

Finally, DMHAS has a "Facebook" page for users of this form of social media. The intent is not to replicate what already exists on the DMHAS website but rather to help individuals know when and how to access the website for treatment service resources, as well as other relevant information pertaining to behavioral health.

CRIMINAL JUSTICE POPULATIONS

By July 1, 2011, a preliminary pilot implementation report will be drafted that will: 1) determine the scope of the pilot; 2) roles of each party in the pilot program; 3) costs associated with the pilot; and a recommendation as to the number and location of pilot sites situated in Geographical Area Courts.

The first Proposed Outcome for Strategy 6 was for *"DMHAS, CSSD,and the Office of the Public Defender will meet to discuss the possibility of developing a pilot program modeled after DMHAS' Jail Diversion Program"* for *"unsentenced inmates who have an unplanned release from custody by the courts"* Such a pilot program would include an increase in services and service capacity, requiring additional resources. Due to funding limitations, DMHAS is delaying plan development for this pilot until available resources are determined. Until then, existing collaborations to address Strategy 6 will continue as follows:

- The DMHAS Jail Diversion program, in collaboration with CSSD and the Office of the Public Defender, is present at every arraignment court and currently serves a significant number of individuals with substance use disorders.
- As described in the 2011 Criminal Justice Policy Advisory Commission (CJPAC) Reentry and Risk Assessment Strategy, DMHAS and CSSD will continue to operate programs that connect unsentenced inmates to community treatment upon planned release from custody by the court.
- In SFY12 and SFY13 DMHAS was able to provide modest budget increases to permit increased capacity in two pretrial diversion programs that serve individuals with substance disorders in New Haven court.
- In October 2011 DMHAS implemented a new diversion program in the two Hartford courts for adults at arraignment who need an immediate admission to a residential detoxification program, a residential substance abuse treatment program, or rapid admission to a substance abuse IOP to be released from custody. This is the only program in the state that can arrange such services prior to arraignment.

Criminal Justice and Behavioral Health Data Linkage Initiative

At the June 6, 2010 meeting of the Criminal Justice Policy Advisory Commission (CJPAC), members endorsed a proposal to link individual records across the criminal justice (arrests, incarcerations, adult probation and parole) and behavioral health populations. In December 2011, a Steering Committee with representation from the Judicial Branch (CSSD), Department of Correction, Department of Public Safety, Department of Mental Health and Addiction Services, Board of Pardons and Paroles, and Office of Policy and Management was formed. The University of Connecticut Health Center's Correctional Managed Health Care division was later added.

Each party has contributed five years of data (e.g., SFY 2006 – SFY 2010) which has been linked and de-identified. A Memorandum of Understanding covering the data sharing protocol, confidentiality and governance, and documentation of data sets (e.g. data dictionaries) was developed and analysis is underway.

DEMANDS FOR SERVICES

DMHAS will track individuals admitted to treatment regarding the wait time between first contact and first treatment service.

Also, DMHAS will continue to monitor its annual client satisfaction survey as to access to services to evaluate the responsiveness of the treatment system to admit persons demanding treatment.

See Strategy #8 for an update

Strategy #7

Implement provisions of the Criminal Justice Policy Advisory Committee Community Re-entry Strategy. The Preliminary Action Steps of Strategy 7 indicates that "DMHAS will convene an interagency workgroup to develop a detailed Action Plan to establish a comprehensive substance abuse service system for reentry." Such an Action Plan would include an increase in services and service capacity, and would require additional resources.

DMHAS is delaying development of an Action Plan until resources are available. Until then, existing collaborations to address Goal 7 will continue as follows.

- DMHAS, DOC, CSSD, and Board of Parole and Pardons (BOPP) have constant formal and informal communications to manage referral of discharging inmates to the community service system.
- DMHAS, DOC, and CSSD will continue to operate reentry programs as discussed earlier.
- State agencies and the Judicial Branch will continue to develop and implement the reentry strategy as discussed in the 2011 CJPAC Reentry and Risk Assessment Strategy.

Strategy #8

Address data management and policy provisions of P.A. 09-149

DMHAS implemented two new data systems in SFY 2010. The Avatar system collects client level data from state-operated facilities. This system was implemented in mid-May 2010. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers. DDaP was implemented in mid-July 2010. Since these systems were implemented, DMHAS has implemented a data warehouse that standardizes and stores the data from both of these information systems. The data warehouse became fully operational in March 2011 and the department has aggressively worked to enhance its reporting capacities. These new data systems have greatly expanded the department's ability to collect and report on client outcomes. Providers have been required to report outcome data on an episodic basis (every 6 months) and efforts have focused on reporting compliance and data quality. The sections that follow highlight the status of certain measures.

DMHAS has established baseline data of the two data systems and is in the process of ensuring data quality on all fronts. DMHAS' new data systems now captures the date a person requested service from a substance abuse treatment agency; DMHAS is now using this data element to track how long it takes before a client receives their first service at that agency. Now that all data has been consolidated in the data warehouse, a report is being developed that will measure the "time to treatment". Also, DMHAS plans to continue to determine the correlation between performance measures and National Outcome Measure System (NOMS) on a sample of individuals served. DMHAS has been able to report NOMs to each substance abuse agency in their FY12 annual quality reports.

DMHAS issued provider Quality Reports throughout SFY 2012 to all DMHAS funded and state-operated providers. These "report cards" compared how providers were performing in relation to DMHAS benchmarks and statewide averages for key indicators such as abstinence, arrests, stable living, employment, use of 12 step programs, and treatment completions. The reports also show utilization rates and the degree to which consumers are satisfied with their services. Currently these Quality Reports have been redesigned to be more consumer-friendly. Since the report cards were implemented, data quality has significantly improved as providers have focused more attention on data reporting and data quality. The report cards will likely be made available to consumers in FY 14 and will help inform them as they make decisions regarding where to access treatment. These reports are also being used to target monitoring and corrective actions by identifying providers with poor performance.