
BIENNIAL REPORT

on the

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
Thomas A. Kirk, Jr., Ph.D., Commissioner

December 2003

Acknowledgements

We wish to acknowledge the following persons for their support in the development of this report.

POLICY STEERING COMMITTEE

	MEMBER	DESIGNEE
Department of Mental Health and Addiction Services	Thomas A. Kirk, Jr. Commissioner Co-Chairperson	
Office of Policy and Management	Marc S. Ryan Secretary Co-Chairperson	John A. Mengacci Undersecretary
Judicial Branch	Judge Joseph H. Pellegrino Chief Court Administrator	William Carbone
Department of Children and Families	Darlene Dunbar Commissioner	Peter Panzarella
Department of Correction	Theresa C. Lantz Commissioner	Patricia Ottolini
Department of Education	Betty J. Sternberg Commissioner	Edward Davis
Department of Motor Vehicles	Gary J. DeFilippo Commissioner	Marilyn Lukie
Department of Public Health	J. Robert Galvin, M.D. Commissioner	Michael Hofmann
Department of Public Safety	Arthur L. Spada Commissioner	Major Ralph Carpenter
Department of Social Services	Patricia Wilson-Coker Commissioner	Kevin Loveland Rose Ciarca
Department of Transportation	James F. Byrnes Commissioner	Susan Maloney
Board of Parole	Michael L. Mullen Chairman	Anthony DiPietro

For their cooperation and effort in the preparation of this report, we acknowledge the following persons.

**OPERATIONAL
WORKGROUP**

MEMBER

Department of Mental Health and Addiction Services	Alfred Bidorini Christina Edelwich Carol Meredith Daniel Olshansky	Chairperson
Office of Policy and Management	Barbara Parks Wolf Joan Hubbard	
Judicial Branch	Rena Goldwasser Peter Kochol Bernard Blanchette	
Department of Children and Families	Deanna Paugas Joseph Sheehan Lester Horvath	
Department of Correction	Frank Hall	
Department of Education	Nancy Pugliese	
Department of Motor Vehicles	Marilyn Lukie	
Department of Public Health	Charles Nathan	
Department of Public Safety	Gary Lopez	
Department of Social Services	Mark Heuschkel Hilary Silver	
Department of Transportation	Robert Whitney	
Department of Veterans' Affairs	Matthew Snow	
Board of Parole	Anthony DiPietro	

We also wish to acknowledge the assistance of all other agency staff for their contributions.

Table of Contents

Acknowledgements	i
Table of Contents	iii
Executive Summary	3
Biennial Report	
I. Background	11
II. Treatment Service Data	13
III. Prevention and Deterrence Data	52
IV. Statewide Cost Analysis	59
V. Collaborative Structure	61
VI. Initiatives	61
VII. Ongoing Collaborative Efforts and Status Update	64

EXECUTIVE SUMMARY

Executive Summary

A. 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 was amended changing the submission of the report from annual to biennial.

In a show of commitment from all state agencies involved in the delivery of substance abuse services, a Memorandum of Agreement (MOA) was executed in State Fiscal Year 1999/2000 (SFY 2000). The MOA provided the framework for interagency support to identify ways in which a comprehensive substance abuse prevention, intervention, and treatment services information system might be accomplished. This broad-based interagency collaboration has resulted in the submission of three previous annual reports: *Annual Report on the Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs* (February 2000, July 2001, and February 2002).

The 2000 *Annual Report* provided a description of the current capacity to meet the legislative intent, and recommended approaches to achieving a comprehensive, fully integrated substance abuse services information system. The 2001 *Annual Report* built upon those efforts, demonstrated the progress made towards achieving the legislative directive, and focused on three important aspects of fulfilling the requirements of the legislative mandate, namely:

1. establishing uniform procedures and a minimum data set for substance abuse treatment and prevention services across all state agencies;
2. sharing data across state agencies to determine the interrelated service needs of those receiving substance abuse treatment; and
3. demonstrating the level of interagency collaboration leading to more effective and efficient use of scarce resources.

The 2002 *Annual Report* included agency specific data to show trends related to substance abuse services to inform and influence agency and system-wide policymaking. It demonstrated the growing interest in and commitment to developing a comprehensive

substance abuse services information system, as agencies increasingly realize the benefit of a coordinated service system that addresses all the clients' needs. In this spirit, the 2002 *Annual Report* contained additional findings from Data Sharing Project initiated in 2001. Using Probabilistic Population Estimation (PPE), an analysis was conducted to determine the overlap of persons treated for substance abuse and served in Connecticut's criminal justice, and health and human services systems. Work continues under the Data Sharing Project using various analytic methods to determine how well Connecticut's treatment system performs.

This, the first *Biennial Report*, demonstrates the gains made over the past year particularly the implementation of the uniform data collection system for state funded and operated substance abuse treatment services. Once fully implemented, the Interagency Substance Abuse Treatment Information System (I-SATIS) will become a critical asset to improving the delivery of substance abuse services throughout the state.

B. 2002 Accomplishments

The 2003 *Biennial Report* clearly demonstrates the accomplishments made in 2002 based upon the continued broad-based commitment and support from participating state agencies. This forum has fostered an environment where shared interests and common goals can be nurtured. Ongoing dialogue among state agencies has led to a better understanding of client confidentiality, data collection and information infrastructures, and service delivery systems.

Major accomplishments realized during 2002 include:

- the addition of mortality data and drug-related deaths from the Department of Public Health,
- updated analysis of state agencies' populations and overlap with the substance abuse treatment population, which included Medicaid recipients, and
- implementation the I-SATIS Core Data Set.

While progress has been made, there remain some obstacles to overcome. With the enactment of stronger federal requirements under the Health Insurance Portability and Accountability Act (HIPAA), confidentiality safeguards continue to be a common concern possibly limiting the extent of cross-agency data sharing. Also, infrastructure costs for revamping state agencies' information systems to meet any new data collection requirements pose a real impediment. Finally, limited resources to house and analyze the data could hinder future progress.

C. Progress in Cross-Agency Data Sharing

Data Sharing Project

Building upon work begun in 2001, the 2003 *Biennial Report* provides further analysis of population overlaps using PPE. In 2002, the range of populations included in the PPE expanded to include the Medicaid population, all arrest data (previously only DWI and drug arrests) and an additional year of data (SFY 2001). With the accumulation of three state fiscal years of data, preliminary analysis was conducted on the effects of substance abuse treatment as measured by defined outcomes (e.g., criminal justice involvement). With the initiation of I-SATIS in July 2002, requiring all state agencies that provide (operate or fund) substance abuse treatment services to submit to DMHAS a core set of client-level data along with a unique identifier, a key component of the legislative mandate has been fulfilled.

A summary of the PPE analysis has been provided in a separate document that highlights key results. This document is available on the web at

D. Prevention

The State Prevention Council, created in 2001, has provided the framework and direction to establish standard measures of prevention services and outcomes. The Council, as stated in its January 2003 *Statewide Comprehensive Prevention Plan*, has as one of its main objectives to improve data collection of prevention programs to enhance system measurement capabilities. The Council has defined three distinct action steps and desired outcomes as follows:

- 1) *Collect basic participant information, e.g. demographics, numbers served.*
Promulgate a minimum data set of measures for agencies to use with their programs on timetables they develop.
- 2) *Compile outcome and indicator measurements in identified program area.*
Determine program results measures for agencies to implement with programs and providers. Define related indicators and track statewide status on them.
- 3) *Train, assist, monitor and intervene, as needed with providers.*
Enhance professional skills, support & provide oversight for services improvement.

The Statewide Comprehensive Prevention Plan is available on the web at <http://www.opm.state.ct.us/pdpd4/prevention/2003PLAN.htm>.

E. Treatment Needs Assessment

In October 2001, DMHAS received competitive funding from the Center for Substance Abuse Treatment to assess the prevalence of substance use among adults within the state. This the third federally funded needs assessment study for Connecticut builds upon past efforts at identifying those with a substance use disorder needing treatment. DMHAS has

contracted with Yale University and the University of Connecticut Health Center, to conduct a study of adult probationers and a telephone household survey. In the general population study, Latinos/as will be over sampled to assure an accurate assessment of treatment need within this population. Both studies will greatly add to Connecticut's knowledge of substance abuse and the need for treatment, guiding resource allocation and policymaking.

F. Service System Expenditures

Overall, funding for substance abuse prevention, deterrence and treatment services has grown from SFY 1999 to SFY 2002. Within service categories there has been some minor fluctuations with treatment being the exception. **The increase in treatment funding for SFY 2002 is solely due to reporting of Medicaid dollars which had not been included in past years.** In SFY 2002, six of thirteen reporting agencies reduced expenditures for substance abuse related services, primarily in prevention services.

Service Expenditures in Millions of Dollars by SFY

Services	Prevention*	Deterrence	Treatment	Total
SFY 1999**	\$ 53.7	NA	\$ 136.8	\$ 190.5
SFY 2000	\$ 54.8	\$ 6.8	\$ 152.4***	\$ 214.0***
SFY 2001	\$ 55.9	\$ 8.5	\$ 153.2	\$ 217.6
SFY 2002****	\$ 53.6	\$ 7.6	\$ 175.0	\$ 236.2

* Includes education, substance abuse prevention and intervention funds.

** Expenditures for SFY 1999 updated to include Parole and DVA, but not DPH. DSS Prevention dollars moved to Treatment.

*** Expenditures for SFY 2000 updated to include DVA. DSS Prevention dollars moved to Treatment.

**** DSS Treatment dollars previously omitted were added.

BIENNIAL REPORT

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. In specific, the statute requires data be collected on:

- the use of prevention, education, treatment, and criminal justice services related to substance use, abuse and addiction,
- client demographic and substance use, prevention, and treatment information, and
- the quality and cost effectiveness of substance abuse related services.

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 was amended changing the submission of the report from annual to biennial.

In a show of commitment from all state agencies involved in the delivery of substance abuse services, a Memorandum of Agreement (MOA) was executed in State Fiscal Year 1999/2000 (SFY 2000). The MOA provided the framework for interagency support to identify ways in which a comprehensive substance abuse prevention, intervention, and treatment services information system might be accomplished. This broad-based interagency support has resulted in the submission of three previous annual reports: *Annual Report on the Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs* (February 2000, July 2001, and February 2002).

The 2000 *Annual Report* provided a description of the current capacity to meet the legislative intent, and recommended approaches to achieving a comprehensive, fully integrated substance abuse services information system. The 2001 *Annual Report* built upon those efforts, demonstrated the progress made towards achieving the legislative directive, and focused on three important aspects of fulfilling the requirements of the legislative mandate, namely:

1. Establishing uniform procedures and a minimum data set for substance abuse treatment and prevention services across all state agencies.
2. Sharing data across state agencies to determine the interrelated service needs of those receiving substance abuse treatment.
3. Demonstrating the level of interagency collaboration leading to more effective and efficient use of scarce resources.

The 2002 *Annual Report* included agency specific data, which began to show trends related to substance abuse services and activities, informing and influencing agency and system-wide policymaking. It also demonstrated the growing interest in and commitment to developing a comprehensive substance abuse services information system, as agencies increasingly realize the benefit of a coordinated service system that addresses all the clients' needs. Clearly, categorical, single-purpose information systems are no longer adequate to inform policymaking and program development. In this spirit, the 2002 *Annual Report* contained additional findings and analysis of the Data Sharing Project initiated in 2001. Using a statistical method known as Probabilistic Population Estimation (PPE), the number of substance abuse treatment clients who were also served in Connecticut's criminal justice, and health and human services systems was determined. The Data Sharing Project continues to provide the basis for future in-depth studies regarding cost-effective approaches to serving persons across service systems.

This first **Biennial Report** highlights achievements made in 2002. Many important milestones have been reached in the past year through the ongoing commitment of the participating state agencies. In particular, implementation of the Interagency Substance Abuse Treatment Information System (I-SATIS) is most noteworthy. I-SATIS marks the beginning of a central data repository containing substance abuse treatment information on individuals served in DMHAS, the Department of Children and Families (DCF), the Department of Correction (DOC), and the Judicial Branch's Court Support Services Division (JB-CSSD). While modest in its initial range of data items, I-SATIS provides the data infrastructure necessary for future enhancements. Most importantly, I-SATIS contains a unique identifier to track individuals across various public payers and providers of care. While accomplished with no additional funding, expansion beyond the current core data items, (e.g., incorporating outcome measures) may require significant investment in individual agency information systems.

During 2002, interagency data sharing continued with the addition of mortality information. These data along with other indicators such as alcohol-related accidents, and drug arrests form the basis for trend analyses as part of a multifaceted look at substance abuse and its consequences. Finally, ongoing application of PPE to determine the extent that individuals treated for substance abuse are also served in other state service systems such as criminal justice and welfare has now become an integral part of this report.

Beginning with the **2005 Biennial Report**, the Data Sharing Project and I-SATIS will provide the foundation for ongoing, routine reporting of Connecticut's substance abuse treatment service system. Client demographic, service trends and outcome findings will become standard components providing a centralized information resource for policymaking and service system planning. Finally, over the next two years attention will focus on building an infrastructure for reporting substance abuse prevention data. This work has already begun with the past efforts of the Governor's Prevention Initiative of Youth's State Agency Workgroup and most currently through the State Prevention Council.

II. Treatment Service Data

A. Results of the Data Sharing Project

Probabilistic Population Estimation (PPE)

The 2002 **Annual** and 2003 **Biennial Reports** contain results from in-depth analyses based upon the Data Sharing Project initiated in December 2000. Preliminary findings were reported in the 2001 **Annual Report** utilizing data from seven state agencies and the Judicial Branch for persons served within the criminal justice, and health and human service systems. Estimates of “population overlaps” were determined for persons served in the various state agencies and receiving substance abuse treatment as reported to DMHAS’ Substance Abuse Treatment Information System (SATIS). The statistical method PPE (see Appendix A) was used to estimate these overlaps.

Participating state agencies transferred data on individuals within selected populations (see Table 1). Included in the data transfer were date of birth and gender, required to calculate those individuals served in the various state agency populations and receiving substance abuse treatment. Other data items included in the Data Sharing Project were race, uniform region of residence, and selected agency-specific data (e.g. probation status) for more in-depth analysis.

Table 1
Data Sharing Project
Participating State Agencies and Populations

Agency	Population Included in Data Sharing
Department of Mental Health & Addiction Services (DMHAS)	Substance abuse treatment clients reported to the department’s SATIS including funded, operated, and non-funded services Mental health clients receiving services through the department’s funded and operated programs
Department of Social Services (DSS)	State Administered General Assistance, Temporary Family Assistance welfare recipients, and persons on Medicaid
Department of Correction (DOC)	Prison admissions and releases
Department of Children & Families (DCF)	Substantiated (open) abuse and neglect cases involving biological or adoptive parents or guardians of children
Department of Public Safety (DPS)	All persons arrested
Department of Motor Vehicles (DMV)	Persons with driver license suspensions for refusal to submit to a sobriety test, failure to pass a sobriety test, or a court conviction in or out of state
Department of Transportation (DOT)	Any motor vehicle accidents involving alcohol and/or drug use on state roads, or those resulting in a fatality on a local road
Judicial Branch Court Support Services Division (CSSD)	Probationers, including pre-trial offenders ordered to accelerated rehabilitation and /or diversion rather than traditional probation supervision, as well as post-conviction individuals with regular probation sentences, and persons under investigation to determine if they qualify for probation

Analysis of Population Overlaps

Table 2, presents population overlaps in two distinct ways. First, those within the column labeled *Percent Overlap Within DMHAS SATIS* are persons reported to DMHAS' treatment services database and who were matched to another agency population, i.e. 23% of SATIS clients were on probation in SFY 2001. On the other hand, the column labeled *Percent Overlap Within State Agencies Receiving Treatment* are persons within other state agency populations, who were identified in DMHAS' treatment services database, i.e. 13% of the probation population received substance abuse treatment services in SFY 2001. Overlap percentages for the three years are fairly static, showing only slight fluctuation. DMHAS data included only treatment services in licensed or state operated programs excluding case management, shelter and AIDS services.

Table 2
Population Overlap for Substance Abuse Treatment:
SFYs 1999, 2000, and 2001

Agency/Population	Persons Served			Percent Overlap with DMHAS SATIS			Percent Overlap within State Agencies Receiving Treatment		
	1999	2000	2001	1999	2000	2001	1999	2000	2001
DMHAS SATIS	31,612	34,766	35,769						
Judicial Branch - CSSD Probation	54,851	67,044	67,044	25	28	23	15	14	13
DSS SAGA/Medical	31,228	32,244	37,705	26	24	27	27	26	25
DOC Admissions/Releases	25,124	24,540	24,752	17	16	16	22	23	23
DMHAS Mental Health Treatment	28,556	29,278	29,259	11	10	9	12	12	12
DPS	78,179	74,332	75,035	24	21	22	10	10	11
DCF Abuse/Neglect Cases	27,792	34,870	31,878	8	9	8	10	9	9
DMV DWI – Per Se	10,199	10,348	11,187	5	5	5	16	18	17
DSS TFA Recipients	49,259	36,335	33,199	6	5	4	4	5	5
DSS Medicaid	99,413	98,137	110,706	10	10	10	3	4	3
DSS SAGA/Adults	4,314	3,640	3,648	2	1	2	14	13	16

Notes:

1. Percent receiving substance abuse treatment services is based upon programs reporting to DMHAS' SATIS.
2. Percents cannot be totaled, as persons may be served in more than one agency in a SFY, e.g. arrested, incarcerated, and placed on probation.
3. Percents are based upon a 95% confidence interval.
4. Includes adults, eighteen years and older, except for DOC admissions/releases, and substance abuse treatment admissions reported to DMHAS. Both include persons under 18 years old, as well.

