SAFE RFI
Concept Questions – Drug Testing

1. DCF and DMHAS are interested in service delivery models, utilization protocols, and technology that accomplish SAFE program objectives while reducing administrative and drug testing costs in child welfare practice. How should drug testing be administered, organized, and structured? What technology can be employed to reduce cost and improve service?

**Norchem Sentry Information Technology**

We are pleased to announce SENTRY, Norchem’s evidence directed information management tool. SENTRY is a solution that will revolutionize your drug testing program by providing a cost effective means of improving outcomes and monitoring compliance. SENTRY provides immediate access to information that will allow the user to intervene quickly when necessary. Fast and appropriate intervention will aid in reducing recidivism while improving outcomes and lowering costs. SENTRY is developed, managed and supported by Norchem; no more confusing third party management.

**What will SENTRY do for you?**

- Randomization of complex drug test schedules, multiple panels and frequencies. An easy to use interface allows you to customize a randomization schedule to fit your needs. Improves effectiveness of drug testing dollars.

- Social workers have real time access to client/participant information. Keep and maintain notes, testing schedules, testing results, call-in logs all in one place. Reduced clerical work will allow more time for higher value activities.

- Positive/Abnormal testing results may be setup to alert social workers via emails, or text messages for immediate action. Alerts allow for easy early intervention and positive reinforcement, both important to improving outcomes.

- Easily organize your clients/participants into groups with common characteristics. Allows statistical tracking for groups and IVR (Interactive Voice Response) schedules attached at the group level. Statistical tracking allows for program evaluation and adjustment to maximize impact of your important budget dollars.

- SENTRY is fully integrated with Norchem’s laboratory, which allows you to track in real-time the status of specimens as they are received and tested. Saves social worker time for other activities.

- Real-time reports and statistics, compliance reports, drug testing statistics and more. Compliance reports provide easy access to information for court, client meetings, reducing time spent on clerical activities and freeing up social worker time for higher value activities.

- Eliminate errors such as misspelled names and incorrectly filled out chain of custody forms.

- Participating collection sites know who is supposed to test that day and may view a photo of the client/participant uploaded by the social worker as an additional validation of identity. Prevention of non-scheduled testing improves the impact of testing, outcomes and the effectiveness of the budget dollars spent.

- Strict security makes sure only authorized personnel are able to view and make changes to client/participant information and schedules. The security is also flexible enough that information sharing among agencies and 3rd parties is just a click of the mouse away. This facilitates the sharing of information between all parties involved (social worker, supervisor, court, judge, treatment facilitates) for improved outcomes.
Sentry can be accessed via any internet enabled computer with Firefox or Internet Explorer 8. Security is bank quality 128bit SSL Encryption to protect your data. Social worker can access information from any computer with internet access when they are out in the field, keeping them on top of any issues and improving productivity.

Please view the 3 minute Sentry video at www.norchemlab.com. (A link is also attached to this email)

2. What are the practical, financial, and technical benefits and limitations of each type of testing being considered (urine, hair, saliva, patches, and oral swabs). Base your response on experience, published literature, data, and/or research studies where available.

**COMPARISON OF DRUG-USE DETECTION USING SALIVA, URINE, SWEAT or HAIR**

Urine has long been the standard specimen to test for drugs-of-abuse because most drugs are primarily eliminated through the urine. The kidneys have a concentrating effect so that the drug level can be higher in the urine than it was in the blood. The high concentration of drug and the availability of a large volume makes urine an ideal specimen for testing.

Compared to urine, the level of drugs found in saliva, sweat or hair is small and amount of saliva, sweat or hair is limited. For the testing laboratory, this means a greater difficulty and expense in performing the test.

**Urine:** Most drugs are eliminated from the circulation within 2 – 5 days after use. However, chronic use can prolong that detection window for certain drugs (marijuana might be detected for as long as six weeks following the last use by a chronic user).

**Hair:** Drugs circulating in the blood are incorporated into the growing hair follicle. Once that small segment of hair has grown past the scalp (about 5 days) it can be cut and analyzed. Hair provides a history of drug use lasting until the hair is cut. The oldest hair is furthest from the skin. Hair grows about ½ inch per month and most laboratories only test the most recent 1½ inches (the most recent 3 months). Generally, a single use of a drug does not deposit enough drug in the hair to be detected. Multiple use is usually required for detection.

**Sweat Patch:** Drugs eliminated in the sweat accumulate in a sweat patch, which is subsequently analyzed. This provides a monitor of drug use for the time the patch is worn (as long as 2 weeks).

**Saliva:** Most drug levels in saliva directly reflect the blood level (this may not be the case for THC. Some studies indicate that THC does not pass from the blood to the saliva). Therefore the results may be related to intoxication and impairment. Oral fluid eliminates the need for same sex collectors for observed collections and addresses issues associated with specimen dilution.

Although urine has been the mainstay of drug-testing programs, saliva, sweat and hair are important alternatives to urine based programs but those who direct these programs need to be aware of the differences in terms of 1)
collection of the specimen, 2) drug detection times, 3) adulteration potential, 4) courtroom reliability, and 5) sensitivity

1. Collection
   • Urine collection requires bathroom facilities, invasion of privacy,
   • Hair collection has an advantage in that an identical specimen can be collected if a repeat collection is required.

2. Drug detection times
   • Saliva: 1 - 2 days
   • Urine: 2 - 5 days
   • Sweat: 1-2 wks (the length of time the sweat patch is applied)
   • Hair: 3 months

3. Adulteration potential
   • An industry has grown up around efforts to subvert urine drug testing.

4. Courtroom reliability

5. Indication of impairment
   • Drug levels in saliva correlate well with blood levels and therefore can indicate impairment at the time of the collection.

PRO’S
   • Hair expands the time window for the detection of illicit drugs (up to about 3 months)
   • The collection process is somewhat less invasive and embarrassing than urine collections
   • Hair analysis can accurately identify a chronic drug user (Brief periods of abstinence from drugs will not alter the outcome of hair analysis). (1)
   • Hair testing is good choice for pre-employment testing programs

CON’S
   • Hair tests are poor at detecting the presence of marijuana.(2)
   • Hair tests are poor at detecting infrequent or one-time drug use.
   • Hair tests do not detect recent use (the hair impregnated with the drug requires 5 days to exit the scalp).
   • It takes more time for the laboratory to perform the hair analysis
   • Hair analysis is generally more costly.(2)
   • There is some evidence that drugs attach to the melanocyte and melanosomal protein in the hair. Consequently, studies show that dark-haired individuals might trap more drug than do light-haired individuals. (4). Hence, hair color might present a drug test bias.
   • Hair is more affected by external contamination. In studies performed by the US Dept. of the Navy, they were unable to remove external contamination by any washing technique. Because of this, they abandoned the use of hair analysis for drugs of abuse.(5)
   • Urine Drug Testing is better for random, post-accident and for-cause drug testing programs.
3. What are the recommended/preferred sample collection, handling, storage, and quality assurance protocols that will ensure high access, reliability, validity and that result are interpreted appropriately?