Figure 1
Percent of Persons Receiving Substance Abuse Treatment
Severed by Other State Agencies State Fiscal Year 2001

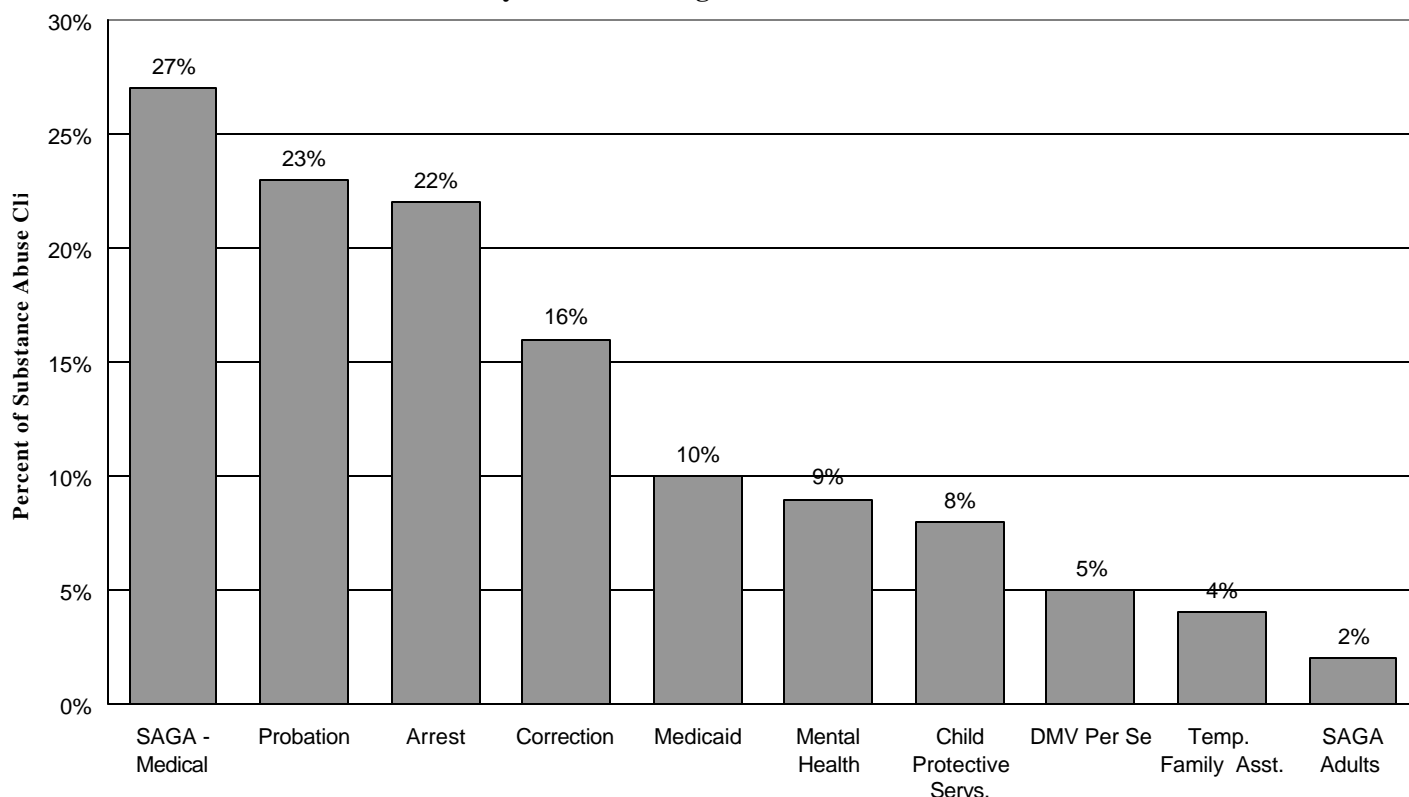
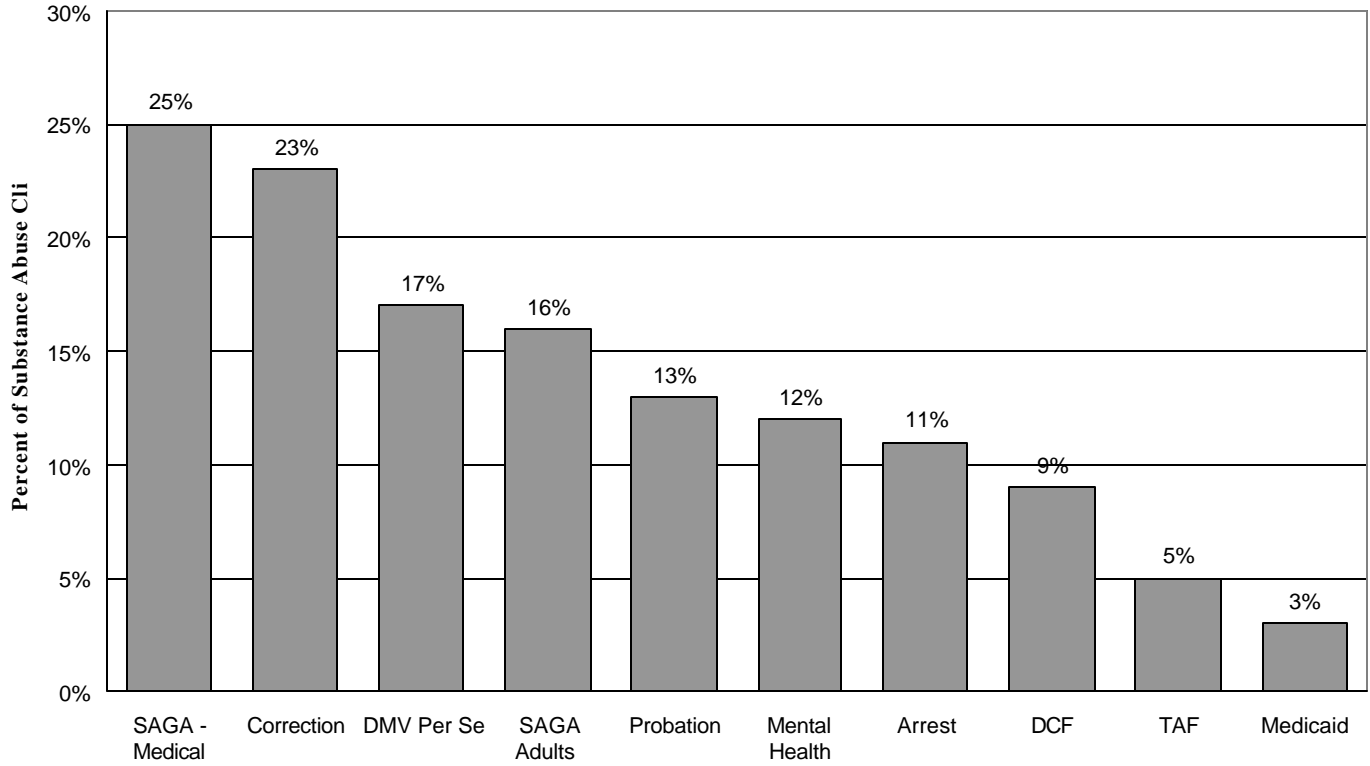


Figure 1 (above) graphically displays the percent of persons receiving treatment and served in other state agencies SFY 2001. Persons served in Connecticut's treatment system also interact with many state agencies from the criminal justice system to child protective services. As can be seen in Figure 1, a relatively high percent of persons receiving treatment are also involved with the criminal justice system through probation (23%), having been arrested (22%) or incarcerated (16%). Singularly, the greatest percent of those in treatment are those receiving state welfare through State Administered General Assistance (27%).

In applying PPE and comparing results from year to year, an enhanced understanding of access to substance abuse treatment by various populations can be realized. This knowledge, coupled with needs assessment findings which estimate treatment need within particular populations (e.g., welfare recipients, probationers, etc.), can provide a powerful decision-making tool, guiding resources allocation to clearly defined needs. Figure 2 (below) provides a look at the percent of persons served in state health and human services, and the criminal justice system who also received treatment for substance abuse. This information is helpful in understanding how well Connecticut is meeting the need for treatment. For instance, a Yale University (Schottenfeld, 1996) study found about 60% of both men and women arrestees are in need of treatment. At best, less than 40% of criminal justice clients needing treatment received it. In another Yale study, 12% of Temporary Family Assistance (TFA) recipients were identified as in need of treatment, yet less than half (5%) of them received it.

Figure 2
Percent of State Agency Populations
Receiving Substance Abuse Treatment
State Fiscal Year 2001



One important aspect of PPE is the ability to analyze trends. Figure 3 (below) takes a look at the percent of persons receiving treatment and arrested. Overall, the percent of those arrested in the year they received treatment (either before, during or after) has dropped (24% to 22%) over the three-year period. Of those receiving treatment, men more so than women and whites more so than non-whites were likely to have been arrested.

Figure 3
Arrest Rates
Persons Receiving Substance Abuse Treatment
State Fiscal Years 1999 - FY 2001

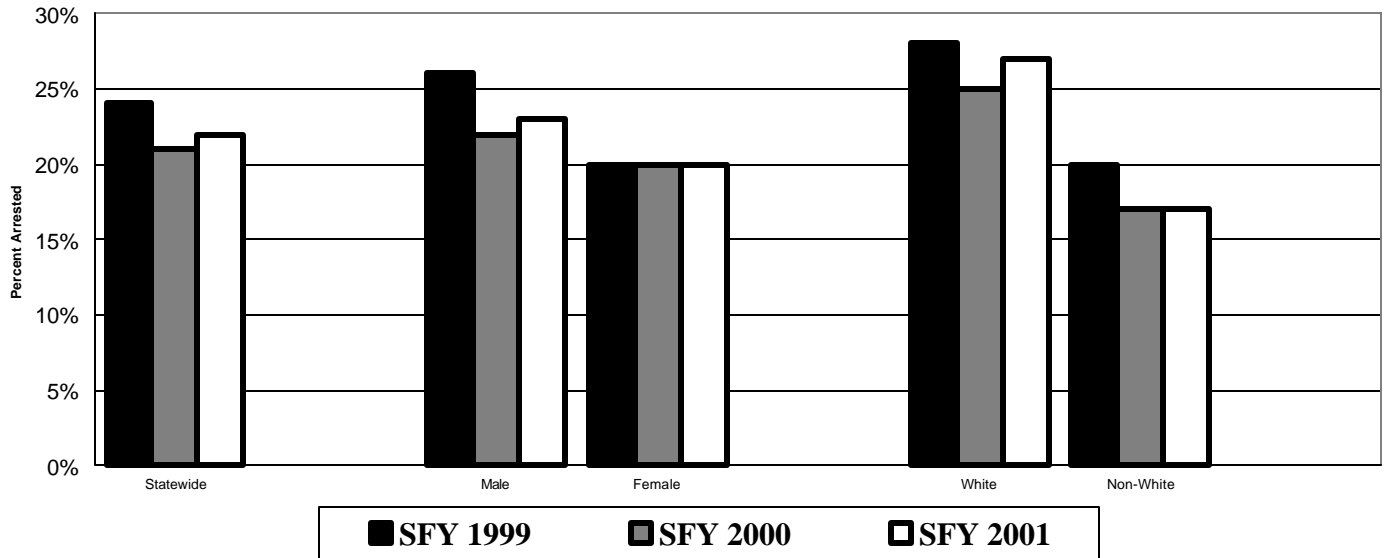
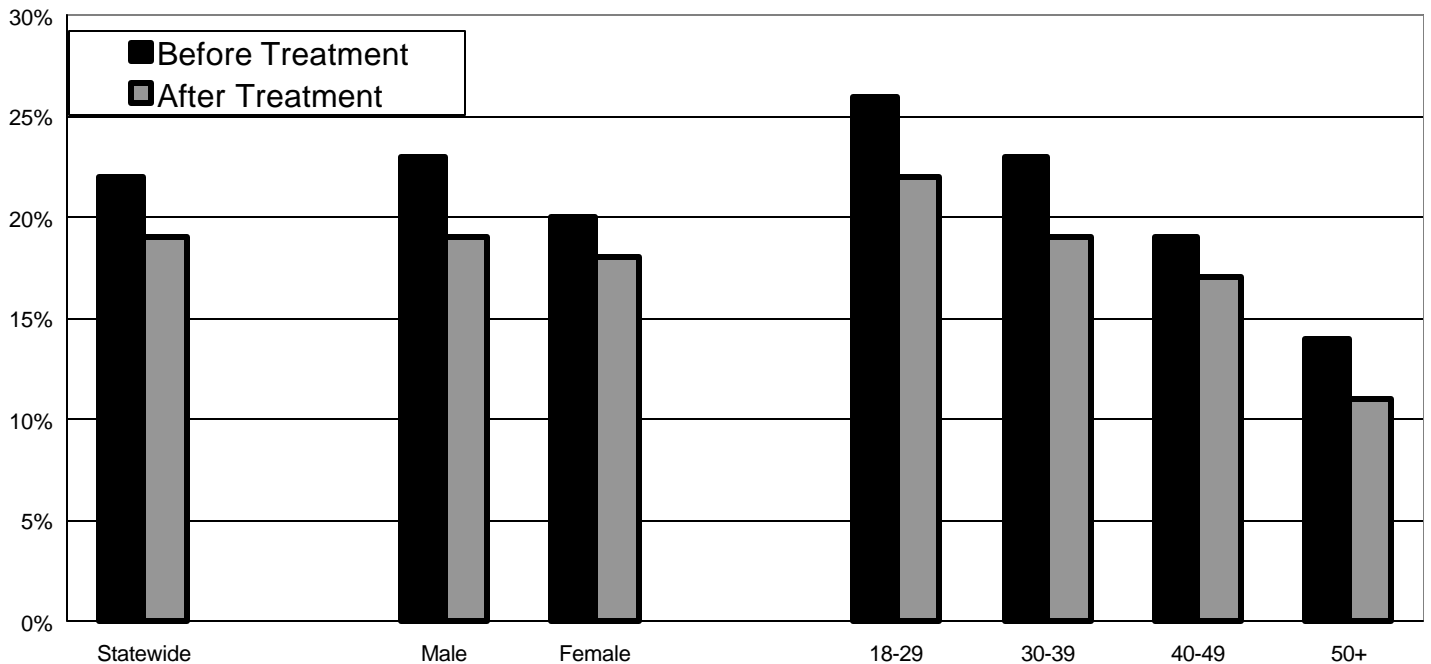


Figure 4
Arrest Rates Before (SFY 1999) & After (SFY 2001) Treatment
Adult Substance Abuse Treatment Clients Served in SFY 2000



One important outcome measure of treatment success is reduced criminal justice involvement. Figure 4 (above) shows decreased arrest rates post-treatment for men and women as well as across all age groups. This represented an overall reduction of 15%, with non-whites (not shown) having the greatest decrease at 29%. While similar studies have shown a greater reduction (up to 30%) in arrests one-year post treatment, the PPE analysis follow-up period was up to two years. Also, arrests for outstanding warrants for crimes committed prior to entering treatment are included in the PPE analysis. Overall, these findings are consistent with other studies and demonstrate the possibilities of PPE to measure treatment success.

B. Preliminary Results of the Uniform Data Collection

Five agencies submitted core data to the I-SATIS for three SFYs, 2000-2002. Table 3 shows the record volume of data submitted. Core data items include a unique client identifier, town of residence, treatment admission and discharge dates, date of birth, major and minor levels of care, gender, race and ethnicity.

**Table 3
Core Data Submittal: Record Summary**

Agency	SFY 2000	SFY 2001	SFY 2002	SFY Total
DMHAS	65,416	64,998	64,777	195,191
DOC	2,993	3,402	3,283	9,678
DCF	1,348	2,204	1,615	5,167
DVA	72	86	64	222
Judicial	51,554	52,983	58,083	162,620
Totals	121,383	123,673	127,822	372,878

Preliminary analysis of I-SATIS shows the following client characteristics and services used for the Departments of Children and Families, Mental health and Addiction Services, Correction, Veteran Affairs and the Judicial Branch for SFY 2002:

- There were over 50,000 unduplicated individuals reported to I-SATIS.
- Clients were mostly white (56%) followed by blacks (24%) and Hispanics (19%) with the only exception being the DOC which had a much higher proportion of non-whites.
- A vast majority were male (76%), with DCF reporting the highest percent of women (33%).
- Over 50% of clients had one treatment episode, while 20% had more than three.
- Outpatient treatment (34%) was the most utilized care followed by intervention and evaluation (17%), medical and ambulatory detoxification (15%), case management (11%), and methadone maintenance (9%) and residential rehabilitation (8%).

State agencies will continue to report clients receiving substance abuse treatment through state funds to the DMHAS repository each September. As the capacity to report the I-SATIS unique identifier grows, additional analysis will be performed.

C. DMHAS Client Demographics, Trends and Effectiveness

Many Connecticut substance abuse treatment programs report client information to DMHAS, through its SATIS. Submitted routinely via an electronic reporting system, client-level data contain information on each admitted or discharged client. The range of client information collected at admission includes: demographic, employment, education, type of drug use, frequency of drug use, living arrangements, and arrest history. Discharge data include the client’s status at discharge (completed treatment or not), service referral information, and outcome measures, such as employment, arrests during treatment, referrals to self-help groups, and living arrangements.

All substance abuse treatment programs licensed by the Department of Public Health (DPH) are required, by state statute, to report clients served to DMHAS’ SATIS. Additionally, some non-licensed, state-operated programs report clients treated, including DMHAS state hospitals and DOC prison-based services. The strength of DMHAS’ SATIS is its established record of routinely collecting data for clients receiving services in a variety of treatment settings. This mandatory reporting system ensures that privately insured, fee-for-service, and publicly supported clients are included in the department’s database. The only substance abuse treatment clients not included in this database are those who receive services through Veterans' Administration, general hospitals (if not funded by DMHAS), or private practitioners. Approximately 75% of clients reported to DMHAS can be considered a “public” client, in that they have no insurance, or have their treatment service paid from a governmental program, such as Medicaid.

Client Demographics and Trends (DMHAS)

Over thirty thousand individuals were served in nearly 250 substance abuse treatment programs reporting to SATIS during each of the past four SFYs. The vast majority (98%) were adults 18 years and older. These individuals accounted for over 67,000 treatment service episodes in SFY 2002.

**Table 4
Percent of Treatment Episodes
by Service Type, SFYs 1999-2002**

SFY	Detoxification	Outpatient	Residential	Methadone
1999	35	27	18	16
2000	29	31	16	15
2001	35	32	17	15
2002	35	30	19	21

Of all those receiving treatment for substance abuse or dependence, the most demanded services are residential detoxification and outpatient, followed by residential rehabilitation and methadone maintenance (Table 4). Requests for methadone maintenance services increased 6 percentage points in SFY 2002.

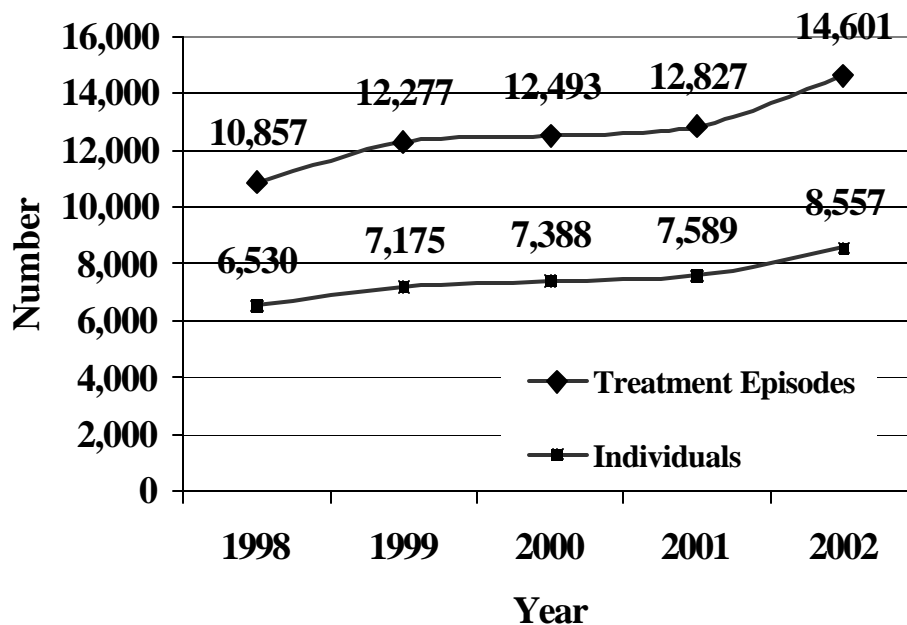
Individuals accessing treatment services over the past 4 years were consistently:

- male (70-71%),
- white (55-56%),
- between the ages of 35 and 44 (39%), with
- an average age of 35 years.

For admissions in SFY 2002, clients were, on average, 33 years old for outpatient services, and 37 years for methadone maintenance and residential detoxification services. Most persons report that they are unemployed or not in the labor force. Only 18% reported full-time employment, and another 6% reported part-time employment in SFY 2002. Most report no source of support (52%), while 21% report receiving public assistance, including disability funds.

While whites account for the majority of clients receiving substance abuse treatment, Latino clients increased by 31% (Figure 5) since 1998, making them the fastest growing treatment population in the state. Treatment episodes increased by 34% in the same period, with the largest increase (14%) in SFY 2002.

Figure 5
Latino Treatment Episodes and Individuals
SFY 1998 - 2002



A majority (58%) of clients reported a combination of problem substances at admission in SFY 2001 and SFY 2002. Of those using multiple substances, 72% reported using two problem substances, and 28% reported three substances in 2001 and 2002.

Although alcohol, as a self-reported problem substance, has declined 13 percentage points since 1998, it remains the most often reported problem substance (Table 5). Along with the decline in alcohol, cocaine has been reported less often as a problem substance at admission, declining 5 percentage points since 1998. Marijuana has remained about the same, however heroin has steadily increased since the mid 1990's (39%).

**Table 5
Percent of Problem Substances
Reported at Admission by SFY**

Problem Substance	State Fiscal Year				
	1998	1999	2000	2001	2002
Alcohol	66	64	61	60	53
Cocaine and/or Crack	47	47	46	44	42
Heroin	42	44	45	43	45
Marijuana	23	22	22	24	24

Note: Prior to 2001, clients reported up to three problem substances (primary, secondary, tertiary) at admission. Since 2001, clients may report up to five problem substances.

Looking solely at the *primary* problem substance reported by individuals entering treatment in SFYs 2001 and 2002:

- alcohol was most often the primary problem substance,
- followed by heroin, representing a larger percentage (42%) of treatment episodes in SFY 2002, and lastly
- cocaine and crack.

Differences in reported problem substances by race and ethnicity (see Table 6) are clear and consistent, over the past 2 years:

- White clients most often reported alcohol. There was a drop of 9 percentage points for alcohol and 6 percentage points for heroin in SFY 2002.
- African-American clients equally reported alcohol and cocaine. Alcohol dropped 7 and cocaine dropped 5 percentage points in SFY 2002.
- Latino clients reported heroin as the most prevalent problem substance upon admission to treatment, with an increase of 8 percentage points in SFY 2002.

Table 6
Percent Problem Substances Reported
by SFY and Race/Ethnicity

Race/ Ethnicity	Problem Substance			
SFY	Alcohol	Cocaine	Heroin	Marijuana
White				
2001	65	35	44	21
2002	58	35	38	21
African-American				
2001	63	60	33	32
2002	56	55	30	29
Latino				
2001	39	43	69	23
2002	39	43	77	24

Note: Bold indicates a significant drop in use.

Populations of Interest

Dually Diagnosed Clients: Within Connecticut’s treatment population, providing services for dually diagnosed clients (i.e. those who have a substance use disorder and a co-occurring mental illness) continues to challenge the system. Roughly, 37% of people who abuse alcohol and 53% of people who abuse illicit drugs also have at least one serious mental illness. Dually diagnosed clients are much more likely to use acute treatment services such as medical detoxification services (59%) when compared to non-dually-diagnosed clients (34%). Dually diagnosed clients use more service episodes, approximately three per person annually, while on average all clients use 1.6 episodes.

Table 2 PPE Overlap Analysis, page 12, shows the percentage of persons receiving services in the substance abuse treatment system who also receive mental health services declining slightly over the past 2 years to 9% in SFY2001. However, the percentage of persons receiving services in the mental health system who also receive substance abuse services remained constant at 12%. Additionally, substance abuse is a greater factor in arrests than mental illness, particularly for persons with co-occurring disorders. According to the Bureau of Justice Statistics Special Report (July 1999), 59% of mentally ill prisoners had a co-occurring substance abuse disorder, and 31% had a parent or guardian who abused alcohol or/and drugs. Of persons identified with alcohol dependency, 34% were also mentally ill, and due to drinking 17% lost a job, 24% had problems at school or work, and 46% got into a physical fight. These rates are higher than the rates for inmates without mental illness.

Mental Health Consumer Survey: 2000-01

The first statewide survey of mental health consumers in Connecticut was conducted by peer-surveyor teams supervised by a consumer advocacy agency under contract with DMHAS.

Consumers were surveyed as to how well addiction services meet the needs of those receiving mental health services.

Of 1,108 mental health consumers responding, almost half (547) reported a current or past history of substance abuse, with about half of those (259) reporting current problems. Seventy-eight percent of consumers with current substance abuse problems were in addiction treatment. The most common barriers to treatment reported were access problems (32%), involvement in an addiction self help group (16%), and not wanting to be in treatment (16%).

Women: Many of the women treated have dependent children (42%) under the age of 18 or are pregnant require special care. Over the years, there has been increased emphasis on women's service needs, with a focus on specialty programs (see Figures 6 and 7). This is evidenced by increased utilization of specialty residential care including:

- an overall 18% increase of women served from 325 in SFY 1998 to 382 in SFY 2002, and a 17% growth of "bed days" from 31,814 in SFY 1998 to 37,100 in SFY 2002.

Figure 6
Women Served in Specialty Residential Programs
SFY 1998 – SFY 2002

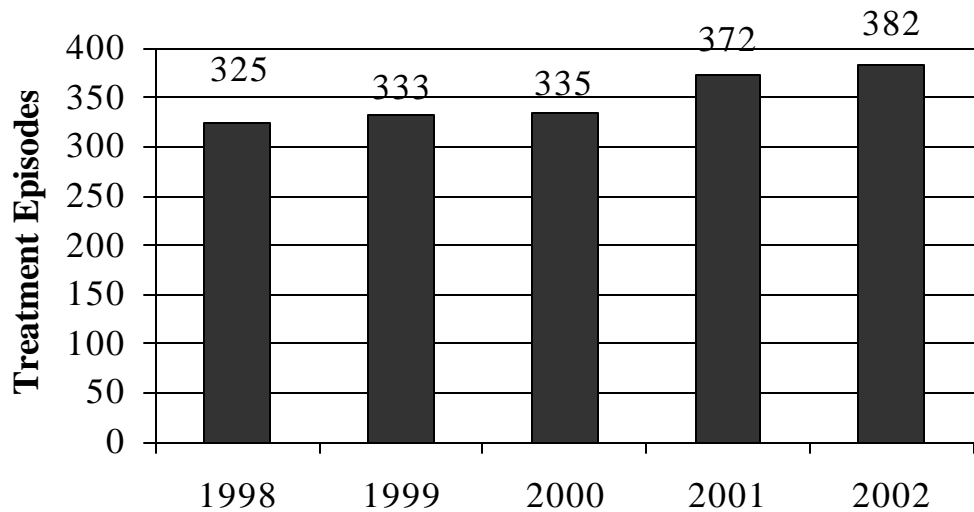
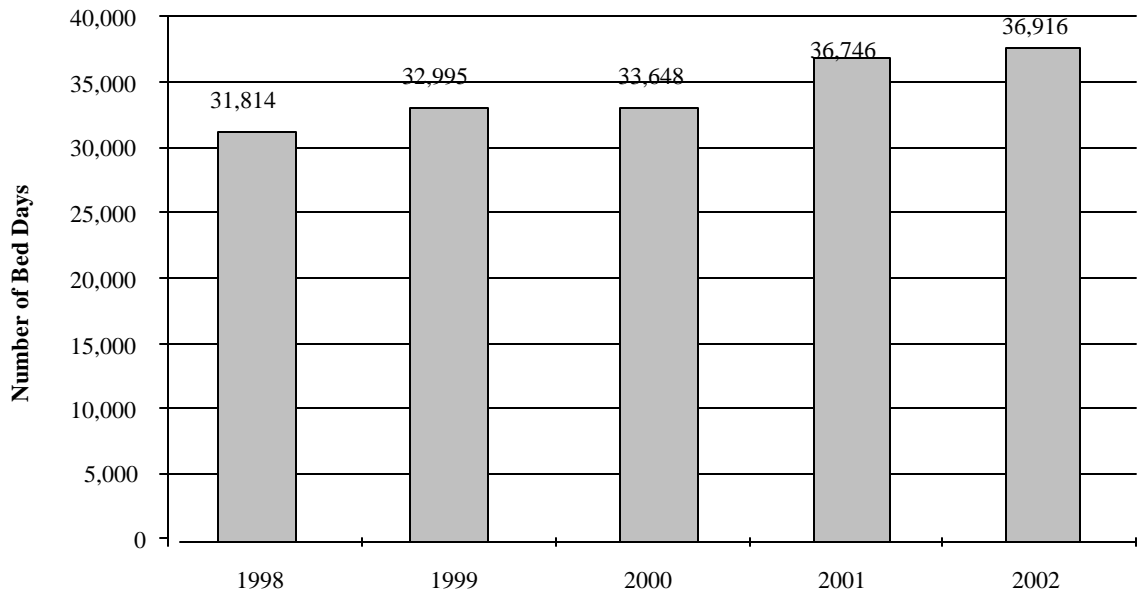


Figure 7
Bed Days: Women's Specialty Residential Programs
SFY 1998 – SFY 2002



Client Outcomes

Through the federally funded Treatment Outcomes and Performance Pilot Studies (TOPPS II), DMHAS in conjunction with the University of Connecticut Health Center conducted two outcome studies on the effectiveness of substance abuse treatment. Both studies focused on special populations of addiction clients: 1) those with concurrent mental health disorders, and 2) pregnant and parenting women in treatment. The first outcome study was designed to assess the prevalence of mental health problems in the general population of addiction clients, as well as the treatment experiences and outcomes of dually diagnosed clients. The second outcome study examined the effectiveness of different treatment approaches for substance abusing pregnant and/or parenting women.

Admission data were collected from a sample of 386 clients across residential and outpatient programs in the state. For the women's study, a total of 153 female clients, 86 from specialty women's programs and 67 from generic substance abuse treatment programs were enrolled and then followed up. Seventy percent of those participating were located and given a follow-up telephone interview by UCHC researchers six months after treatment. The TOPPS II outcomes studies found that:

- Substance abuse treatment was positively related to post-treatment improvements in

such variables as substance use, use of health and mental health services, homelessness, criminal behavior and employment.

- Positive post-treatment effects in substance use, health services utilization, housing stability, criminal activity and employment status were evident across different levels of service and sociodemographic groups.

Salient findings were produced in a policy document, *Getting Better*, which is available at the following web site <http://www.dmhas.state.ct.us/oppas/TOPPSII.pdf>. The final technical report was submitted to the federal Center for Substance Abuse Treatment in June 2003 and is currently under being reviewed.

D. DCF Demographics, Trends and Effectiveness in Funded Adolescent Substance Abuse Treatment Programs,

In SFYs 2001 and 2002, significant changes took place in the DCF data collection system for funded adolescent substance abuse treatment programs. The DCF data collection system is transitioning towards an automated system for all providers of adolescent substance abuse outpatient and residential treatment services. Automation of the residential treatment data began in July 2001, with outpatient treatment services scheduled for the second half of SFY 2002. Refer to the 2001 *Annual Report* for DCF SFY 2000 treatment service data.

The MultiSystemic Therapy (MST) Juvenile Aftercare Program

MST, a home-based treatment program for juvenile offenders, involves the whole family, and targets problems within the family, school, and peer groups. MST services are focused on youth on parole from the Connecticut Juvenile Training School (CJTS), formally known as Long Lane School. Recidivism rates are lower for juvenile offenders receiving MST, than for juveniles participating in traditional juvenile justice rehabilitation programs. MST is also a much less costly intervention than staff-secure residential placement.

DCF implemented MST within the Hartford, New Haven, Bridgeport, Plainville, and Waterbury areas for youth involved in the juvenile justice system. DCF also implemented MST within the North Central Region (specifically New Britain and Hartford), for youth served by the child welfare system. The primary diagnoses of youth referred are disruptive behavioral disorders and/or substance abuse. Youth involved with the juvenile justice or child welfare systems with mental health issues are at high risk to develop substance abuse problems. There are a total of 103 MST slots currently, with plans to expand to 180 slots, to serve about 450 youth per year.

DCF contracted with two independent evaluators to determine the productivity and recidivism rate of youth served in the MST program in Connecticut. DCF also maintains

Performance Based Contracting (PBC) data to provide an ongoing system to measure MST capabilities. Preliminary results of the MST, along with the PBC data, follow.

Two new initiatives, the Hartford Youth Project funded by the Center of Substance Abuse Treatment and the MST Dissemination of Contingency Management funded through the National Institute of Drug Abuse with the Connecticut Center for Effective Practices will conduct follow-up studies on some MST clients at 6 and 12 months. This will allow for further evaluation on the cost-effectiveness of MST, and explore the characteristics of clients that do best within the program. See the 2002 *Annual Report* for a program description.