**NORCHEM OBSERVED COLLECTION PROCEDURE**

**IMPORTANT POINT:**
The collector and the donor shall keep the urine specimen in view at all times prior to its being sealed with tamper-evident sealing label.

**PRIOR TO COLLECTION:**
1. Collection facilities must be clean, well lighted, and dedicated solely to urine collection during the collection process.
2. The toilet water must not be available to the donor for specimen adulteration:
   - **REGULAR FLUSHING TOILETS:** Bluing agent (or dye) should be placed in the toilet bowl and tank, and secure the tank cover with tamperproof tape.
   - **PRESSURE FLUSHING TOILETS** (no water tank): Bluing tablets (or dye) should be placed in the toilet bowl after each flush or before the next donor.
3. No other source of water should be accessible to the donor during the collection process.

**COLLECTION:**
1. Collector must positively identify the donor. If the collector is not the caseworker for the donor then collector must ask the donor for a photo ID (driver’s license, etc.) In the absence of a photo ID, the only other form of acceptable ID is for the donor's identity to be verified by their caseworker, or supervisor, in person.
2. Collector must assure that all applicable information on the Chain-of-Custody (COC) form is complete.
3. Collector must ask the donor to remove unnecessary outer garments (such as coat or jacket) and to remove all items from their pockets, and pull their pockets inside out.
4. All personal belongings, such as purse or briefcase, are to remain outside the collection location (with the outer garments).
5. Collector instructs donor to wash and dry hands. **DO NOT USE SOAP. USE WATER ONLY!**
6. Collector instructs donor to FILL the specimen collection bottle.
7. Donor enters the toilet stall with the collector, or otherwise partitioned area, that allows for individual privacy.
8. Collector observes the urine pass from the donor’s body to the collection bottle.
9. Collector is advised to wear rubber gloves.

**UPON RECEIVING SPECIMEN FROM DONOR:**
1. Collector visually checks the specimen for signs of contamination or adulteration (discoloration, precipitation, etc.) and notes all observations in the **TEST REQUEST** space provided on the Chain-of-Custody (COC) form.
2. In the presence of the donor, **collector measures the temperature of the specimen using the temperature strip provided on the container, within four (4) minutes from the time of urination.** The acceptable range is 90.0 - 100.0 degrees Fahrenheit.

3. Record the temperature on the COC form.

4. If tamper proof tape was used on the toilet water tank, check that the tape was not tampered with.

5. **COLLECTOR AND DONOR SHALL KEEP THE SPECIMEN IN VIEW AT ALL TIMES PRIOR TO THE SPECIMEN BEING SEALED WITH TAMPER-EVIDENT TAPE.**

6. Make sure the specimen bottle is **Tightly** capped.

7. **Seal the specimen by placing the tamper-evident tape over the lid of the bottle with the ends of the tape coming down the sides of the bottle.**

**UPON RECEIVING SPECIMEN FROM DONOR (Continued):**

8. Have the donor place their initials on the line of the specimen seal: [Donor’s Initials]. **This is to certify that the specimen has been sealed with a tamper-evident sealing label in the donor’s presence, and that the donor gave the specimen.**

9. Using a **ballpoint pen,** donor and collector now sign and date the COC form in the areas provided. **Make sure the donor’s printed name and signature name are in fact the same** (occasionally donors sign using a different name, such as a maiden name).

10. Collector places the sealed specimen bottle in the tamper proof transport bag, seals the bag, and places the chain of custody form in the side pouch.

11. Collector encourages donor to wash hands.

**SPECIMEN REJECTION CRITERIA:**

You may reject a donor specimen if one or more of the following occurs:

- **IF THE DONOR OBSCURES THE COLLECTOR’S VIEW THE URINE PASSING FROM HIS/HER BODY INTO THE COLLECTION BOTTLE,** discard the specimen and request another specimen from the donor.

- **IF THE SPECIMEN IS ABOVE OR BELOW THE ACCEPTABLE TEMPERATURE RANGE (90 – 100 degrees Fahrenheit),** discard the specimen and request another specimen from the donor.

- **IF THE SPECIMEN IS BLUE OR GREEN IN COLOR (DUE TO THE PRESENCE OF BLUING AGENT/DYE),** clearly state this fact on the COC form, and send specimen to NORCHEM Laboratory.

- **IF THERE IS THE DISTINCTIVE ODOR OF BLEACH IN THE SPECIMEN, COLLECTION AREA OR ON THE DONOR,** clearly state this fact on the COC form, and send specimen to NORCHEM Laboratory.

- **IF THERE IS AN INSUFFICIENT VOLUME OF SPECIMEN TO PERFORM THE REQUIRED ANALYSIS,** discard the specimen and request another specimen from the donor. Insufficient volume here means that **THE SPECIMEN LEVEL MUST BE ABOVE THE LEVEL OF THE TEMPERATURE STRIP ON THE SPECIMEN COLLECTION BOTTLE, OR CONTAIN AT LEAST 15mL OF SPECIMEN.**

**IN THE EVENT A SPECIMEN IS REJECTED:**

1. **DENOTE THE REASON FOR REJECTION IN THE TEST REQUEST SECTION OF THE COC FORM.**

2. **INFORM THE DONOR THAT THE SPECIMEN IS UNACCEPTABLE FOR ANALYSIS AND THAT THEY WILL NEED TO TAKE A SEAT AND SUBMIT ANOTHER SPECIMEN. THEY MAY DRINK MODERATE AMOUNT OF WATER (APPROXIMATELY 8OZ.) BUT THEY ARE NOT PERMITTED TO LEAVE AND RETURN AT A LATER TIME OR DAY,** unless otherwise specified by the employer/client.

3. **IF THE DONOR FAILS TO COMPLY, DO AS FOLLOWS:**
   A. **NOTIFY THE EMPLOYER/CLIENT REGARDING THE SPECIMEN REJECTION PROBLEM.**

**Laboratory Certification / Quality Assurance**

The most appropriate certification for forensic (legally defensible / court ordered) testing is by the College of American Pathologists - Forensic Drug Testing (CAP-FDT). This certification is specific to forensic drug testing. *It is important to note that proficiency testing and certification are not the same.* Proficiency testing is typically performed 3 – 6 times per year, while certification requirements are routine. Some laboratories claim they meet certification standards because they participate in proficiency testing from CAP, however, proficiency testing alone does not meet the high standards of the actual certification. The CAP-FDT was specifically designed to be the most appropriate certification for court ordered testing and legally defensible results.