Outcomes

MST is more effective than usual services in reducing recidivism based on a criminal search history, including felonies and misdemeanors, convictions and pending charges. Results for youth who have successfully completed MST treatment show a significant difference in recidivism rates with a 50% lower rate, compared to a comparison group of juveniles with usual services. Additionally, MST:

- reduced crime among youths,
- reduced substance abuse by youth, and
- is a cost-effective means of dealing with serious antisocial behavior in adolescents. (Per case cost is less than residential placement.)

The evaluations also provided suggestions for MST improvements, including:

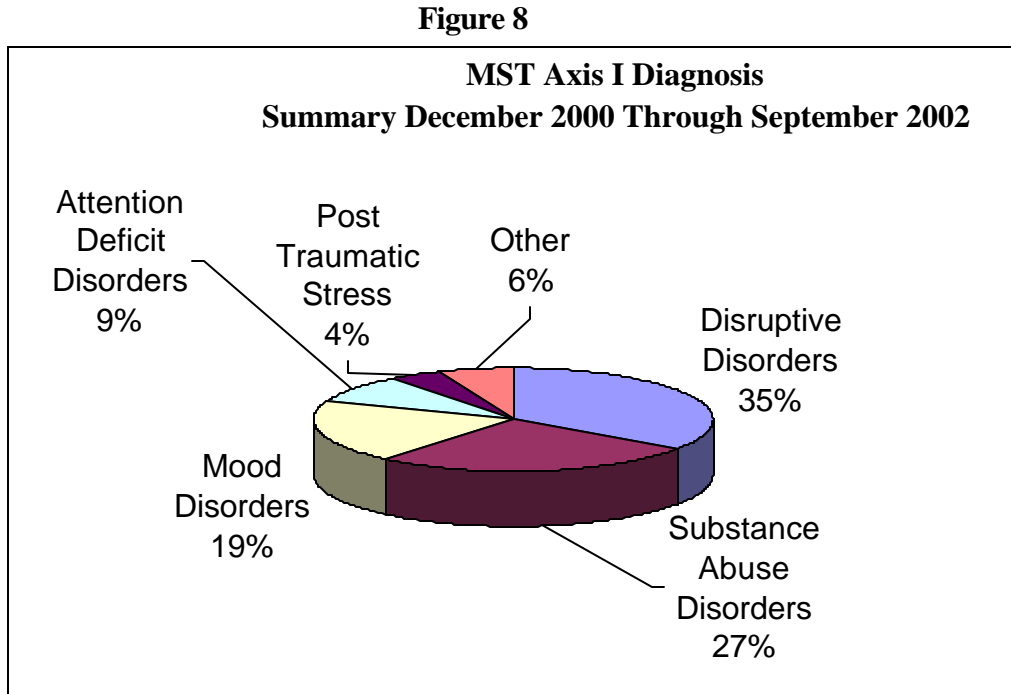
- to explore gender-specific MST Services,
- to address differences for youth of color and historically underserved special populations,
- to work with the courts and probation offices to increase early behavioral health treatment and to further reduce incarceration, and
- to develop a collaborative plan to support the selection, training, implementation, evaluation and management of treatment fidelity of evidence-based models.

Most youth receiving MST in Connecticut have various legal statuses, including parole (46%), probation (25%), FWSN (10%), and pre-adjudicated (4%). Only 14% have no legal system involvement. Currently, MST services are mostly in the North Central Region, but are expanding in the other regions. Within MST programs:

- 58.5% were males,
- approximately one-half (50.2%) were white,
- followed by Latino (21.9%), and
- African American (19.0%), and

- most youth start treatment between 14-16 years of age.

Figure 8 shows that most youth served by MST have a primary diagnosis of disruptive/conduct disorders (35%), followed by substance abuse disorders (27%). It should be noted that a majority of cases have more than one diagnosis.



The DCF MST data show that approximately 75% of MST participants were successful on key measures, including:

- retention in program for 3-6 months (83%),
- meeting 80% of family goals (67%),
- living in home during MST treatment (77%),
- abstinence from substance use for 30 days prior to discharge (71%), and
- no convictions during MST treatment.

Preliminary Evaluation Results

1. Hartford Behavioral Health (HBH)/MST Services

HBH provided MST services from August 7, 2000 through June 6, 2002. The descriptive evaluation of clients and services was to determine if the model meets the target population and the mix of interventions. Treatment retention and engagement of this population has been a challenge using traditional clinic-based models.

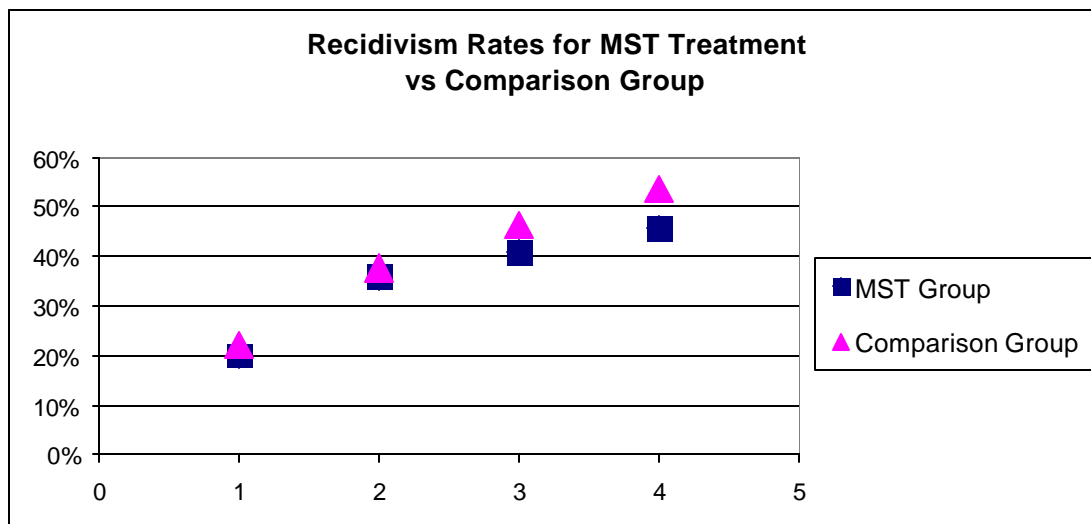
Of the 81 youths and families referred to HBH, 61 received services. Defiance, often paired with substance abuse, criminal behavior, or family conflict, was the most frequent reason for referral. Youth were in grades seven through ten, and between 14-16 years of age. Over half of the participants were male, 67% came from single-parent households, and over two-thirds of the participants received public assistance. Hispanic families accounted for 43% of the families served. Nearly 75% of the clients were successfully discharged from the program, having been abstinent from substance abuse 30 days prior to discharge and no evidence of convictions due to re-arrest. Most of the families (57) were able to reach 80% of their MST treatment goals.

2. Community Solutions Inc. (CSI)

CSI provided a Juvenile Aftercare Program, starting November 1999, for 95 juveniles released from CJTS in Hartford, New Britain, New Haven, and Bridgeport. Sixty-one boys (64%) and 34 girls (36%) comprised the group. The MST and the comparison groups were equally diverse: 40% African American, 26% white, 35% Hispanic, and less than 1% Asian or other. Fifty-six (59%) who were enrolled in the program in its first year were successfully discharged (clients reached 80% of their goals while abiding by the law). African Americans (71%) were most successful in program completion, followed by whites (68%), and Latinos (41%).

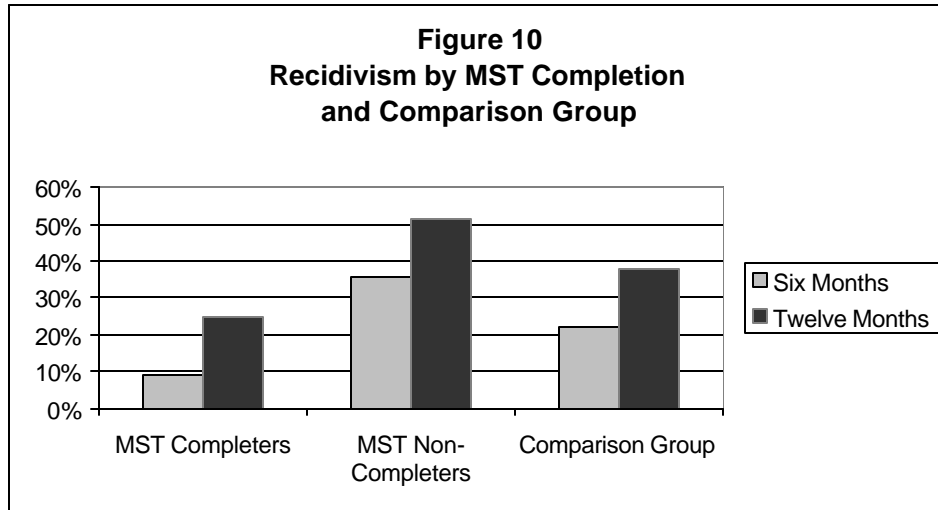
The cumulative recidivism rates for the MST group were only slightly less than those for the comparison group and not statistically significant (Figure 9). MST participants were also less likely to have felony convictions or pending charges, but this was not statistically significant. At 12 months, an examination of the seriousness of the lead offense for recidivism revealed similarity between the groups. Furthermore, recidivism at 12 months was broken down by type of aftercare placement. The recidivism rate for MST participants did not differ from those in residential placement.

Figure 9



Legend: 1 = 6 months, 2 = 12 months, 3 = 18 months, 4 = 24 months

Results for youth who successfully completed MST treatment (**Figure 10**) show a significant difference in recidivism rates, to that of the comparison group. However, those who did not complete MST had the highest rates of recidivism. Recidivism rates for those receiving MST were slightly lower than that of the comparison group for African Americans, moderately lower for Caucasians, but somewhat higher for Hispanic youth.



MST is as effective as residential treatment, which is significantly more expensive, indicating that MST is a treatment method that can reduce the costs associated with residential care, at no increased risks to the community.

3. North American Family Institute, Inc. (NAFI)

NAFI provided MST services from November 6, 2002 through May 30, 2002. Referral sources included the Hartford Juvenile Drug Court, the Waterbury Public Defender Office, CJTS/parole, Riverview Hospital for Children and Youth, and New Choices, a short-term residential substance abuse program for youth on probation.

Of the ninety-three clients reviewed, eighty-eight (95%) received treatment, and five cases were discharged prior to treatment. The youth served were 14 - 15 years of age, in the ninth or tenth grade. Fifty percent were white, 66% were male, nearly 33% were identified in need of special education, and 33% repeated at least one grade. Forty-seven percent were from single-parent households, many reside in urban or suburban communities, and approximately 33% receive public assistance. The most frequent reasons for program referral were truancy, running away from home, substance abuse, and criminal behavior. Additionally, almost one-third of the clients had been referred, upon release, from residential placement.

Positive program outcomes for clients and their families included: successful discharges (met at least 80% of their treatment goals), 90% improved school attendance, and 89% had remained drug free for the last 30 days of treatment. Additionally, the length of the

MST treatment appears to have a positive effect on program outcomes; 66% of successful discharges participated in the program six months or more. For those unsuccessfully discharged, any change within the family that may have beneficial effects in the future is also noted and seen as a success. Most often success is attributed to parents' commitment and increased parenting skills.

About 66% of the youth who were administered drug screens tested negative throughout program participation, and 75% were not re-arrested during participation.

E. Project SAFE

Project SAFE responds to the needs of child welfare clients who are experiencing alcohol and other drug (AOD) problems. Project SAFE offers centralized intake procedures and priority access to substance abuse evaluations, drug screens and outpatient treatment services to primary caregivers of children involved with DCF child protection services.

Several pilot projects began in the last quarter of SFY 2002 to increase treatment engagement and retention, and to address broader issues that often impede participation in treatment. Services include a comprehensive bio-psycho-social evaluation for better assessment and data collection in ten agencies; in-home evaluations for clients who refuse or are unable to attend evaluations at agencies in two regions; and revision and implementation of an improved substance abuse screening tool for social workers in one region. Engagement teams in two urban settings provide in-home, intensive case management to clients who are homeless, or are at risk of homelessness.

For SFY 2002, Table 7 shows:

- The number of unduplicated clients increased by 10% from SFY 2001, and 17% from SFY 1999.
- The number of referrals for initial evaluations and/or drug screens decreased by 2% from SFY 2001 and 23% from SFY1999.
- The percentage of clients who showed for their first evaluation or drug screen decreased by 3% from SFY2001, but has been relatively stable for the past 3 years.

The percentage of clients recommended for treatment services after evaluation increased by 1% from SFY2001, but increased 6% over the past 3 years.

**Table 7
Project SAFE Clients Referred for Evaluations by SFY**

Variable	1999	2000	2001	2002
Total unduplicated clients	6,375	7,265	6,777	7,462
Total referrals for an initial evaluation and/or drug screen:	5,776	5,060	4,565	4,473
Total/% who "showed" for first evaluation/drug screen.	3,916 (68%)	2,669 (53%)	2,575 (56%)	2,388 (53%)

Ethnic and gender percentages remained fairly constant over the past 4 years for clients referred to Project SAFE. Except for SFY 1999, percentages include referrals for an initial evaluation, and re-referrals. Project SAFE clients are mostly:

- female (57% in SFY1999 increasing to 65% in SFY 2002),
- whites (51% in SFY 1999 increasing to 54% in SFY 2002), followed by
- African Americans (27% in SFY 1999 decreasing to 25% in SFY 2002), and
- Hispanics (remaining relatively stable at 20-21% throughout the 4 year period).

F. Department of Veterans' Affairs

The Veterans' Recovery Center (VRC) provides long-term residential care for eligible veterans seeking a sober environment, with a current capacity of 63 beds. The VRC seeks to return all capable veterans back to independent functioning in their respective communities. Generally, rehabilitation efforts (including medical treatment, psychiatric care, and vocational rehabilitation) will be completed within two years upon admission. The VRC offers 6 months of intensive substance abuse treatment, followed by 12 months of residential aftercare services for successful graduates of the intensive program. Within the past three SFYs, only 5.8% of those treated were readmitted for care in the VRC.

During the past four SFYs, there were 307 admissions to the VRC program. Upon admission, information is collected on each resident including demographics, employment, education, and substance abuse information. Clients served are mostly male (99%) and white (51% in SFY2002). Residents seeking treatment are increasingly older (Table 8), with 73% of veterans admitted being 45 years or older in SFY 1999, rising to 82% in the past two SFYs. Although clients are predominantly between the ages of 45-59, clients 60 years and older doubled in SFY 2001.

**Table 8
Age: Percent by SFY**

Age	1999 (%)	2000 (%)	2001 (%)	2002 (%)
22-30 years	3.9	1.3	1.1	
31-44 years	23.4	16.7	17.2	
45-59 years	67.5	76.4	70.1	
60+ years	5.2	5.6	11.5	
<hr/>				
Average Age	47.9	49.1	50.3	49.4

Over the past four SFYs, veterans reported that alcohol (55%) and cocaine (22%) were the most often reported problem substance. Alcohol decreased significantly in SFY 2002, with smaller increases in cocaine and heroin (Table 9).

Table 9
Primary Substance Problem(s) by SFY

Primary Substance Diagnosis	1999 %	2000 %	2001 %	2002 %	4 Year Totals %
Alcohol	50.0	60.5	60.9	43.8	54.7
Cocaine	21.4	17.3	21.7	29.7	22.1
Heroin	7.1	9.9	5.4	9.4	7.8
Marijuana	0.0	1.2	2.2	1.6	1.3
Polysubstance*	21.4	11.1	9.8	15.6	14.0

* Cannot identify the most problem substance

The period of service (Table 10) that comprises the bulk of veterans seeking care is Vietnam War veterans, although there has been a sizeable increase in the number of Desert Storm veterans seeking VRC treatment in SFYs 2001 and 2002.

Table 10
Period of Service by SFY

Period of Service	1999 %	2000 %	2001 %	2002 %
WWI	2.6	0.0	0.0	0.0
Korean	0.0	4.4	8.1	1.6
Vietnam	90.9	92.8	74.4	84.4
Persian Gulf	3.9	1.4	0.0	0.0
Desert Storm	2.6	1.4	17.5	14.1
Total	100	100	100	100

G. Department of Social Services (DSS)

Table 11 shows that the number of persons within each age category receiving substance abuse services through DSS' Medicaid Managed Care funding. Data is provided quarterly and should not be aggregated since many of the same individuals will be counted in more than one quarter. As can be seen, the number receiving substance abuse treatment fluctuates from quarter to quarter and year to year. Due to changes in the Managed Care Organizations during SFYs 2001 and 2002, interruptions in the flow of data regarding behavioral health services occurred. This resulted in a decline in the reported number of persons receiving substance abuse treatment during the last six months of SFY 2001, and during SFY 2002. DSS estimates that the actual number of persons receiving substance abuse treatment during SFYs 2001 and 2002 was higher than reported.