**HISTORICAL DEVELOPMENT OF CERTIFICATION PROGRAMS FOR DRUG TESTING LABORATORIES**

**CLIA ’88 (Clinical Laboratory Improvement Act of 1988):**

CLIA was enacted to ensure that all laboratories provide accurate results for medical diagnosis and treatment decisions. CLIA has applied a single set of requirements that apply to almost all laboratory testing of human specimens. CLIA also established enforcement procedures and sanctions applicable when laboratories fail to meet standards. Compared to most clinical tests, the legal consequences of a positive urine drug test may be severe and present a heightened probability of a legal challenge. Therefore, drug tests are considered “forensic testing”. However, the CLIA laboratory certification program does not provide for quality assurance and performance testing specific to forensic urine drug testing. Additionally, CLIA does not specifically have trained inspectors to perform on-site evaluation of forensic laboratories.

**SAMHSA (Substance Abuse and Mental Health Services Administration, NIDA (Final guidelines, F.R./Vol 53. No. 69/April 11, 1988):**

SAMHSA was created in response to demands for scientific and technical standards for Federal Workplace Drug Testing Programs and for the certification of laboratories engaged in urine drug testing for federal agencies. SAMHSA is distinguished from CLIA by its strict emphasis on legal defensibility and by its deliberately restricted regulatory scope, it is limited to urine testing for five drug classes. The SAMHSA Guidelines that ensure legal defensibility include: 1) rigorous chain-of-custody for the collection, testing, and storage of specimens, 2) strict laboratory security with restricted laboratory access and locked specimen storage, 3) precise requirements for quality assurance, 4) performance testing specific to urine assays for five drug classes, 5) specific educational requirements for laboratory personnel to ensure their credibility as forensic drug testing experts. The SAMHSA Guidelines make it clear that they do not apply to drug testing performed under any legal authority other than Mandatory Federal Workplace Drug Testing. Specifically, neither criminal justice drug testing programs nor non-federal workplace drug testing fall under the regulatory scope of SAMHSA.

**CAP-FUDT (College of American Pathologists / Forensic Urine Drug Testing):**

The gap left between CLIA and SAMHSA made the development of a separate laboratory certification program essential to assure the protection of individual rights and the legal defensibility of forensic urine drug testing performed outside the limited context of federal programs. In 1988 CAP, in consultation with the American Association for Clinical Chemistry, developed the FDT accreditation program designed specifically for non-federal workplace drug testing. It was modeled after the SAMHSA program and includes the five items above to ensure legal defensibility but the scope of the program was expanded to cover any drug test performed on urine. The objective of the CAP-FDT program is to improve the quality of laboratory services so that all testing is performed in a scientific and legally defensible manner. The CAP-FDT program emphasizes the importance of confirmatory tests to meet forensic requirements.
The chart below shows the distinctions between the CLIA, CAP-FDT and SAMHSA certifications.

<table>
<thead>
<tr>
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<th>CLIA 88</th>
<th>CAP / FDT</th>
<th>SAMHSA</th>
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<tbody>
<tr>
<td>Mission</td>
<td>Medical / clinical emphasis for diagnosis and treatment</td>
<td>Legal defensibility for all clients</td>
<td>Legal defensibility of results only for those covered under federally mandated testing</td>
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<td>Quality Control Frequency</td>
<td>2 levels / run Run size not defined</td>
<td>3 levels / run 10% of tests</td>
<td>3 levels / run 10% of tests</td>
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<td>Calibration Frequency</td>
<td>Every 6 months or as needed</td>
<td>Daily</td>
<td>Daily</td>
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<td>Cut-off Levels</td>
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<td>Specified by Laboratory</td>
<td>Specified by Federal Guidelines</td>
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<td>Covered Tests</td>
<td>Screening Tests Only</td>
<td>Screening and Confirmations for all tests performed in laboratory</td>
<td>Screening and Confirmations for NIDA 5 drugs only</td>
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<tr>
<td>Proficiency Testing</td>
<td>Frequency 3 events / year</td>
<td>4 events / year</td>
<td>6 events / year</td>
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<td>Scope of Testing Screen Tests Only</td>
<td>Screening and Confirmation Tests</td>
<td>Screening and Confirmation for NIDA 5 drugs only</td>
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<td></td>
<td>Laboratory Security Unrestricted</td>
<td>Restricted / Recorded Access</td>
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<td>Specimen Security None</td>
<td>Locked and Documented</td>
<td>Locked and Documented</td>
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<td>Inspection Frequency</td>
<td>On-site Every 2 Years</td>
<td>Every 2 Years</td>
<td>Every 6 months</td>
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<td>Formal Self-Evaluation N / A</td>
<td>Annual</td>
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<td>Client Support</td>
<td>Technical Consultation None Required</td>
<td>Required</td>
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<tr>
<td></td>
<td>Education None Required</td>
<td>Required</td>
<td>None Required</td>
</tr>
</tbody>
</table>

**Confirmation Testing**

Specimens that screen positive should be confirmed by either Gas Chromatography / Mass Spectrometry (GC/MS) or Liquid Chromatography / Mass Spectrometry / Mass Spectrometry (LC/MS/MS).

**“The Platinum Standard” for Confirmation Analyses at Norchem**

Gas Chromatography/Mass Spectrometry (GC/MS) has long been the “gold” standard in forensic toxicology laboratories as a confirmation technique. In the past few years a new generation analytical technique called Liquid Chromatography/Mass Spectrometry /Mass Spectrometry (LC/MS/MS) has been developed. This new confirmation method provides added sensitivity, selectivity, and better turnaround times at no added cost.
The dual “mass-spec” of the LC/MS/MS provides for more specific and more sensitive analyses. The “more specific” feature means that it is better at distinguishing the illegal drug from interfering substances like adulterants. The “more sensitive” feature means it can measure the drug at much lower concentrations, making LC/MS/MS analyses less susceptible to dilution efforts by the donor. In fact, LC/MS/MS will detect compounds at one-thousandth the concentration that can be achieved with GC/MS. (picograms/mL vs nanograms/mL).

Norchem has recently acquired two Varian and two Waters LC/MS/MS instruments. In all cases, we have been able to improve:

- **Specificity**: ability to discern and isolate a specific drug from possible interfering substances.
- **Sensitivity**: ability to detect drugs at very low levels, even with interfering adulterants and substances present.
- **Linearity**: ability to directly analyze drug concentrations over a wider range, especially at very high concentrations, allowing for faster turn-around-time in reporting to clients.

Our LC/MS/MS methodologies meet or exceed Kelly-Frye standards for test results entered into evidence. A select group of nationally recognized toxicology laboratories have embraced and successfully implemented LC/MS/MS analyses for forensic, general and clinical toxicology, as well as the highly specialized and demanding analyses of drugs in alternative matrices like hair, saliva, and sweat (alternative matrices require greater sensitivity than GC/MS can provide).

4. What are the current market laboratory costs: i) by drug panel type (e.g., 5 panel vs. 3 panel); ii) by volume of tests and, iii) by type of tests? What are the current market laboratory costs for confirmation testing? How do bundled and unbundled rates compare and what are the advantages/disadvantages of bundling?