DSS also estimated the number of Medicaid managed care members receiving substance abuse treatment services (not shown) in each calendar year (CY). DSS estimates that:

- Persons under 18 receiving substance abuse treatment has grown with 625, 650, and 769 individuals treated in CYs 1999, 2000, and 2001, respectively.
- Persons 18 and over receiving substance abuse treatment has grown with 3,626, 4,730, and 3,914 individuals treated in CYs 1999, 2000, and 2001, respectively.

DSS also provides substance abuse treatment through two contracts funded by the Social Services Block Grant. While there are no data readily available on persons served in SFY 02, one contract targeted 60 unduplicated women. The second contract provided centralized intake and triage for an estimated 2,500 triages.

Table 11
Persons in Medicaid Managed Care
Receiving Substance Abuse Treatment Services

	Quarter															
	First				Second				Third				Fourth			
SFY	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002
Persons under 18 years	95	197	192	269	125	208	252	302	131	234	281	272	164	215	184	N/A
Persons 18 years or older	1,312	1,421	1,732	1,373	1,142	1,365	1,758	1,892	1,177	1,642	1,424	2,010	1,287	1,794	1,469	N/A
Total	1,407	1,618	1,924	1,642	1,267	1,573	2,010	2,194	1,308	1,876	1,705	2,282	1,451	2,009	1,653	N/A
% Change from same quarter in previous SFY	N/A	15%	19%	-15%	N/A	24%	28%	9%	N/A	43%	-9%	34%	N/A	38%	-18%	N/A

NOTE: Data for the First and Fourth quarters of SFY 2001 are partially estimated because one of four MCOs did not report. Fourth Quarter SFY 2002 numbers are not available, as reporting is semiannual effective, 4/02.

H. Department of Correction (DOC)

The DOC Addiction Services Unit makes available substance abuse treatment for offenders through a continuum of care that includes:

- Tier 1 - Substance Abuse Education (6 sessions),
- Tier 2 - Intensive Outpatient (30 sessions),
- Tier 3 - Daycare, Non-Residential (64 sessions), and
- Tier 4 - Therapeutic Community (6 months).

According to the DOC's objective classification system, approximately 88% of the 18,373 inmates under custody had a significant need for drug and alcohol treatment in SFY 2002. During SFY 2002, 29% of the sentenced inmates in need of substance abuse treatment received Tier 2, Tier 3, or Tier 4 treatment services. Table 12 shows that as the number of inmates with a significant treatment need has increased slightly from SFY 2000 to SFY 2002, the percentage of inmates receiving treatment has increased in a similar manner.

Table 12
Percent of DOC Inmates
Needing and Receiving Treatment By SFY

SFY	2000	2001	2002
# of Inmates	17,409	17,459	18,373
% Inmates with Significant Treatment Need	85%	87%	88%
% Inmates in Need Receiving Treatment	27%	29%	29%

Table 13 summarizes program activities for DOC substance abuse services (Tiers) across all programs for SFYs 1999, 2000, 2002 and 2003.

Table 13
Clients Served by
DOC Addiction Services by SFY

	1999	2000	Percent Change from 1999	2000 Percent Completed	2001	Percent Change from 2000	2001 Percent Completed	2002	Percent Change from 2001	2002 Percent Completed
Number of Inmate Requests	16,163	21,759	34		27,024	25		23,494	-13	
	<i>Served</i>	<i>Served</i>	<i>Served</i>		<i>Served</i>	<i>Served</i>		<i>Served</i>		<i>Served</i>
Substance Abuse Education (Tier 1)	6,872	5,877	-14	60	6,112	4	69	6,171	1	59
Intensive Outpatient (Tier 2)	1,870	1,178	-37	67	2,299	95	67	2,309	<1	72
Daycare Non-Residential (Tier 3)	450	396	-12	73	392	-1	74	382	-3	67
Therapeutic Community (Tier 4)	750	807	8	51	882	9	48	909	3	45
Total Served in Tier Programs	9,942	8,258	-17		9,685	17		9,771	<1	

Outcomes

Urinalysis results indicate that for the past SFYs, of those Tier 2, 3 or 4 program participants tested, less than 1% tested positive for substance use.

Brown Study (See VII.G for background.):

This study evaluated two groups of male inmates released in 1996 and 1997. One group had participated in Addiction Services programs, while the control group had not. A total of 831 inmates were included in the study to determine whether the cost of the Tier programs were justified in terms of three outcomes: (1) re-arrest within six, twelve and twenty-four months; (2) the severity of crimes committed post-release; and (3) disciplinary incidents while incarcerated.

Major Findings

- Inmates who attended any Tier program while incarcerated were significantly less likely to be re-arrested at every time period examined (six, twelve and twenty-four months). For example, 32.5% of inmates who attended Tier programs were re-arrested within one year of release compared to 45.9% of those who did not attend Tier programs.
- Attending any Tier program significantly reduced the severity of crimes committed in the year after release. Crime severity reductions for Tier attendees were over twice as large in magnitude as those experienced by non-attendees.
- The net return on investment in Tier programs ranged from \$5,780 for Tier 1 to \$38,487 for Tier 3 (or from 2 to 43 times the cost of the Tier programs).
- Completion of Tier programs resulted in greater reductions in re-arrest rates, and persisted over a longer period of time. At 18 months, 57% of non-attendees had been re-arrested, compared to 29% of those who completed any Tier.

Cost-effectiveness

Re-incarceration costs and prison overcrowding are important considerations, but are a small portion of the tangible and intangible benefits that accrue to society, through Tier programs. By reducing criminal activity and helping released offenders to lead productive lives, Tier programs also decrease the costs of law enforcement, courts, sentencing and adjudication, property stolen and losses to victims. Also, by increasing safety and security in the community, Tier programs offer substantial additional benefits to society, with associated dollar benefits much greater than those reported.

I. Department of Motor Vehicles (DMV)

A person who has two or more suspensions for alcohol-related violations/convictions on their driving history since October 1, 1995, must participate in and complete a substance abuse treatment program as required under CGS Section 14-227f. An alcohol-related violation is either a refusal to submit to or failure to pass a sobriety test. An alcohol-related conviction is a court conviction for driving under the influence. The program consists of three separate and distinct phases. Phase I consists of a physical, mental, and psychological assessment, an isolated 48-hour group instructional session, and an exit interview. Phase II includes aftercare for a minimum of 20 hours. When a person finishes Phases I and II, the treatment provider submits a certificate to this effect to DMV; if all elements in the person's case are favorable, their license is restored. Thereafter, the person must complete Phase III, which consists of 4 counseling sessions over 12 months. During treatment, a person may be required to submit to random blood and/or urine screening, and verified attendance at self-help treatment meetings. For each subsequent suspension for an additional alcohol-related violation/conviction, the person must repeat participation and successful completion of the substance abuse treatment program.

Table 14
Persons Completing Treatment Program

# Persons	SFY 2000	SFY 2001	% Increase	SFY 2002	% Increase
Enrolled				689	
Completing Phase I and II	241	434	80%	597	38%
Completing Phase III	239	282	18%	513	82%

The number of persons completing Phases I and II increased significantly in SFY 2001 (80%) and SFY 2002 (38%). The number of persons completing Phase III increased to a lesser degree (18%) in SFY 2001, but more significantly in SFY 2002 (82%). Clients in Phase III are counted after they complete the program, and may be enrolled in a previous year.

J. Judicial Branch - Court Support Services Division (CSSD)

Judicial-CSSD provides intake, assessment, referral and supervision services for adult (age 16 and older) pre-trial and post conviction offenders. Judicial-CSSD administers a statewide network of community based treatment and intervention services for non-incarcerated offenders that includes substance abuse and mental health treatment. Licensed and/or certified treatment providers under contract to Judicial-CSSD deliver a full continuum of treatment and intervention options available to the court. The intake, assessment and referral process includes the administration of a validated risk/needs assessment tool, the Level of Service Inventory-Revised (LSI-R), to determine the

appropriate level of supervision and care needed, including referral for substance abuse treatment. Judicial-CSSD funds approximately 2,400 adult service outpatient treatment slots and over 300 residential treatment beds, throughout the state. Treatment slots include specialized residential services for women and children (four programs statewide), youthful offender programming for young adults 16-21 years old (two programs statewide, one residential and one day program), one Latino youthful offender program, and outpatient substance abuse intervention and education services provided at seventeen Alternative to Incarceration Centers (AIC) and three-day Incarceration Centers located statewide and delivered to approximately 1,730 offenders on any given day in SFY 2002.

Adults with Substance Abuse Issues in Criminal Court

The Judicial-CSSD adult network of specialized programs and services includes substance abuse evaluations, clinical treatment, detoxification services, intensive outpatient treatment, specialized services for women and children, and youthful offenders, traditional inpatient drug and alcohol treatment programs, culturally specific Latino treatment programs and substance abuse testing. Outcome results for each of the past 3 SFYs show that:

- 77% of adult probationers receiving substance abuse treatment services were successfully discharged from service treatment programs, and
- 66% of individuals in the AICs successfully completed the programming.

A longitudinal study (1996) of alternative diversionary programming, including substance abuse treatment and services, showed that offenders in community programs posed less of a risk as measured by new arrests than a comparison group of incarcerated offenders. A second, three-year longitudinal study, initiated in May 2002, will evaluate the effectiveness of diversionary programming in reducing recidivism.

In SFYs 2001 and 2002 respectively, 15,270 and 15,833 adult offenders under supervision received substance abuse treatment and intervention services through the continuum of Judicial-CSSD contracted adult service providers and AICs.

Table 15 shows aggregate demographic data for adults under CSSD supervision receiving intervention and treatment services, including clinical outpatient treatment through adult service contracts, intervention services at AICs, inpatient clinical treatment in contracted residential placements, clients served in specialized programming including women and children, Latinos, and intensive services for youthful offenders (16-21 years). Most importantly, Table 15 shows that for SFY 2002, when compared to SFY 2001, there was:

Outpatient Services

- a 2% increase in adults served,

- a slight decrease in white adults, with a corresponding increase in Latino and African American adults, and
- a decrease in males aged 16-21 years, a small increase in males 22-30 years and 45 years or more, with a slight increase in females in most age groups.

Residential Treatment

- a 47% increase in adults served,
- relatively no change in ethnic/race groups over the past 3 years,
- a slight decrease in females 16-21 years, with an increase in females 22-30 and 31-45 years, and
- a slight increase in males, ages 16-21 years, with a decrease in males 22-30 and 31-45 years old.

The increase in the number of adults served in residential treatment was achieved as a result of the Collaborative Contracting Project (see VII.C.) and the purchase of additional beds for the CSSD network over the past two years. This has enhanced CSSD's ability to provide residential treatment services and reduce the waiting list for beds in the network.

Table 15
Judicial-CSSD Outpatient and Residential Services –
By Race, Gender, Age and SFY

SFY	Outpatient			Residential		
	2000	2001	2002	2000	2001	2002
Total Clients	13,815	14, 232	14,562	759	864	1,271
Percent Change		3	2		14	47
Ethnic Breakdown: Percent						
White	43	41	39	40	34	38
Latino	22	23	24	22	25	23
African American	34	34	35	37	36	36
Native American	<1	<1	<1	<1	6	<1
Other	<1	<1	1	<1	4	2
Asian/ Pacific Island	<1	1	<1	<1	<1	<1

Age	16-21	22-30	31-45	45+
Outpatient				
Males	%	%	%	%
2000	29	22	28	6
2001	29	22	25	6
2002	24	24	25	8
Females				
2000	5	4	6	<1
2001	6	4	7	1
2002	7	5	7	2
Residential				
Males	%	%	%	%
2000	26	25	33	3
2001	26	24	32	4
2002	28	20	25	4
Females				
2000	2	5	5	<1
2001	5	4	6	<1
2002	4	8	10	<1

Table 16 refers to all individuals under probation supervision, not just offenders receiving adult treatment and intervention services in the CSSD network. It shows a slight decrease in the total number of individuals under probation supervision, with the number of female and male probationers remaining the same between SFYs 2001 and 2002. In this same period, youthful offenders (16-20) increased 7 percentage points, 21-35 year-olds decreased by 22 percentage points and offenders, age 36 and over, increased by 15 percentage points.

Table16
Probationers Under CSSD Supervision by Gender, Ethnicity, Age
(All Clients, Not Just those Receiving Substance Abuse Services)

Gender	SFY 01	SFY 02
Female	12,883	12,675
Male	45,361	45,387
Total	58,244	58,062
Ethnicity		
White/Caucasian	53%	53%
Latino	18%	18%
African-American	28%	28%
Native American	1%	1%
Other	<1%	<1%
Age		
16-20	15%	22%
21-35	50%	28%
36+	35%	50%

Juveniles with Substance Abuse Issues in Juvenile Court

The Judicial-CSSD provides adolescent substance abuse services including court-based assessments, outpatient clinical treatment, and substance abuse testing through a statewide network of community based contracted programming. The intake, assessment and referral process includes the administration of a validated risk/needs assessment tool, the Juvenile Assessment Generic (JAG) in combination with the Substance Use Survey (SUS). These assessment tools are used to determine the appropriate level of supervision and care needed, including referral for substance abuse treatment. They also provide information used by Juvenile Probation Officers in developing case plans that include appropriate treatment. Short-term inpatient substance abuse treatment is provided with a limited number of slots at the Children's Center New Choice Drug Treatment program, a 45-day program that serves all courts and is funded by DCF. Outpatient treatment referrals are made, as appropriate, from various diversion programs to community-based providers. Substance abuse prevention and education services are provided at juvenile detention centers.

The number of juveniles referred to Superior Court, Juvenile Matters for delinquency and Families with Service Needs (FWSN) status, increased from 12,172 in 2001 to 13,188 in SFY 2002. Additionally, data show:

- 35% of families of court referred juveniles were assessed with alcohol and/or drug abuse issues, an increase of 5% over the previous fiscal year, and
- clinical court-based assessments for juveniles conducted upon court order or as part of a pre-disposition study increased 19% from SFY 2001 to 2002.

**TABLE 17
STATEWIDE JUVENILES REFERRED FOR FWSN/DELINQUENCY
BY GENDER, AGE, ETHNICITY FOR SFY 2001, 2002**

	SFY 2001				SFY 2002				
Males	White	African American	Hispanic	Other	White	African American	Hispanic	Other	
16	101	50	31	4	276	90	87	15	
15	1,439	693	508	53	1440	645	520	46	
14	968	514	398	42	1069	565	389	42	
13	629	336	273	27	709	405	289	23	
12	368	264	160	14	391	279	155	16	
11	212	164	101	15	174	164	88	2	
10	109	95	53	5	91	96	51	5	
9, or <9	96	125	72	7	110	118	57	1	
Totals	3,922	2,241	1,596	167	4,260	2,362	1,636	1,500	
Total	7,926				Total	8,408			
Females	SF 2001				SFY 2002				
16	52	22	16	2	224	76	68	15	
15	777	417	302	42	793	421	291	46	
14	618	315	254	47	605	355	239	24	
13	308	245	165	19	402	259	180	13	
12	140	134	84	7	175	132	100	15	
11	47	61	33	5	73	62	33	0	
10	23	24	13	1	31	20	23	0	
9, or <9	20	37	13	3	31	50	23	1	
Totals	1,985	1,255	880	126	2,334	1,375	957	114	
Total	4,246				4,780				
TOTAL All Juveniles	12,172				13,188				

Table 17 shows for SFY 2002:

- the percentage of females in the system increased slightly from 35% in 2001 to 36% in 2002,
- 15-year-old juveniles (males and females) of all ethnic groups represent the largest number of referred juveniles (32%), followed by 14-year-olds (25%)
- 66% of juveniles referred to court were 13-16 years, down from 77% in SFY 2001, and
- the majority of juveniles (male or female) are white, followed by African American.

Table 18 shows aggregate data for juveniles who entered Judicial-CSSD funded programs for SFYs 2000 through 2002. These numbers represent a subset of the larger numbers of juveniles overall who are referred to the Superior Court (noted above). While these programs are not solely substance abuse related, it gives an indication of the juveniles who may receive substance abuse services through juvenile contracted services. Of the total 4,333 juveniles who entered CSSD funded programs in SFY 2002:

- African Americans (36%) receive the majority of services, followed by Latinos (32%) and Whites (29%), and
- males have a higher access referral rate (64%) to treatment services than their rate of receiving services (57%); likewise proportionally, females receive services at a higher rate (43%), than their access referral rate (36%).

Table 18
Juveniles Who Entered Judicial-CSSD Programs
By Race, Gender, Age, and SFY

Race/ Gender	White		Latino		African American		Asian- Pacific Islander		Native American		Other		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Male														
SFY	#	%	#	%	#	%	#	%	#	%	#	%	#	%
2000	827	16	935	19	1,237	24	33	<1	32	<1	99	2	3,163	63
2001	834	17	809	17	1,024	21	21	<1	32	<1	38	<1	2,758	57
2002	687	16	776	18	901	21	17	<1	12	<1	61	1	2,454	57
Female														
SFY	#	%	#	%	#	%	#	%	#	%	#	%	#	%
2000	537	11	602	12	666	13	12	<1	13	<1	69	1	1,899	37
2001	619	13	689	14	728	15	12	<1	3	<1	63	1	2,114	43
2002	572	13	584	14	662	15	9	<1	3	<1	49	1	1,879	43

AGE	12 and Under		13		14		15		16 and Over		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Male												
SFY	#	%	#	%	#	%	#	%	#	%	#	%
2000	362	7	426	8	884	18	1,205	24	184	4	3,061	61
2001	279	6	421	9	773	16	1,074	22	203	4	2,750	57
2002	263	6	414	10	707	16	904	21	182	4	2,470	57
Female												
SFY	#	%	#	%	#	%	#	%	#	%	#	%
2000	127	3	352	7	600	12	795	16	123	2	1,997	39
2001	151	3	365	8	681	14	843	17	80	2	2,120	43
2002	151	4	305	7	521	12	774	18	129	3	1,880	43

Juveniles with Substance Abuse Problems in Juvenile Detention

The number of juveniles referred to state operated detention centers increased by 77% from SFY 1999 to SFY 2001, but then decreased by 14% from SFY2001 to SFY 2002. Again, this is a subset of the total number of juveniles referred to Superior Court and indicates the numbers of juveniles who may require substance abuse treatment. Routine

substance abuse screening is done on all children who are admitted to detention and all juveniles who receive substance abuse education services as part of the life skills programming offered to residents. Juveniles identified as needing treatment at the detention center are referred to the most appropriate level of care, including Judicial-CSSD contracted treatment services. Of the juveniles referred to detention in SFY 2002:

- 39% were African American, 30% were white, 31% were Latino
- 66% were males,
- 7% were under age 13; 40% were 13 - 14 years old; 42% were 15 years old; and 11% were 16 years old, and
- approximately 1,600 (53%) received substance abuse assessments at the detention center, the same as the previous year.

Detainees in 2000 are similar to all juveniles referred to juvenile court for delinquency and/or FWSN in that:

- approximately 50% screened positive for drug abuse; 15% for a serious alcohol problem; 37% for a serious drug problem,
- substantial rates of family and/or parent dysfunction (family history of mental illness, substance abuse or suicide risk, history of suicide attempts, mental health issues, and problems with social skills, school and peer relationships) were identified,
- 13% are on suicide watch at any given time,
- 53% are diagnosed with disruptive behavior disorder, and
- 62% screen positive for mental health problems in schools.

K. Board of Parole (BOP)

The BOP provides intake, assessment, supervision, and support services for post-incarcerated offenders with sentences greater than two years. The BOP contracts with CSSD to provide outpatient drug treatment services and assessments through the University of Connecticut Health Center (UCHC) and a network of non-profit service providers. The UCHC Addiction Services At Parole (ASAP) program provides on-site evaluations and outpatient drug treatment at Parole District Offices in Hartford, New Haven and Waterbury through a partnership of parole officers and treatment clinicians. Nearly 95% of substance abuse tests taken of parolees in active treatment were found to be drug free. The Bridgeport District Office provides on-site drug treatment evaluations and referrals through LMG, a substance abuse health care agency. BOP also has access to the Judicial-CSSD network of residential substance abuse treatment programs. All parolees are drug tested throughout parole supervision, as a deterrence to possible relapse. As of June 2002, BOP was supervising 1,954 parolees, a 7% increase from 2001.

L. DPH Mortality Data

As part of DMHAS' ongoing efforts to fulfill the legislative mandate, DMHAS and DPH signed a MOA, effective August 2002 to annually transfer the Connecticut death file for

Connecticut residents to analyze trends among DMHAS clients. Additionally, DMHAS receives a file for Connecticut residents who died out of state which will provide aggregate information regarding deaths caused by substance abuse related causes. For CYs 1995 through 2001, DMHAS received a total of 214,702 records: 208,531 full records for persons in the Connecticut Registry, and 6,171 partial records for state residents who died in other states. In addition to primary and secondary causes of death, available information for the state registry includes: year of death, age at death, sex, race, Hispanic origin, education and occupation. Information for out of state deaths includes: primary cause of death only, sex, race, and age at death. Analysis will be presented in next biennial report.

DMHAS will collaborate with DPH, as part of a recent legislative mandate under Public Act 03-159: *An Act Concerning The Treatment Of Drug Overdoses*, to review drug overdoses. Under this legislation, the Commissioner of Public Health shall publish a report on statewide drug overdose trends that reviews state death rates from available data to ascertain changes in the causes or rates of fatal and nonfatal drug overdoses for the preceding period of not less than three years. The report shall include: (1) Trends in drug overdose death rates; and (2) suggested improvements in data collection.

III. Prevention and Deterrence Data

The capacity to collect prevention data is still under development. Working with the Center for Substance Abuse Prevention (CSAP) and funds received through the State Incentive Grant, a pilot data collection process has begun in selected programs. (See IV.B.). Additionally the State Prevention Council has provided the conceptual framework upon which state agencies can begin to move forward to provide a core set of prevention services data.

A. Student Survey Findings

In Spring 2000, the UCHC conducted a DMHAS-sponsored student survey. A total of 9,130 students in 24 towns and cities, representing 21 school districts, completed the self-administered survey. Findings showed significant decreases among gateway drugs - tobacco, alcohol, marijuana, and inhalants. Compared to a similar survey in 1997, cigarette use among 7-8th graders dropped by nearly 50%, and by 33% among 9-10th graders. Similarly, marijuana use in the past month declined from 10.5% in 1997 to 7.2% in 2000 among junior high students, and from 26.9% to 22.0% among 9 and 10th graders. Alcohol use, which decreased significantly earlier in the decade, continued with small but steady declines in the rate of reported use. In 2000, 24% of junior high students reported current use of alcohol compared to 27.1% in 1997. The recent use of inhalants also dropped among 7-10th graders.

A small increase was noted in the percentage of students reporting use of ecstasy. However, the prevalence of MDMA use remained very small. Although these reductions in use by youth are part of a national downward trend, Connecticut youth continue to drink and use marijuana at higher rates than their peers nationwide do. For example,

51.7% of Connecticut 10th graders reported using beer, wine or other alcoholic beverages in the past month, versus 41% nationwide. A follow-up school survey was conducted in the first half of 2002, with results expected in spring 2003.

B. DMHAS Prevention Programs

The Minimum Data Set, discussed in Section IV.B, is an effort to uniformly collect prevention service data by tracking service activities and participant demographics. Prevention staff provided technical assistance and training to increase providers' reporting capabilities. Numbers for SFY 2002 represent approximately 60% of services provided by prevention programs.

DMHAS has several categories under which prevention programs are provided. Following are brief descriptions of the prevention services and the activities supported.

Best Practices: This initiative applies substance abuse prevention science and research-based innovations to populations across the lifecycle. The thirteen funded programs target individuals, family members, institutions, communities, schools and other organizations with multiple prevention strategies. In SFY 2002, 3,179 events were sponsored that reached 15,044 participants.

Resource Links: Programs provide population-based services to support individual and community prevention activities addressing all substances, and build capacity of local communities to gain knowledge and resources to address addiction prevention issues. Programs use a range of strategies from information dissemination to environmental changes (social policy). Approaches include advancing cultural competency (both prevention and treatment), and promoting the integration of strength-based strategies to build healthy communities and young people. In SFY 2002, 18 programs provided 5,770 events.

The Governor's Prevention Initiative for Youth (GPIY): Twenty-one community-based programs statewide implement innovative and science-based interventions aimed at reducing drug use by youth, age 12 to 17 years. In SFY 2002, 4,675 events reached 37,514 participants.

Family Strengthening Programs: Children of Substance Abusing Parents (COSAP): Funded by CSAP, COSAP develops and evaluates effective prevention interventions for children of substance abusing parents. Families receive culturally competent services derived from the science-based Strengthening Families Program model, offered through community-based organizations. In SFY 2002, 6 programs reached 3,120 participants.

PRISM: The Achievement Through Mentoring and Disaster Relief initiatives served 3,766 individuals in SFY 2002.

C. DCF Prevention Programs

In SFY 2002, 1,744 young people participated in 18 DCF funded substance abuse prevention programs. Slightly more females (53%) than males participated. The majority (50%) of children were 10 - 12 years old, followed by 13-17 year olds (33%). Children were mostly Latino (36%), followed by African American (32%), white (25%), other (7%), and Asian (< 1%).

Participants received a total of 131,246 service units, defined as one hour of service per child. The services most frequently provided were social skill training; health/drug education/promotion; parent/family involvement activity; and community in-service involvement. Youth participating remained fairly constant for 3 years, increasing 16% in SFY2002 to 1,744 youth.

D. Department of Public Safety (DPS)

Connecticut participates in the national Uniform Crime Reporting Program. In CY 2001, Possession or Sale of Drugs arrests increased 5% from CY 2000 to 19,058 arrests in CY 2001. The distribution by sex, race and age remained unchanged: males 84%, whites 66%, African Americans 33%, Asian <1%, and 86% 18 and older.

In CY 2001, Driving Under the Influence arrests increased 3% from CY 2000 to 11,752 arrests. The distribution by sex, race and age remained unchanged: 83% male, 87% white, 6% African American, and 99% 18 and older.

The Statewide Narcotics Task Force Public Education Section supplemented local efforts and provided resources as follows, in SFY 2002:

- 48 persons attended 2 core DARE programs,
- over 201,600 pamphlets were provided on Club Drugs, inhalants, etc. ,
- 488 marijuana odor identification tablets were distributed, and
- 442 English, and 871 Spanish posters were distributed.

Local police officers made 4,119 substance abuse prevention presentations, using the educational materials provided. A total of 322 local and state DARE Officers taught a core drug resistance curriculum to over 38,000 students in 159 communities and 415 schools.

The street value of drugs seized in SFYs 2001 and 2002 is shown in Table 19. In SFY 2002, there was a significant increase in the Southwest region, attributed to a major drug seizure.

Table 19
Street Value of Seized Drugs
by Region in Millions

Region	South-west	South Central	Eastern	North Central	Seized at Bradley International Airport	North-west	State Total
2001	\$.509	\$1.287	\$4.309	\$5.016	\$1.4	\$3.233	\$14.354
2002	\$26.531*	\$8.884	\$6.323	\$2.846	\$1.8	\$3.978	\$48.562

*7 members of a State Narcotics Task Force assisted DEA in a controlled delivery of 120 kilograms of cocaine in Norwalk, CT.

Family violence is an indicator and often an outcome of substance abuse, and is known to be cyclical in nature. Although the number and rate of family violence incidents has remained fairly constant for the past 5 years, it has risen during the past 3 years to 20,927 incidents in 2001. Of the total incidents of family violence, over one third involved alcohol or drugs, nearly 20% involved a child(ren) as an offender or victim, and another 25% included a child(ren) as a witness to the incident.

E. Department Of Transportation (DOT)

Over the past decade, there has been an increase in the usage of vehicles and drivers in Connecticut, with commensurate increases in crashes. However, alcohol-related accidents decreased during that time. Clearly, however, alcohol and drugs are a significant factor in accidents. In CY 2000, 26% of all traffic fatalities involved alcohol or drugs. Of all accidents involving alcohol or drugs:

- 6% resulted in fatalities,
- 56% resulted in injuries (including disability), and
- 38% resulted in property damage.

Alcohol impaired driving still remains the number one highway safety problem in Connecticut. A fatal crash is defined as alcohol or drug-related if either a driver or a non-motorist (i.e. pedestrian) had a measurable or estimated blood alcohol concentration (BAC) of 0.01% or more. Alcohol related crashes and fatalities remained fairly constant over the past five years; total fatalities averaged 324 per year. Of the 342 in-state fatalities in 2000, 146, or 42.7%, were alcohol or drug-related. DOT has set the following performance goals to measure the success of the prevention and intervention strategies in the state: To reduce the number of alcohol-related fatal crashes to 113 in 2002, 108 in 2003, and 103 by 2004.

As shown in Table 20, the percentage of alcohol/drug-related fatalities in Connecticut during 2000 (42.7%) was higher than the national percentage of 39.8%, and slightly lower than the 44.0% in the other New England States. Of Connecticut fatalities

involving alcohol, 28.6% were estimated to have come from “high” BAC crashes (BAC=0.10%+). The national estimate for “high” BAC cases was 30.8 percent, and was 32.6 percent in the other New England States.

Table 20
Alcohol-Related/High BAC Crashes-2000

	Connecticut	U.S.	New England
Percent of Alcohol Related Fatalities	42.7 ¹	39.8 ²	44.0 ²
Percent of High BAC (0.10%+) Crashes	28.6 ²	30.8 ²	32.6 ²

1. Source: Connecticut Department of Transportation 2. Source: Fatal Analysis Reporting System (NHTSA)

Table 21 shows the age groups of drinking drivers killed during the five-year period (1996 to 2000) along with the numbers of licensed drivers in these same age groups. The table also shows the rate of drinking drivers killed (fatalities per 10,000 licensed drivers). The table indicates that persons under the age of 40 made up the majority of the fatalities (74%) while they comprised just 39% of all licensed drivers.

Table 21
Fatally Injured Drinking Drivers by Age Group

Age	Drinking Drivers Killed (1996-2000)		Licensed Drivers (2000)		Rate ³
	Number ¹	% of Total	Number ²	% of Total	
<21	44	11.5	125,702	4.7	3.5
21-29	112	29.2	328,261	12.8	3.3
30-39	127	33.2	560,565	21.1	2.3
40-49	56	14.6	571,249	21.5	1.0
50+	44	11.5	1,056,816	39.8	0.4

1. Source: Fatal Analysis Reporting System (NHTSA), 2. Source: FHWA, 3. Fatality rate per 10,000 Licensed Drivers

Table 22 shows additional information utilized to track the state’s progress in decreasing alcohol-related accidents. DOT set the following performance goals to reduce the mean BAC at the time of arrest:

- to .164% by the end of 2002,
- to .162% by the year 2003, and
- to .160% by 2004.

Table 22
Alcohol-Related Measures
for Impaired Driving

Performance Measure	1996	1997	1998	1999	2000
Alcohol-Related Injury Crashes	1,106	1,052	1,114	1,057	1,144
Alcohol-Related Injury Crashes: Percent	3.3	3.2	3.5	3.2	3.3
DUI Arrests ¹	10,324	11,794	11,910	8,799	9,849
DUI Arrests per 10,000 Licensed Drivers	40	50	51	37	44
Mean BAC in DUI Arrests	.167	.168	.168	.167	.168
DUI Arrests from Crashes: Percent	23.3	22.7	22.6	23.3	23.7

Source Connecticut DOT

F. State Department of Education (SDE)

The Safe & Drug-Free Schools supports violence prevention in and around schools, strengthens programs that prevent the illegal use of alcohol, tobacco and other drugs, involves parents, and coordinates with federal, state and community efforts. All 176 Local Educational Agencies use these funds to establish, operate, and improve local programs targeted at school drug and violence prevention, early intervention, and rehabilitation referral, serving all students in grades Pre-Kindergarten to 12.

The Priority School District Extended School Hours Grant funds extended hours for public school buildings for academic enrichment and support, and recreation programs for district students. Formula based, the program is administered in the eight towns with the largest population, and the 11 towns with the largest number and ratio of children in the Temporary Family Assistance program. Table 23 shows the numbers of towns, schools within those towns, students and parents served by SFY. In SFY 2002, 15% more students were benefiting from this program from SFY 2000.

Table 23
Impact of Grant Funds

SFY	# Towns	# Schools	# Students	# Parents
2000	16	136	30,847	5,235
2001	16	134	31,755	2,512
2002	16	115	35,342	2,225

G. Infoline

Infoline, the state's primary information and referral network, receives calls from persons seeking information on available substance abuse services. The numbers in Table 24 represent persons who may not be currently involved in the service system, but recognize their need for services. Requests for services and support groups have increased annually, a significant increase of 102% from CY 1998 to CY 2002. In spring 2003, United Way of Connecticut issued a study titled, *A Social Barometer for Connecticut: Substance Abuse-Related Requests 1998 - 2002* which can be accessed at <http://211infoline.org/documents/sbjune03.pdf>. The United Way report indicates that service requests for users of alcohol and other drugs have increased by over 210% over the five-year period while all service requests increased by 159% in the same period.

Table 24
Substance Abuse Related Calls
Infoline by Calendar Year

Service	1998	1999	2000	2001	2002
Prevention/Intervention Services	944	1,478	1,234	1,920	2,426
Treatment Services	6,340	8,803	9,163	11,939	15,101
Recovery/Support Services	491	621	743	893	1,286
Total of all Services	7,775	10,902	11,140	14,752	18,813
Support Groups	1998	1999	2000	2001	2002
Alcohol and Drug Dependency Support Groups	3,339	4,330	3,674	4,684	5,797
Families/Friends of Alcoholics and Drug Abusers Support Groups	2,245	2,403	2,140	2,193	2,407
Total of Support Groups	5,584	6,733	5,814	6,877	8,204
Services/ Support Groups	1998	1999	2000	2001	2002
Total of Services/ Groups	13,359	17,635	16,954	21,629	27,026

Data Source: Infoline

H. Office of the Chief Medical Examiner (OME)

According to the OME, the number of deaths in the state in which drugs were a factor has nearly tripled from 1997 to 2000. The percentage of cocaine and heroin of all drug related deaths has decreased.