Costs for any type of testing, both screen and confirmation are determined by numerous factors including; specimen volume, substances tested, type of testing, number of pick-up locations, transportation methods, etc. The bundled pricing is based on the positive rate for screen testing and is used to determine a “screen with confirmation” cost. The screen with confirmation provides a faster result (social worker does not need to contact the laboratory to request a confirmation), which supports faster intervention if necessary.

Field test kits (instant devices) are subject to an individuals interpretation of the result, may still require additional laboratory testing and do not provide a legally defensible result. Norchem does not provide or recommend the use of field test kits.

5. What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?

Not sure what Recovery Coaches are. No response.
6. What recommended standards should be used for chain of custody and what are the market per-test costs for sample collection? What are the costs per test if dedicated staff and collection sites are implemented? What would be the advantages/disadvantages of a "two-tiered" system (see above) in which high level chain of custody standards are required for child welfare driven testing and lower standards are required for testing in the context of treatment monitoring. How could third party reimbursement of drug testing be maximized?

The chain of custody process is a very important aspect of substance abuse testing. It ensures proper handling of the specimen and when done correctly ensures the ability for a laboratory to defend the process. Proper chain of custody handling protects the requesting agency and the donor.

The Sentry substance abuse monitoring program provides the ability to verify donor identity (ID number and uploaded donor picture), compliance with the correct scheduled day to test and an electronic generated chain of custody that ensures all fields are correctly filled-in, which eliminates penmanship issues and provides for a faster collection.

Collection costs vary. They are often more costly in rural areas. Collection facilities that provide observed collections are typically harder to locate in rural areas. If an agency’s testing volume is sufficiently high and if space is available in the agency’s building, there may be an option for the laboratory to staff it’s own collectors in the agency’s facility. This does require a high volume of testing, however, it can potentially support a cost savings for specimen collections.

7. What are the recommended performance measures of drug testing protocols and procedure?

Norchem recommends the following:

A. Use a highly certified laboratory. Either CAP-FDT or SAMHSA. Not a CLIA only certified lab.
B. Require confirmation by GC/MS or LC/MS/MS and not by other methods such as repeat analysis, Thin Layer Chromatography, etc.
C. Require that results reported within 24-48 hours of receipt to the laboratory for urine screen and confirmation testing.
D. Utilize the Norchem Sentry web based substance abuse monitoring program. Sentry is fully integrated with our laboratory and is not supported by a third party. Sentry is specifically designed to Improve Outcomes and Lower Costs.

Please visit the Norchem website to view a 3 minute video on Sentry and sign-up for a free webinar that provides the specifics of how Sentry works and the value it provides.

Please contact me with any other questions you may have.

Regards,

Tom Eickmeyer
Account Manager
Norchem Drug Testing
800-348-4422
August 31, 2009

VIA E-mail (judi.jordan@ct.gov)

Ms. Judi Jordan  
Director of Grants Development and Contract Management  
Department of Mental Health and Addiction Services  
410 Capitol Avenue  
Hartford, Connecticut 06134

Dear Judi:

Attached is a response to the Project SAFE Redesign Request for Information. I did not attempt to respond to every question posted in the RFI, but rather made a comment in each of the Concept Question areas. I do plan to attend the Technical Assistance Session on September 11, 2009, where I can further expound upon our comments.

In addition, I have attached an article from “The Open Minds Circle” which is relevant to the discussion of Recovery Specialists. It is important to note that Recovery Specialists, peer counselors and peer supports are all very helpful in the treatment of our clients, but they do not replace professional counselors, therapists and formal treatment programs.

I hope this is helpful, and I look forward to seeing you on the 11th.

Sincerely,

Michael F. Norton, LCSW  
Vice President of Clinical Operations

MFN:hot  
Attachments
Concept Questions

Drug Testing:
Clients who self report as needing treatment per use of GAIN-SS or similar screening tool administered by DCF can be referred directly to intake at provider agency eliminating entire cost of evaluation, urine screening, hair test. This also eliminates delay in treatment admission process which can be up to 30 days between initial DCF contact and actual admission to treatment.

Current practice is that urine screens are ordered for ALL Project SAFE evaluations. A significant savings in the cost of drug testing could be realized if clinicians performing evaluations were given more discretion in determining the cost effectiveness of drug screening and also which lab to use when drug screening is performed. There can be a savings of up to 60% of the cost of screening using different labs.

Hair testing is prohibitively expensive and sectional testing at $191.00 should only be used in the most extreme circumstances of child welfare, if at all.

Screening Evaluation and Access to Treatment:
Self-motivated clients, identified by self report at DCF (using GAIN or a similar screening tool) would be more efficiently admitted to treatment if referred directly to intake appointment at substance abuse or mental health provider agency. This procedure could eliminate delays of up to 30 days between identification of treatment need and actual admission to treatment. It also could provide more effective engagement based on the “strike while the iron is hot” concept. A client’s self motivation can dissipate during the delay.

Elimination of unnecessary evaluations would provide cost savings which funds may be better utilized in other client engagement strategies like RSVP.

In addition to the need for treatment and referral to appropriate level of care, Project SAFE evaluations should identify ALL barriers to treatment engagement such as childcare needs, transportation, family system resistance to treatment, third party payer restrictions, prohibitively high co-pays and/or deductibles. These barriers and client-centered, recovery-oriented strategies to overcome them should be integral to the evaluation report and the treatment planning.
**Treatment Services and Systems Design**

DMHAS has issued grants to agencies who provide substance abuse treatment to pregnant and parenting women. This gender-specific program includes IOP, group and individual counseling and childcare services. There is a strong parenting component as well as trauma sensitive programming which works very well for the DCF Project SAFE caseload.

Recovery Case Manager/Specialist protocols can be modeled after DMHAS SA Case Manager program for high utilizers. Recovery Specialist could be assigned up to 25 DCF clients to provide assistance, guidance, transportation, etc. throughout the initial stage of engagement in treatment. This Case Manager will reduce the fragmentation during initial stages and thereby improve the rates of engagement and treatment success and also reduce recidivism rates among DCF Project SAFE client population.
Joseph Sullivan

From: OPEN MINDS Circle [casey@openminds.ccsend.com] on behalf of OPEN MINDS Circle [openminds@openminds.com]
Sent: Sunday, August 23, 2009 10:32 AM
To: Joseph Sullivan
Subject: Is the Recovery Model a Euphemism for State Cost-Cutting?

To view this document on our web site - visit: http://www.openminds.com/circlehome/circle/commentary_grahamrecovery.htm.

Is the Recovery Model a Euphemism for State Cost-Cutting?

Do you think the recovery model is being used as a veil for state cost-cutting of mental health services? My recent piece, How are States Employing the Recovery Model?, took a look at the 'state of the nation' regarding the implementation of recovery-oriented care systems. Shortly after it published, OPEN MINDS Circle member Scott Graham with Criterion Health wrote to me, "In my travels...the most significant observation I've made about the recovery model is that it has become a euphemism for state cost cutting. Psychosocial programs have been shut down and housing programs have been closed—replaced by peer support efforts. State and local officials then wonder why their emergency rooms and jails have filled up and why the homeless population has increased. I do think that peer-run programs are great and have efficacy when they are added as another choice for consumers to access."