**Table 25
Drug Related Deaths**

Drug	1997		1998		1999		2000	
	#	%	#	%	#	%	#	%
All Drugs	43		74		96		122	
Cocaine	11	26	12	16	18	19	19	16
Heroin	15	35	23	31	17	18	55	45

IV. Statewide Cost Analysis

Funding information that is directly or indirectly involved with the delivery of substance abuse services is gathered from thirteen state agencies, including the Judicial Branch and OPM. 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. While CGS Section 17a-451(o) speaks about prevention and education, for purposes of 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* to give perspective to law enforcement activities. A summary of statewide service expenditures is shown in Table 26, while substance abuse service expenditures by agency are included in Table 27.

The increase in total service expenditures for SFYs 2000 and 2001 is partially due to the identification and inclusion of service expenditures in additional agencies that were not included in previous reports. A cost benefit analysis is not possible until uniform data regarding individuals served and the amount of services can be collected across agencies.

In SFY 2002, six of thirteen agencies reduced expenditures for substance abuse related services, primarily in prevention services. Prevention service total expenditures returned to the SFY 1999 level. Deterrence expenditures decreased by nearly one million dollars, while treatment expenditures increased by nearly twenty million dollars.

Table 26
Service Expenditures by SFY
(Millions of Dollars)

Services	Prevention*	Deterrence	Treatment	Total
SFY 1999**	\$ 53.6	NA	\$ 136.9	\$ 190.5
SFY 2000	\$ 54.6	\$ 6.8	\$ 152.6***	\$ 214.0***
SFY 2001	\$ 55.9	\$ 8.5	\$ 153.3 ****	\$ 217.7****
SFY 2002	\$ 53.6	\$ 7.6	\$ 175.0	\$ 236.2

* Includes education, substance abuse prevention and intervention funds.

** Expenditures for SFY 1999 updated to include Parole and DVA, but not DPH. DSS Prevention dollars moved to Treatment.

*** Expenditures for SFY 2000 updated to include DVA. DSS Prevention dollars moved to Treatment.

**** DSS Treatment dollars previously omitted were added.

Note: A report “Prevention Services Funding: SFY 2002”, prepared by the State Prevention Council, looks at prevention services appropriations in three broad categories. One of these categories, Behavioral Services, includes substance abuse as a component. Please refer to that report for a broader context.

Table 27
Substance Abuse Service Expenditures
by Agency - SFY 2002

Agency	Prevention	Deterrence	Treatment	Total
DMHAS	\$ 16,621,878	\$ 0	\$ 116,520,942	\$133,142,820
Judicial-CSSD ¹	\$ 12,913,434	\$ 0	\$ 11,059,113	\$ 23,972,547
DCF ²	\$ 3,199,751	\$ 0	\$ 13,217,341	\$ 16,417,092
DOC	\$ 0	\$ 0	\$ 7,944,653	\$ 7,944,653
SDE ³	\$ 9,423,418	\$ 0	\$ 0	\$ 9,423,418
DMV ⁴	\$ 0	\$ 0	\$ 0	\$ 0
DOT	\$ 55,000	\$ 3,241,014	\$ 0	\$ 3,296,014
DPH	\$ 240,000	0	\$ 0	\$ 240,000
DPS	\$ 105,000	\$ 4,335,012	\$ 0	\$ 4,440,012
DSS ⁵	\$ 0	\$ 0	\$ 25,779,972	\$ 25,779,972
DVA	\$ 0	\$ 0	\$ 464,109	\$ 464,109
OPM	\$ 11,011,615	\$ 0	\$ 0	\$ 11,011,615
PAROLE ⁶	\$ 0	\$ 24,000	\$ 0	\$ 24,000
TOTAL⁷	\$ 53,570,096	\$ 7,600,026	\$174,986,130	\$236,156,252

¹ Treatment expenditures include \$2,128,267 transferred from Parole.

² Prevention dollars include all prevention programs, not just those specific to substance abuse. Treatment includes Adolescent Outpatient & Residential Treatment Services and Protective Service Substance Abuse Services.

³ Includes Safe & Drug-Free Schools, Youth Service Bureaus, and After-School Priority Schools.

⁴ Clients pay for retraining/education and required substance abuse treatment programs.

⁵ Medicaid expenditures for substance abuse treatment are based on HEDIS diagnoses, using all ICD-9 codes that start with 291, 292, 303, 304, and 305. This excludes pharmacy,

transportation, and Medicare crossover claims, none of which has a diagnosis on the claim. It may exclude claims that were not paid when the data was requested.

Treatment includes \$45,984 from Social Services Block Grant.

⁶All of the Board of Parole's outpatient and residential drug treatment expenditures are transferred to, and captured in, Judicial Branch expenditures.

⁷ Administration costs are not included.

V. Future Directions

A. Data Sharing Project and I-SATIS

Application of PPE to interagency data analysis provides a basis for a broader utilization of existing data sets for program management, evaluation, and policymaking. The efficiencies realized by using existing data resources for program administration and evaluation are, if anything, even more important in the current constraining economic times. Similarly, the protection of personal privacy and confidentiality of client records has increased in importance with growing regulation of access to person identifying information. Four areas of future development will be pursued to maximize PPE.

1. **Ongoing Data Sharing:** Data sharing should become a routine operating procedure of the participating agencies. The quality of the data and the efficiency of the data sharing process will increase yearly, and will build a longitudinal database to support longer-term measurement of cross-agency population overlaps, treatment access, and outcomes among publicly funded programs.
2. **Production of Standard Reports:** Routine production and analysis of standard reports, to monitor access to care and treatment outcomes for participating agencies, is an important step towards integrating such data into the management of programs and service systems. Standard reports should be developed in consultation with state agency staff and program managers, and include cross-sectional analysis. These standard reports would provide information on treatment effectiveness relevant to:
 - demographic, clinical, and other client groups,
 - program types and treatment approaches,
 - geographic factors
 - changes in program performance over time, and
 - the impact on public policy and program funding.
3. **Inclusion of Additional Data Sets:** The scope of current data sets could be expanded and analyzed in conjunction with other relevant data, including public health, education, and employment data. For example, mortality and hospitalization rates can measure cost to society, while wage earning data can provide a measure of treatment success as a person progresses in their recovery.
4. **Availability of Ad Hoc Reports:** All participating agencies should be able to request analysis that address their unique perspective and supports their management needs. Similarly, legislators and other policymakers should have access to information regarding departmental caseloads, client movement among various state agencies' programs, and treatment outcomes provided by a cross-agency data analysis.

B. Interagency Substance Abuse Treatment Information System (I-SATIS)

Efforts begun in July 2002 to build a core data set will continue, as participating state agencies report annually to the DMHAS data repository, I-SATIS. One limitation that will diminish over time is the percent of clients without a unique identifier. This is certainly true for the DMHAS client data collection system, as name only became a required data item in SFY 2001. In SFY 2002, DMHAS was able to build the unique identifier required in I-SATIS on 60% of all clients reporting to its substance abuse treatment information system. As capacity increases to provide a unique client identifier across all reporting state agencies, the scope of analysis will grow. With this increased capacity, analysis on shared resources and clients will be explored, leading to a more comprehensive understanding of the state funded system of care.

VI. Collaborative Structure

Interagency Policy Steering Committee (IPSC)

The IPSC oversees the development and implementation of the fully integrated substance abuse information system to accomplish the legislative intent. Membership is comprised of Commissioner designated staff, responsible for setting policy within their state agency, the Judicial Branch, and OPM. The IPSC provides direction to the Interagency Operational Workgroup by establishing data system priorities, recommending policy direction and resource needs, guiding the *Biennial Report*, and approving interagency collaborative studies and planning efforts based on a shared vision. The IPSC is Co-Chaired by John Mengacci (OPM Undersecretary) and Thomas A. Kirk, Jr., Ph.D. (DMHAS Commissioner), who oversee the ongoing interagency process.

Interagency Operational Workgroup (IOW)

The IOW, staffed by participating agency program staff, provides a forum for detailed discussion of the integrated substance abuse services information system. IOW members provide expenditure and client data regarding substance abuse services included in this report, and participate in two sub-committees. The IOW discusses issues, progress, and recommendations, and is instrumental in the drafting of the *Biennial Report*.

VII. Initiatives

A. Uniform Procedures and Core Data Sets for Reporting Substance Abuse Treatment and Prevention Services

Status: Lacking resources to conduct a formal systems analysis, a review of current information systems focused on data items common to most state agencies, or a “core data” set. Cost to state agencies to implement the uniform data collection procedures was a major consideration. As part of the analysis, consideration was also given to those data items that would constitute the ideal or “optimum” data collection system, one that would fully meet the breadth of the legislative requirements.

In order to facilitate this process, two subcommittees of the IOW address the different and unique needs of treatment and prevention services.

1. Treatment Subcommittee

Members represent DOC, DCF, DMV, DSS, DVA, Judicial-CSSD, BOP, DMHAS, and OPM. Progress was made in several areas.

The Core Data Set (CDS) (those data currently available or easily obtained) includes gender, town of residence, race/ethnicity, date of birth, treatment admission and discharge dates, and level of care.

Status: Protocol guidelines for implementation of the substance abuse treatment core data set and the data transfer specifications were developed, using a unique identifier. Standardized data collection started on July 1, 2002 for SFY 2003, contingent upon the technical and work force requirements of individual agencies, and DMHAS' capacity to develop a data repository for all participating state agencies' data. A uniform data collection procedure was developed to collect each participating agency's annual substance abuse treatment file, and data transfer to DMHAS' central data repository began September 2002 for SFYs 2000, 2001 and 2002.

Direction: Further data analysis will be conducted. Data for SFY 2003 will be submitted on September 30, 2003, and annually thereafter, for subsequent years.

The Optimum Data Set (ODS) includes additional data elements beyond the CDS to allow for trend analysis and measurement of outcomes. Incorporating data elements that are not currently collected by agencies will be difficult, time consuming, and costly. DMHAS' Substance Abuse Treatment Information System (SATIS) data items will form the basis of the ODS, including measures of alcohol and other drug severity of use, client functioning, and outcomes.

Direction: Further discussion is needed to more accurately define the data elements that would be beneficial, possible for collection, and tailored to specific populations. Also, the impact on agency data collection, and information systems, in particular the costs involved in "re-tooling" current systems, requires further analysis.

Administrative data, those data that are available in each agency's information system as part of its service delivery or mission, can be shared and matched to other agency population databases. Sharing administrative data requires no modification to existing data systems, and addresses key confidentiality concerns. Two methods have been considered.

Third-party match is sometimes called the "black box" technique, as the data are, for the most part, not handled by any individual. Once a computer program has been designed to each agency's specifications, there is little or no human intervention in the process. The

combined data are matched, identifiers are removed, and original data returned to the respective agencies. Only matched, non-person-identifying data are released for use.

Direction: A project will be explored to conduct more in-depth studies, such as cost offsets and outcomes. Under consideration is the matching of wage earning data with substance abuse treatment clients to determine the correlation of services with pre/post earning potential. While promising, these initiatives are not likely to realize their full analytical potential due to inadequate funding.

Probabilistic population estimation (PPE) is a unique and patented method for linking individuals across administrative databases (arrest, mental health, addiction services, etc.), based on the probability of individuals in two or more databases having the same date of birth and gender. Application of PPE is beneficial when either no unique identifier (Social Security Number, name, etc.) is available, or when confidentiality must be maintained.

The Subcommittee pursued the PPE methodology first, because 1) it could be implemented with minimum cost and effort to each agency, 2) funds were available from the federal Office of Applied Studies for implementation, on a limited basis, and 3) most importantly, all agencies were satisfied that client confidentiality is maintained.

Status: Previous efforts were expanded to estimate client overlap across various state agencies using PPE, including SFY 2001 treatment data, new data elements, and expanded populations (Medicaid reimbursed services). In 2002, a special focus was placed on outcome data for persons involved in the criminal justice system.

Direction: Participating agencies will continue to send annual data updates with further analysis and outcome studies planned, pending available funds.

2. Prevention Subcommittee

Members represent DCF, Judicial Branch-CSSD, DMHAS, DMV, OPM, and the DOT, DPS, DPH, and SDE. Previously, members identified common data elements and the difficulty of incorporating these elements where not currently collected, and reached consensus on common definitions for prevention services including prevention, intervention, education, and deterrence. The committee conceded that because of the nature of prevention and its focus, it would be difficult for all agencies with prevention resources to collect program data on individuals.

Direction: The Prevention Subcommittee will suspend activities while the State Prevention Council, created in 2001, continues its activities. The Council completed a survey of member agencies that included number of children served by prevention program in SFY 2002, age, region, and number of providers. The analysis is available through a State Prevention Council report.

B. New Collaborative Efforts

1. DPH Mortality Data

DMHAS and DPH signed a MOA, effective August 15, 2002, to annually transfer the Connecticut death file, excluding out of state deaths for Connecticut residents, to DMHAS to analyze death trends among DMHAS clients. DMHAS received mortality data for CYs 1995 through 2000. Additionally, DMHAS received a file for Connecticut residents who died out of state which will provide aggregate information regarding deaths caused by substance abuse related causes. Similar information was requested for CY 2001.

2. Office of Health Care Access (OHCA) Hospital Data

In February 2002, DMHAS initiated discussion with OHCA to receive aggregate hospital discharge data for the purpose of determining population overlaps between general hospitals and persons in the substance abuse information system. In spring 2003, OHCA and DMHAS came to agreement on the format of aggregate discharge data on individuals treated in general hospitals for substance use disorders. Currently, review of these reports is underway.

3. DCF Hartford Youth Project (HYP)

DCF received a federal Cooperative Agreement grant from the Center of Substance Abuse Treatment to strengthen community for youth based on KidCare and Systems of Care principles. DCF will partner with the UCONN Research Team, two Outreach organizations and 8 treatment providers. The HYP MIS will create a system for information sharing, outreach, data collection and analysis for the network of providers and Engagement Specialists to advance substance abuse treatment for adolescents in Hartford. Currently, DCF is developing a statewide Behavioral Health Data Systems (BHDS) for all behavioral health services that will coordinate with the HYP data collection efforts, as the data warehouse. The HYP MIS will include a live database for real time retrieval of information by HYP partners, and a year of formalized follow up information with analytic research. A live database addresses the common problem of communication incompatibility. The HYP MIS will be designed to easily expand to other cities and towns, and will pay particular attention to: intake, screening, assessment, entitlement opportunities, services coordination, ongoing services provision, and discharge and aftercare planning.

The HYP MIS will allow and encourage HYP Partners to create and manage a shared treatment plan using a security and password control function, driven by the Informed Consents and Releases of Information (ROI) forms. The BHDS and HYP MIS will encourage use through end user training. Version I will capture the data elements for intake, screening, engagement specialist's activity log, preliminary treatment components, and follow up appointments after the second treatment session. Data will be

extracted from the BHDS on a monthly basis and imported to the HYP MIS. The first extracts for BHDS will be created in April for March 2003 data.

VIII. Ongoing Collaborative Efforts and Status Update

The 2000, 2001, and 2002 *Annual Reports* contain additional information describing collaborative efforts. Please refer to those reports for background information.

A. The Governor's Prevention Initiative for Youth (GPIY)

Purpose: The objective of the GPIY is twofold: 1) to reduce drug use, including tobacco and alcohol by young people between the ages of 12-17 years; and 2) to coordinate all state funded substance abuse prevention services in the state. Funding for GPIY activities (\$9 million for three years) is provided by the federal Center for Substance Abuse Prevention (CSAP) to DMHAS.

Status: GPIY is in its fourth year of funding after approval of a no-cost extension, and the third year of program development. To date, the GPIY State Agency Workgroup has developed and reached consensus on two critical planning and system improvement tools:

- an Intermediate Outcomes Guide, as a planning and evaluation tool for community providers, and
- a science-based document, defining various levels of research-based programming shown to produce positive outcomes.

As part of the GPIY, DMHAS will evaluate service goals and objectives, manage grant expenditures, and add to the general knowledge of effective programming for at-risk populations. The GPIY provides funding to twenty-one (21), community-based substance abuse prevention projects. The primary benefits include:

- establishing partnerships in local communities to prevent alcohol, tobacco, marijuana, and other drug use by youth,
- using a risk and protective factor framework to implement a community prevention action plan to better understand individual and community strengths and weaknesses, and
- piloting CSAP's software application MDS, which provides for electronic data collection of aggregate prevention units of service by strategy and target population.

B. Minimum Data Set (MDS)

Purpose: In an effort to uniformly collect prevention service data, CSAP developed a data collection software application. This information system prototype enables prevention program providers to track service activities and population demographics.

MDS provides disk and Web-based software for capturing, organizing, and reporting information on substance abuse prevention, including core definitions for services, and a uniform coding system for strategies. CSAP works collaboratively with interested states in software implementation and data collection training. MDS allows prevention service and target population data collected to be analyzed for prevention programming, resource allocation, process evaluation, and data sharing. MDS reports may also facilitate information sharing and linkage among prevention providers.

Status: In October 2000, Connecticut became one of five states to pilot MDS-3, an updated internet-based version of the MDS software. Six prevention programs were selected to pilot the MDS-3, and to provide feedback to CSAP on the software design and implementation. Data collection began in the spring of 2002. During SFY 2002, DMHAS focused on two MDS objectives:

1. To improve the quality of data submitted by modifying and enhancing monitoring processes resulting in the identification of deficiencies in the collection, reporting and/or editing of MDS data. Technical assistance was provided to programs for more timely and accurate data.

To improve the quality of MDS data, DMHAS provided training. In October 2001, all MDS reporting programs participated in an MDS “Basic Training”, which reviewed coding and reporting processes, identified and addressed common reporting errors, and allowed participants to enter data with DMHAS support. In January 2002, an optional training was offered to provide the skills to utilize the enhanced reporting applications. In February 2002, a second “Basics” series was offered to all new program hires to address unreliable data resulting from staff turnover.

2. To implement a web-based version of the system (MDS-3): Throughout the year, DMHAS facilitated the implementation of MDS-3, including: surveying all prevention Best Practice and GPIY programs to examine technological preparedness for a web-based application, pursuing the necessary security access for all MDS users, revising reporting and monitoring forms and procedures, educating prevention staff and program users, and providing a short test period. In July 2002, all Best Practice and GPIY programs began submitting data online via MDS-3.

Direction: Continue to identify and address information system “bugs” enhancing program utilization of the MDS; create and disseminate quarterly reports of regional and statewide MDS prevention service data for use as quality assurance, program planning, and marketing tools, and increase the number of DMHAS funded programs that report on MDS-3 by training and collecting MDS data from all Regional Action Councils and Statewide Service Delivery Agents by April of 2003.

C. Collaborative Contracting Project (CCP)

Purpose: In an effort to streamline funding and monitoring of substance abuse treatment clients served through DCF, DOC, DMHAS, the Judicial Branch-CSSD and OPM, these

agencies are exploring ways to jointly fund substance abuse treatment services. Development of uniform service definitions and a unique client identifier complement the interagency data collection efforts.

Status: A model demonstration project involving DCF, DOC and the Judicial Branch will be implemented in SFY 2003. This will serve as a prototype for expanded collaborative contracting efforts in subsequent budget cycles. Governed by the requirements outlined in a MOA, the CCP will provide an opportunity for assessment and design modification, before expansion of the model.

D. Connecticut's Treatment Outcomes and Performance Pilot Study (CTOPPS)

Purpose: CTOPPS, a federally funded project, is in its final phase of developing a statewide outcomes monitoring system for substance abuse treatment programs managed by DMHAS. CTOPPS II has two objectives. First is to implement a revamped treatment service information system. This enhanced system, known as SATIS, allows for assessing fully the psychosocial functioning, medical and mental health status, and substance abuse behavior of clients entering treatment. The second is to conduct two specialized outcome studies evaluating clients' status, after being discharged from treatment. DMHAS' subcontractor, the University of Connecticut Health Center (UCHC), will conduct baseline assessments on 389 clients at time of admission, and again six months following discharge from treatment. Two populations are of interest: pregnant and parenting women, and clients with a co-occurring mental illness. The study will identify treatment effects of clients served in specialized vs. generic programs, and will assess clients for alcohol and drug use, levels of functioning, and other key factors.

Status: Implementation of SATIS is completed. The two outcomes studies began in July 2000. Statewide, twenty-five treatment programs have participated in the study across residential, methadone maintenance and outpatient levels of care. Outcome data were completed for 269 clients post treatment. Study findings are can be found on page 22.

E. Criminal Justice Information System-Offender Based Tracking System (CJIS-OBTS)

Purpose: The CJIS-OBTS will create "a cross-agency criminal justice system of offender data" information system that:

- provides a single repository of offender data, encompassing 47 different offender events, that is accurate, verifiable, timely, and available to all criminal justice agencies on a query, or ad hoc basis;
- integrates data from 15 different systems (with common data or format) in eight different criminal justice agencies;
- informs appropriate agencies involved in all phases of the criminal justice process of the occurrence of significant criminal justice events; and

- provides a measurable, adaptable, and maintainable framework to accommodate future criminal justice operational requirements.

Status: The application development was initiated on September 1, 2001, using consultant services. The baseline system, consisting of real time and historical offender data from court records, correction records, and public safety criminal history records, was tested beginning in December 2002 and became operational in March 2003. Additional offender records from the bail, prosecution, sex offender registry, probation, and parole functions along with full reporting via query, ad hoc, or established periodic procedures are to be incorporated into the system release of the OBTS in late 2003.

F. Project SAFE (Substance Abuse Family Evaluation) Phase II

Purpose: Project SAFE is a national model of collaboration between child welfare and substance abuse treatment systems, that responds to the needs of child welfare clients, experiencing alcohol and other drug problems. The project offers centralized intake procedures and priority access to substance abuse evaluations, drug screens and outpatient treatment services to primary caregivers of children who encounter DCF caseworkers. A contract with Advance Behavioral Health provides DCF caseworkers immediate access to substance abuse assessments, drug screens, and treatment services.

Phase I provided the basis for a DCF and DMHAS partnership to expand the initiative. In this phase, a comprehensive strategic plan was completed, addressing clinical, resource development, and related issues needed to maximize the project and implement a clinical model of services. The plan called for DCF and DMHAS to collaboratively develop resources, and plan and fund initiatives to improve client outcomes. Phase II places trained, highly skilled outreach workers into neighborhoods of larger cities to increase treatment engagement and retention. Outreach workers strive to address broader issues that often impede participation in treatment, such as motivation, basic needs, childcare, transportation, and housing.

Status: Phase II is a catalyst in bringing together the major participants in providing substance abuse services to the target population. Regional DCF workers, DMHAS staff, and substance abuse treatment providers began the process of identifying solutions to the practical concerns of implementing a comprehensive, multi-agency system of care. This is an example of program improvement based on collaboration in the substance abuse treatment system.

G. DOC - Collaborative Efforts

The Center for Alcohol and Drug Studies of Brown University

Purpose: The Center received a three-year grant from the Robert Wood Johnson Foundation to evaluate the effectiveness of substance abuse programs within the DOC. The study addressed recidivism and cost-effectiveness, and provides in-depth information

to 1) strengthen programming in the area of community reintegration, and 2) improve public safety.

Status: Research findings show that inmates who attended DOC addiction programs were significantly less likely to be arrested at every time interval (6 to 24 months) post-release and that if arrested, they tended to commit less serious crimes than non-attendees did. Participation in addiction programs was also associated with a reduction in the number of disciplinary offenses while the inmates were in prison. In terms of the avoided costs of repeat incarcerations, benefits exceeded costs. These results suggest that the programs had a positive effect on inmates' behavior, resulting in substantial benefits to the inmates, DOC, and society as a whole. These findings support the continuation and possible expansion of DOC addiction programs.

National Institute of Justice (NIJ) Grant

Purpose: The DOC's Substance Abuse Treatment Unit, through a NIJ grant, formed a partnership with the Criminology Department of Central Connecticut State University (CCSU) to conduct an in-depth process and outcome evaluation. This evaluation focuses on DOC's Tier 4, six-month Therapeutic Community Programs, funded through the U.S. Department of Justice's Residential Substance Abuse Treatment for State Prisoners Program. The study includes group observations, file reviews, and inmate interviews, and will collect and analyze data for inmates requesting treatment, but not eligible. This information will help strengthen programming and increase efficiency.

Status: CCSU has completed the process evaluation, and the DOC Treatment Enhancement Task Force is currently reviewing the recommendations. The Task Force is reviewing gaps in treatment services and current resource allocations to increase the effectiveness of addiction treatment in DOC. The outcome study examined re-incarceration rates for program participants and was completed in September 2002. Results will be available in 2003. The DOC continues to collaborate with CCSU.

The DOC's Interagency Addiction Treatment Task Force

Purpose: The goal of the Interagency Addiction Treatment Task Force is to enhance the coordination of treatment services of inmates as they enter the DOC system and transition back into the community. The Task Force includes both public and private providers that deliver treatment services, support the inmate's continued recovery, or promote intervention services. Efforts have focused on:

- working with providers to ensure continuity of care for the substance abusing criminal justice client,
- enhancing the screening and referral of inmates to appropriate treatment by reviewing screening instruments, and creating a common screening tool, and
- targeting job placement, substance abuse treatment, housing, employment, family, and health services referrals to inmates within six months of release.

Status: Task Force members concentrated on developing a referral pilot project to link offenders leaving the correctional system to services in the community. The Referral Project has been implemented and is being reviewed. This effort builds on the existing Community Resource Day events held in state correctional facilities. The Task Force also arranged for several opportunities for treatment staff from state and contracted agencies to tour each others programs to gain a better understanding of what services their clients may be coming from, or going to. Work on a common screening tool and consent form for use across agencies continues to be reviewed. This Task Force continues to meet on a monthly basis and address issues that impact the transition of offenders to the community.

Naltrexone Project

Purpose: The Naltrexone project provides treatment options for inmates discharging to the community who have significant histories of opiate abuse. The program provides education and counseling services, as well as Naltrexone administration, and services follow the offender from the facility to the community through a partnership with the Board of Parole.

Status: The program was operational at two correctional institutions (CI); Robinson CI, and Webster CI, and expanded to York CI this year. Since the two-year effort resulted in minimal participation, the program was discontinued in December 2002.

H. Data Sharing Project (Probabilistic Population Estimation-PPE)

Purpose: The Data Sharing Project was designed to achieve several objectives:

1. To engage as many state agencies as possible in sharing administrative data (i.e. existing databases used by a state agency to monitor or track persons as part of that agency's mission) for the purpose of measuring population overlaps. Inappropriate disclosure of client data was a major concern of all participating state agencies. As date of birth and gender were the only data items needed to unduplicate individuals within and across multiple databases, state agencies were confident that client confidentiality would be maintained.
2. To explore the capacity for PPE to measure trends over time of those accessing care across populations of interest.
3. To examine the effects of substance abuse treatment on various populations as measured by defined outcomes (e.g., criminal justice involvement).

Status: Initiated in 2001, eight state agencies transferred substance abuse treatment, human services, and criminal justice data used in determining population overlaps between agency populations and the substance abuse service system, and conducting agency or policy-specific studies. In the first year, an analysis was conducted using criminal justice population data, in particular information on probationers, to test the capacity of PPE to measure outcomes. Analysis continued in 2002 with an additional

year of data (SFY 2001) and expansion to other populations (e.g., Medicaid, juveniles and youth in treatment) to allow for further analysis of trends and expanded capacity to examine demographic factors such as age, race, and gender within various populations. Preliminary results from the project were reported in the 2001 *Annual Report*, and additional analyses focusing on criminal justice data were reported in the 2002 *Annual Report*.

I. Prevention Council

Purpose: In 2001, Public Act 01-121, *An Act Concerning Crime Prevention and a State Prevention Council*, created a Prevention Council to “establish a prevention framework for the state” through a recommended “comprehensive state-wide prevention plan”. The Council’s purpose is also to “better coordinate existing and future prevention expenditures across state agencies, and to “increase fiscal accountability”. The Council, chaired by OPM, includes the heads of DCF, DMHAS, SDE, DPH, Judicial Branch-CSSD, and the Department of Mental Retardation (DMR).

Status: An in-depth inventory for SFY 2002, *Prevention Services Funding* was released July 2002. The report lays the foundation for better coordination of existing and future prevention expenditures across state agencies, and includes 82 prevention programs considered by each agency to provide primary preventive services to children 0 to 18 years old. The Council has adopted the following as its definition of prevention: “promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.” The report includes program names, goals, primary and secondary strategies, funding details including federal funds, and designations of status (discretionary, mandated, or pilot). The report is located on the OPM website at either www.opm.state.ct.us/news.htm or www.opm.state.ct.us/publicat.htm#Justice.

A Comprehensive Statewide Prevention Plan, released December 1, 2002, includes recommendations to improve and coordinate interagency services and training, identify research-based programs that work, and classify agencies’ prevention programs using outcome performance measures, including findings, to increase fiscal accountability.

A Prevention Budget Supplement for SFYs 2004-2005, due February 2003, will present in detail for each biennial fiscal year the Governor's recommendation for prevention service appropriations, classified by Council agencies, including related data for two prior years.

A Report on Future Recommendations, due July 1, 2004, will recommend possible expansion of members, potential use of benchmarks, or continuation of the Council.

J. Partnership Resources and Infrastructure Support Monies (PRISM)

Purpose: In the fall of 2000, DMHAS, in collaboration with six state agencies and the Commission on Children, was awarded funding for the PRISM Initiative. PRISM's goal is to develop a strategy to implement and evaluate exemplary programs that address the problem of mental illness, violence, and substance abuse among children. PRISM funding enhanced the existing Cooperative Agreement Advisory Council promoting GPIY. The resulting Connecticut Coalition for the Advancement of Prevention (CCAP) aligned its goals with recommendations made by the Connecticut ADPC, and the Governor's Blue Ribbon Commission on Mental Health, and supportive data from statewide needs assessments. CCAP's mission is "to advance a coordinated, statewide prevention system that embraces diversity and effectively promotes the health and well-being of all individuals, families, and communities in Connecticut".

Status: In March 2001, a Request For Proposal was distributed statewide, soliciting proposals for exemplary prevention pilot programs. Two proposals began program implementation, Achievement Through Mentoring and Disaster Relief initiative.

The Outcomes and Benchmarks Subcommittee was formed to solicit recommendations on integrating and implementing prevention outcomes into a comprehensive, statewide plan. The sub-committee will:

- define the scope of prevention and the subcommittee focus,
- review national/state/local models (programs and outcomes) to identify a core set of assessment principles/practices/strategies, and
- define specific outcomes and their indicators.

The sub-committee developed an outcomes and indicators document to guide the building, maintaining, and enhancing of the state behavioral health prevention infrastructure and capacity. This document will be instrumental in developing and introducing a common language for state prevention providers; positioning the state and communities to pursue, effectively utilize, and sustain prevention funding; promoting a common understanding of prevention within a statewide infrastructure; serving as a guide in defining and streamlining prevention efforts; increasing public recognition of prevention efforts; demonstrating Connecticut's successes; and defining effective strategies in improving the well-being of individuals, families, and communities.

K. Data Linkage Project (DOL/DMHAS)

Purpose: The pilot will demonstrate the viability and benefit of linking administrative databases across state agencies. The specific goal of this pilot is to link existing agency databases (Department of Labor's wage data and DMHAS' SATIS) in order to match those clients served in both systems for the purpose of matching wage-earning data with substance abuse treatment clients. The analysis will focus on the impact of treatment services on pre/post earning potential.

Status: DMHAS' Research Division and the Office of Program Analysis and Support along with Yale University's School of Medicine are in the process of drafting the

research and data sharing protocols for the Department of Labor's (DOL) review and comments.

L. Treatment Needs Assessment

Purpose: DMHAS, in collaboration with Yale University and UCHC, received funding from the federal CSAT to conduct a series of assessment studies to determine the prevalence of substance use, abuse, and dependence. The study will estimate treatment need across the state, and for high-risk individuals. This three-year study will build upon DMHAS' past efforts at identifying treatment need in the general population, and targeted populations such as arrestees and welfare recipients. DMHAS will use a multifaceted needs assessment strategy that will inform policymaking and resource allocation as it relates to the need for treatment across various populations served by state agencies. The family of studies includes:

The Adult Household Survey (AHS) will determine statewide estimates of treatment need in the general population, with targeted over-sampling of those communities with high concentrations of Latinos. Connecticut's general population (persons 18 years and older) study will serve several important purposes by enabling DMHAS to examine the need for substance abuse treatment. First, data from Connecticut's previous statewide household survey will be compared to detect any changes in the state's treatment need. Second, the AHS will identify emerging issues within subgroups or drug use patterns providing the basis for further review by focus groups or community forums. Third, the AHS will examine the need for treatment, as it exists across varying levels of substance use, abuse, and dependence leading to interventions that are more appropriate. Fourth, findings, disseminated to stakeholders and the public, will increase awareness of the need for treatment, and dispel misconceptions about substance use disorders.

The Substance Abuse Need for Treatment among Probationers (SANTP) Study included structured face-to-face interviews and urine toxicology testing with a sample of adult probationers in Connecticut's three largest urban areas. Conducted in collaboration with Judicial-CSSD, the SANTP will provide rates of alcohol and other drug prevalence, abuse, and dependence, while also exploring co-occurring (psychiatric, trauma, and medical) conditions within this population. An essential component of the study will examine treatment access (history, barriers) and motivation. While Connecticut has been at the forefront of innovative approaches such as jail diversion programs and drug courts, the state is still burdened with prisons overcrowded with individuals with substance use disorders. Findings from the SANTP will provide Connecticut an important opportunity to promote sound policy and program planning, resulting in tangible changes for both the criminal justice and substance abuse treatment systems.

The Analysis of DMHAS' Treatment Service Information System is examining client-level service data to discern patterns and trends in service utilization, problem substances by demographic variables, and geographic variations.

Status: Data collection has been in all studies. Results and findings are scheduled to be available in late 2004.