As a former clinic director and community mental health service director, I agree with Scott. Peer-run services should be part of the care continuum and need to be developed to fit in some of the blanks—but are certainly not a replacement for availability (and financing) of needed services. (Look for my upcoming piece in the OPEN MINDS management newsletter on the many types of consumer-run organizations and where they fit into care delivery systems.) In a time when budgets are tight, parity rules are being written, and health care reform decisions are afoot, we need to keep a vigilant eye on this trend.

If you would like to follow up with Scott Graham on his comments, you can connect with him at scottg@criterionhealth.net. If you would like to share your thoughts on how the implementation of recovery-oriented elements of your local service delivery system are affecting service delivery (or any other observations you have about recovery-oriented system development), just send me a message at openminds@openminds.com.

Sincerely,

Dan Aune, M.S.W.
Senior Consultant, OPEN MINDS

Are you maximizing your collections from providing Medicaid services?

In the next few years, optimal management of Medicaid services is going to be even more important to the success of health and human service organizations. Medicaid is an increasingly large component of behavioral health spending — and additional Medicaid funding accounts for 60% of the Stimulus funding for health care. Even a small increase in Medicaid billing and collections can mean the difference between a profitable program and one that is operating at a loss.

- Has your management team identified all the Medicaid-reimbursable services that your organization can provide?
- Are your clinical programs billing for all of the Medicaid services provided?
- Is your organization collecting all Medicaid billings?

If the answer to any of these questions is "no" — or if your management team needs help answering these questions — you should consider the OPEN MINDS Medicaid Max Assessment.

What will OPEN MINDS Medicaid Max bring to your organization?

- A thorough review of your current Medicaid operations and business management practices (both on paper and on-site with your team) by a senior team member
- Identification of the key initiatives that your organization can take to increase Medicaid revenues
- A planning meeting with our team and yours to review the possible strategies and tactics to launch your Medicaid maximization process - and map out an implementation process
- And, most importantly, an increase in the revenue from the Medicaid services that you currently provide

Want to learn more about the OPEN MINDS Medicaid Max Assessment? Click Here!

Premium members of the OPEN MINDS Circle may access my article from the

8/31/2009
Name of Respondent
Christopher S. Rigling, Psy.D., MBA
Vice President, Programs

Affiliation (Provider, Parent, etc.)
Administrative Services Organization

Agency Name
Advanced Behavioral Health. Inc.

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Concept Questions:

Drug Testing

1. DCF and DMHAS are interested in service delivery models, utilization protocols, and technology that accomplish SAFE program objectives while reducing administrative and drug testing costs in child welfare practice. How should drug testing be administered, organized, and structured? What technology can be employed to reduce cost and improve service?

The connection between parental substance abuse and the potential for child abuse and/or neglect is clear in research literature. Within the current context of Project SAFE, drug testing serves multiple functions. Drug testing is initiated by the DCF social worker as a referral through Project SAFE. The referral is intended to provide information valuable to the child welfare process, regarding the status of a parent’s substance use. The referral is made as an adjunct to treatment as well, a way for the child welfare system to offer that parent support for his or her recovery. Treatment providers utilize the process of drug testing as part of the planned treatment programming. Drug testing can help motivate an individual in recovery. The court system utilizes the results of drug testing within Project SAFE as factual evidence regarding the parent’s substance use, and/or abstinence. Substance use is a key factor a majority of child welfare cases.

Currently, there are two methodologies utilized within Project SAFE, urinalysis and hair testing. Each provides valuable information. Urinalysis provides evidence of recent substance use, while hair testing provides longer-term historical substance use information.

In order to be consistent with the combined goals of providing evidence while enhancing the treatment methods and strategies offered by providers, *testing must be connected to the process of recovery*. For the person receiving the testing, the connection between one’s personal recovery and behavioral health, and their ability to be an effective parent is enhanced by this approach to drug testing. Utilizing Recovery Specialists, as is being done in the RSVP program, combines the need to connect drug testing to recovery, with the ability to utilize a helpful third party not attached exclusively to either the child welfare process or the treatment process.

Drug testing in Project SAFE should be structured around some basic utilization criteria. Currently, drug testing is utilized at a very high rate, without any criteria other than that the child welfare case involves some suspicion of drug use in the parent. This has resulted in increasing utilization and increasing cost, often without a clear strategy or outcome. Utilization Criteria, developed by the Department of Children and Families (DCF), can be applied at the point of referral. These criteria should take into account the nature of the concern about substance use, and the specifics of the child welfare case. The presence of legal involvement as a direct result of substance use, a history of substance abuse treatment, and/or the failure to acknowledge substance use by the parent in light of evidence to the contrary, could be operationalized into a set of criteria. Applying utilization criteria in this way allows for data collection measures which can serve as a baseline against which to measure outcomes.

The current methods for implementing urinalysis within Project SAFE are costly. DCF has recently asked Advanced Behavioral Health to make changes in this system. Instant read urinalysis will be used, in conjunction with a recovery-focused approach to the engagement of
clients in recovery. This method will reduce costs by reducing the initial test cost (as instant-read cups are less than half the cost of sending specimens to a centralized urinalysis vendor), as well as decreasing costs associated with GC/MS (Gas Chromatography/Mass Spectrometry) confirmatory analysis. The frequency of GC/MS analysis is anticipated to decrease under this new system. The combination of reducing the overall urinalysis per test costs, as well as decreasing frequency of expenditure for confirmation will result in significant savings. In a study of self-reported drug use and accuracy relative to urinalysis, it was found that patients “made extremely accurate UDS predictions, particularly when they made drug-positive predictions”\textsuperscript{2}. This accuracy will result in very few disputed results requiring confirmatory analysis, and consequently an overall cost savings.

The value of hair testing in certain cases is undeniable; however, overutilization of hair testing is a trend over the past decade of Project SAFE. Research has supported the strategic use of hair testing as a means for providing a baseline of substance use for a three month period prior to first contact. The unique nature of hair testing also can provide a description of ‘temporal use patterns’, regularity of substance use over time.\textsuperscript{3} In addition, it is widely recognized that hair assays used in conjunction with urinalysis can provide the most effective use of toxicology in treatment and forensic applications.\textsuperscript{4} The applications of clear utilization criteria which only allow hair testing in instances when a baseline of use prior to first contact will be valuable can


\textsuperscript{4} Ibid.
result in savings. Such criteria should be developed by DCF, considering the recency of
evidence from urinalysis, and the status of the child welfare case in question.

2. **What are the practical, financial, and technical benefits and limitations of each type of
testing being considered (urine, hair, saliva, patches, and oral swabs)?** Base your
response on experience, published literature, data, and/or research studies where
available.

As discussed in a previous answer, each type of testing currently being utilized (urinalysis and
hair testing) has its benefits, limitations and costs.

Urinalysis is useful in the detection of a wide array of substance use, but has a relatively small
window of detection; 12 – 72 hours dependent on the substance, with the exception of THC.
While there are limitless numbers of rumors and myths about urinalysis, the scientific evidence
indicates that is a failsafe methodology. As noted previously, the costs associated with urinalysis
are quite variable, and a new initiative in Project SAFE is being implemented in order to help
minimize these costs while still producing the necessary information for DCF and providers.
Instant read tests will be used in conjunction with a motivational enhancement approach intended
to encourage accurate self disclosure about relapse in order to minimize the need for costly
MG/CS confirmatory analysis.

Hair testing increases accurate information when used in combination with urinalysis. Hair
testing is expensive relative to other forms of analysis per unit. However, when carefully and
judiciously utilized, hair testing can be cost effective. In addition, the overuse of multi-section
hair assay analysis increase cost greatly.
3. What are the recommended/preferred sample collection, handling, storage, and quality assurance protocols that will ensure high access, reliability, validity and that result are interpreted appropriately?

Current sample collection, handling, storage, and quality assurance protocols as utilized by LabCorp are those that are industry standard. These standards are also utilized in the current urinalysis methodology for RSVP, as well as in hair testing as administered by Psychmedics. The factors recommended by SAMHSA are:

- Permanent collection site with observed collection;
- A trained specimen collector;
- An FDA cleared collection device;
- Identification of a specimen;
- Having established collection procedure which involves appropriate donor identification, donor preparation, and chain of custody;
- Laboratory testing when needed that is FDA cleared and follows HHS standardized cutoff levels;
- Confirmatory testing using GC/MS (Gas Chromatography/Mass Spectrometry) analysis;
- Medical officer review.

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All of these components are present in both urinalysis testing methodologies and the hair testing methodologies in Project SAFE, with the exception of having a medical review officer (MRO). This lack of a MRO makes interpretation difficult in some cases, especially when there are questions regarding drug interactions, and or complications related to existing medical conditions. Using the physicians that are on staff at DCF can be a helpful adjunct in certain complicated drug testing situations.
4. What are the current market laboratory costs: i) by drug panel type (e.g., 5 panel vs. 3 panels); ii) by volume of tests and, iii) by type of tests? What are the current market laboratory costs for confirmation testing? How do bundled and unbundled rates compare and what are the advantages/disadvantages of bundling?

Laboratory costs are reasonably standardized. In 2005, an RFP process was administered by Advanced Behavioral Health, intended to lead to the re-procurement of laboratory testing for Project SAFE. Several responses were received, and a recommendation was made by ABH to DCF and DMHAS. Unfortunately, because of regulations relative to Title XIX, the re-procurement was not implemented beyond receiving responses to the RFP. However, the bids received in the RFP responses showed that toxicology is a competitive market with a narrow band of pricing among competitors. This is true for both initial testing, and confirmatory testing. No volume discounts were part of any RFP response. Cost savings can be had by utilizing in office instant read urinalysis, and by decreasing the reliance on confirmatory testing. It has been noted that in the history of Project SAFE, tests are positive in about 26-27% of tests on average.

Pricing within bundling is incremental, that is, with each additional substance tested for within a bundled panel, the price per unit increases. This is true for laboratory based testing as well as instant read testing. The advantage of bundling is that it allows for a broad range of substances to be tested for. The disadvantage is that with a larger panel, the tests paid for are often unnecessary. For example, with a 10 substance panel, a few of the substances tested for will be positive very rarely. Expanding the range of substances tested for increase
costs both per unit and overall. The solutions to this problem has been to have a XX panel test of the most common substances and to allow for the requesting of costly extended testing in certain specific situations, approved by specified DCF personnel. This method has increased the cost per unit for specialized testing, as each instance costs more than if the substance tested were part of a bundled rate; yet it decreases overall cost by drastically reducing the frequency of these specialized tests. In certain circumstances, without a medical officer to review the findings, such additional information has decreased the clarity of information derived from test results.
5. **What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?**

The current methodology used in the RSVP program has Recovery Specialists, who are neither DCF employees nor employees of treatment providers, processing urinalysis tests in a structured randomized design. Clients call a number each night to determine if they are required to provide a sample the next morning. Instant read tests are used, costing $4.75 per unit, a savings of $8.75 per unit compared to LabCorp pricing. No administrative fee is paid, an additional savings of $25.00 in comparison with fee paid to providers for administration. When a client receives a positive result that they contend is untrue, they are able to request a GC/MS confirmatory test. There have been no instances of this request since the inception of the RSVP program.

Recovery Specialists act as case managers and as recovery coaches. They are initially trained, and receive ongoing training and supervision in recovery principles. The urine drug testing is framed as a potential advantage in the recovery process of the client, a means to show DCF, and the courts that they are engaging in recovery. Clients discuss their Test results with the Recovery Specialists and the client’s treatment providers as a way to plan for more effective recovery related behavioral choices in the future. The goal of the drug testing in the RSVP program is a way to enhance the recovery process and to increase the client’s ability to make positive choices and to be accountable for their own recovery.
Concept Questions:

Screening, Evaluation and Access to Treatment

8. For those DCF clients that self-identify for treatment through the GAIN-SS or direct report, identify procedures, practices, and policies that would help to strengthen evidentiary support for child welfare practice while enhancing engagement and access into treatment. What might be the advantages or disadvantages of such an approach and what might be done to improve outcomes. What differential practice and policy should be promoted for those clients who are self-motivated and/or self report symptoms to DCF versus those who do not?

A percentage of clients who are administered the GAIN-SS acknowledge substance abuse behavior and/or a desire to engage in treatment. Currently, there is the opportunity for DCF staff to refer these clients to a treatment only referral, not requesting a formal Project SAFE evaluation, though this is rarely done. Providers will administer their own admission/intake assessments, as they are required to do so by licensing, accreditation, and/or other standards of treatment.

It is recommended that a heightened access standard for initial appointments be applied to all Project SAFE referrals that result from a positive GAIN-SS. Getting a client into treatment rapidly (defined as within 72 hours of the GAIN-SS) is consistent with the transtheoretical model of James Prochaska.\(^6\) As this approach suggests, it is important emphasizing the processes of "consciousness raising," "dramatic relief," and "environmental reevaluation"\(^7\) as clients move into the contemplation stage of change. Providers should be contracted with to

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provide ‘rapid access slots’ for such clients, and it should be the policy of DCF that the referring DCF Social Worker provide transportation with the client to this first appointment, thus enhancing the motivation for change, overcoming barriers to care, and the connection between recovery and a positive outcome in the child welfare process.
9. How should evaluation be utilized/structured to support child welfare practice and help to engage adults in treatment while reducing costs and maximizing efficiencies. How can evaluation be most effectively utilized to insure timely access to appropriate levels of care and to strengthen linkages to care. Please describe, in detail, the processes that would need to be developed from time of identification, referral to treatment, entry into care, and continuing service. Be specific regarding the administrative functions that would be required to accurately monitor movement through the system and provide reports to the Departments.

Evaluations of Project SAFE clients are part of several different processes. The evaluation of a client by a treatment provider is intended to assess what level of care is most beneficial for the client and what diagnostic and behavioral information must be considered in the development of a treatment plan. At the same time, the Project SAFE evaluations provide information for the child welfare case, help the caseworker develop a plan for the child welfare case, and provide information for attorneys and judges upon which child welfare cases are adjudicated.

A standardized Project SAFE evaluation should be developed and instituted for all Project SAFE evaluations. From 2003 to 2006, the Project SAFE Comprehensive Evaluation pilot was in place, with the goal of eventually creating a standardized evaluation. Through a committee approach several iterations of an evaluation were created, however none were fully implemented by DCF policy. A standardized evaluation will help all parties develop data standards to interpret the results, and it would help the courts become familiar with standard information on every Project SAFE case that enters court.
The data collected by ABH in Project SAFE, and submitted to the PSDCRS, has been used to monitor access standards, by identifying time from referral to first appointment, and entry into care. This timeframe is not purely dependent on the providers’ practices, as clients often avoid treatment by putting off appointments for a time period or failing to show for an initial appointment. By identifying those clients that are ‘motivated’ (positive GAIN-SS results), and measuring their access to care and connect to care, this can be differentially monitored. As described in a previous response, instituting a heightened access for motivated clients can be monitored and enforced by utilizing current data collection. By combining the collection of data by ABH with the data through the PSDCRS, providers that have effective practice can be identified, and their unique processes can be disseminated among the provider network. In addition, providers that are less effective in providing access, and/or connect to care can be identified and notified of the opportunity for improvement. This information can also be made available to DCF Social Workers so that they can refer clients to more effective providers. Altogether, this system would provide some incentive to providers to improve their practices.

Practice thresholds and key performance indicators can be developed and refined through data analysis, identifying the average percentages of clients referred that access services within a given number of days. Providers that exceed thresholds for an extended period (e.g. greater than 50% of clients evaluated within seven business days for three successive months), could be rewarded by some type of incentive from Project SAFE.
11. Describe a method (e.g. hourly fee-for-service, bundled rate, flat grant with performance incentives for improved engagement/retention, etc.) of reimbursement for evaluation that would increase show rates and incentivize retention in treatment.

Hourly fee-for-service reimbursement methodology has advantages and disadvantages. For providers who are motivated, fee-for-service can increase capture rates for evaluations, while it can also dis-incentivize the acceptance of referrals in populations with a high no-show rate. By providing a no-show fee, an active fee-for-service network can be created. It is possible that DCF could utilize the same type of network credentialing and management that is used currently for court ordered psychological evaluations for Project SAFE evaluators. This will allow for the cultivation of a provider network dedicated to evaluations only, using a standardized Project SAFE evaluation.

Grant funding of network providers allows for the enforcement of standards, and a creative application of incentives for positive performance. In 2005, Project SAFE data was analyzed with regard to the frequency of clients in treatment who receive one session only, two, three, four to seven, and more than seven. The overwhelming majority of clients received only one treatment session in an episode of care, with a descending percentage receiving each additional session. Only a small percentage received more than four sessions in an episode of care. By offering treatment engagement incentives, providers would predictably enhance their efforts at active engagement. Data analysis of clients receiving case management services from Project SAFE Outreach and Engagement case managers has proven that a significant increase in the percentage of clients receiving four or more consecutive treatment
sessions can be achieved. An increase from a baseline of approximately 52% of clients engaging in treatment, to above 80% was consistently demonstrated in O & E cases.
Concept Questions:

Treatment Services and System Design

12. Identify the practices, procedures, policies, and administrative supports that are most likely to maximize engagement in treatment. Outline a potential treatment system that will enhance Project SAFE families and allow for development of recovery supports in the population we serve.

The training and re-fresher training of principles of Motivational Interviewing has been demonstrated in the New Britain Pilot as having a positive impact in maximizing engagement in evaluation and treatment services. When DCF Social Workers, Recovery Case Managers, and treatment providers all receive MI training together, they not only enhance their interviewing practices, but they begin to speak a common language. This consistency of approach helps lead to more positive work in recovery and child welfare outcomes. This training should become a standardized practice for participation in Project SAFE, for DCF staff, treatment providers, and Recovery Case Managers or Specialists.

The standard administration of the GAIN-SS is DCF policy. However, a study of the rates of administration shows that there is a large percentage of cases that do not have a GAIN-SS administration occur. DCF policies and procedures should utilize the data provided through PSDCRS to supervise and enforce this policy. If consistently applied, the GAIN-SS can identify clients that will benefit from enhanced access and active engagement in treatment, thus improving engagement in treatment.
14. How would you design and incorporate a best practice treatment modality for the family? Residential levels of care should not be included in proposed scenarios.

There is very little family therapy provided within Project SAFE. Working with families is more complicated and time consuming than standard individual or substance treatment, and it requires specific training, especially working with families where there is substance use and child welfare concerns. Less than 3% of all claims for treatment services are for family therapy. By providing training and incentivized rates for family therapy, increased family therapy will occur for Project SAFE clients. This would require ongoing training provided by experts in the field, as well as a credentialing standard that is specific for family therapy, with a goal of having trained family therapists provide services in Project SAFE.

A treatment approach that includes a focus on children of substance abusing parents has been developed by SAMHSA and CSAT. The SAMHSA/CSAP Children's Program Kit gives treatment providers and others the benefits of years of research and hands-on experience by NACoA and others in helping COAs and their families. This treatment kit has been suggested as useful in Project SAFE previously, and this recommendation is still worth considering. This program is in use in several states and Native American nations with positive effects for the children and families that participate.
17. What are your recommendations for models that will help clients develop enhance and/or maintain recovery supports within the community?

The case management programs implemented by ABH in combination with Project SAFE have shown great promise in helping clients develop recovery supports, and in the development of community resources. Case management programs work with the clients and families in their communities, utilizing natural support systems that are part of those communities. Schools, community centers, and places of worships are all important resources that clients can better utilized. Case managers often facilitate client participation in other recovery supports including support groups, and AA. Concrete help with housing, employment and education also help clients progress in their recovery and build recovery capital. Finally, the growing trend of community providers attending ‘case rounds’ and/or participating in Managed Service System (MSS) meetings at DCF has enhanced the work with clients, community supports, and the effective connection to community supports.

The opportunity to help CCAR develop recovery centers in other population centers would also help communities develop more recovery supports, and help clients access resources more effectively.
18. How can substance abuse outpatient services under Project SAFE be made more gender responsive?

Over the last five years, DMHAS has led an initiative known as the Women’s Services Practice Improvement Collaborative. Through this initiative, best practices for the delivery of gender responsive treatment have been developed. By inviting Project SAFE providers to be trained in, and implement these best practices, treatment systems can and are becoming more gender responsive.

The WSPIC will be disseminating outcome research results, captured by the data collection of ABH, and analyzed by DMHAS. By applying the knowledge disseminated in this outcome research, the Project SAFE provider network can further enhance gender responsive treatment programming.

By requiring the attendance of Project SAFE providers at gender responsive trainings, both on best practices and outcome research, a gender-sensitive credential ‘rating’ can be developed for providers that have completed a curriculum of training. This certification can be used to help direct referrals in cases which require such treatment.
19. **How can substance abuse outpatient services under Project SAFE be made more trauma responsive and incorporate components of trauma specific treatments?**

DMHAS’ Trauma Initiative has been providing training to providers across Connecticut since 1998. “The primary goal of the Trauma Initiative is to train substance abuse and mental health providers in the treatment of co-occurring post-traumatic stress disorder and other long-term effects of trauma. The purpose of training in this domain of behavioral health is to enhance the capacity of providers to provide treatment.”\(^8\)

By utilizing the same procedures (e.g., ongoing training, dissemination of best practices) and credentialing certification as described above in the discussion of gender sensitive treatment, Project SAFE services will become more trauma responsive, and incorporate components of trauma specific treatments.

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Concept Questions:

Other Service Design Issues

20. How would system communication among all SAFE stakeholders be enhanced?

(DCF regional offices, DMHAS treatment providers, court system)

Multidisciplinary meetings where all participants are encouraged to actively participate, learn from each other, and problem solve leads to better communication and more effective coordination of care and service. Previously, within Project SAFE, there were regional meetings in which providers and DCF staff would meet together and review data, as well as receive training with community service providers. With the recent reorganization of DCF into service regions, it may be time once again to have Quarterly Regional meetings for Project SAFE. In addition, the advent of SAMSS meetings in Middletown, New Britain, Willimantic, and Bridgeport has proven to play an important role in the enhancement of communication.

Another feature that existed in the past was a quarterly Project SAFE newsletter, which celebrated the accomplishments within Project SAFE, and served as a mechanism for notifying DCF staff and providers of policy changes and/or procedural changes. This newsletter was made available to all DCF staff through their website. A web-based newsletter is easily accessed, and can be widely disseminated without substantial cost.

The case management programs provided by ABH within Project SAFE (O & E, RCM, and RSVP) have been a catalyst to communication among DCF, treatment service providers, and
community service organizations. Increasing the geographic scope of case management would have the effect of enhancing communication within the communities served.
24. Can you provide any specific examples of where local or regional Project SAFE processes could be adapted or developed for statewide application?

The New Britain Pilot, RSVP program, and the Middletown Recovery Case Management programs have improved practices and increased engagement in treatment services. The Outreach & Engagement program in New Haven and Hartford had a positive effect on treatment engagement as well.

By regularly bringing providers, DCF staff, Case managers, and community service providers together, families have received increasingly coordinated services and consistent messages regarding the interaction and interdependence of recovery and child welfare processes.

Each of these programs has core aspects which are important ingredients for consideration for statewide expansion:

- Engagement with the client by case managers who are focused on recovery processes and who are independent of the child welfare agency and the treatment system;
- A regularly scheduled meeting with all key stakeholders to develop consistent plans for families, to coordinate and problem solve issues and barriers to effective care and service, to evaluate the outcome of these plans, and to enhance the community service network;
- Shared values and expectations agreed upon by all key stakeholders, and a willingness to ‘share the risk’
26. What would you recommend be offered to enhance the SAFE network and treatment systems statewide? Be specific regarding: a) the training that should be offered b) for what audiences and c) key topic areas to be addressed.

Ongoing trainings in the following areas should be regularly offered to DCF staff, treatment providers, case managers, and community service providers regularly:

- Domestic Violence;
  - Identification
  - Safety Issues
  - Effect upon Children

- Trauma;
  - Its effect
  - Treatment models;
  - Support services involved;

- Child Welfare Processes
  - DCF specific processes
  - Child welfare and the court system

- Substance Abuse and Co-Occurring Disorders;

- Gender Responsive Services

Certain training modules should be geared to the treatment providers, while most of the trainings should be provided to a general audience of all stakeholders. In this way, communication and relationship building is enhanced, and a common language is shared.
Concept Questions:

RSVP Services

27. DCF and DMHAS are interested in developing quality assurance and fidelity measures for the RSVP program. What process would be recommended for developing training, quality assurance and fidelity management protocols to replace this model statewide and to maintain fidelity by minimizing and managing program drift?

By utilizing a single administrative service organization, ABH, who maintains a single database, standardization in policy, procedure and practices can be further developed, implemented and monitored. By adapting from the STAR model in Sacramento, ABH has begun the process of creating manualized policies and procedures for the RSVP pilots, and is utilizing its database to monitor and enforce these procedures.

The development of a fidelity measurement and monitoring system for RSVP is the next step in creating a standardized system. Much like the Treatment Adherence Measures (TAMS) used to monitor adherence in MST, adherence measures can be developed and implemented for RSVP participants. Families participating in RSVP can respond to standard questions about procedures and the quality of services. This data can be used to supervise and monitor model fidelity as the RSVP program grows and develops.
30. What measures of success could be outlined to help DCF measure changes in "recovery capital" among RSVP program participants?

A study of recovery capital among RSVP program participants is an extension of the research of William Cloud and Robert Granfield\textsuperscript{9,10}. Recovery capital refers to three classes of capital, upon which recovery can be built: social, physical and human capital. By collecting baseline data which operationalized recovery capital at the inception of each RSVP case, and by re-measuring recovery capital after set time points (e.g. three months & six months), the effect of RSVP on recovery capital can be evaluated. Preliminary research has begun to operationalize methods for psychometric measurement of recovery capital.\textsuperscript{11} In addition, tying success in recovery (primarily substance abstinence) to recovery capital will assist in refining the practices of RSVP. By investigating what activities each Recovery Specialist engages in that have a higher probability of improving recovery capital and improving outcomes, effective practice patterns can be defined.


Project SAFE Redesign
REQUEST FOR INFORMATION

Responses to the State of Connecticut
Department of Children and Families
& Department of Mental Health and Addiction Services

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CONCEPT QUESTIONS
Respondents may respond to any or all of the concept questions.

Drug Testing

1. DCF and DMHAS are interested in service delivery models, utilization protocols, and technology that accomplish SAFE program objectives while reducing administrative and drug testing costs in child welfare practice. How should drug testing be administered, organized, and structured? What technology can be employed to reduce cost and improve service?

2. What are the practical, financial, and technical benefits and limitations of each type of testing being considered (urine, hair, saliva, patches, and oral swabs)? Base your response on experience, published literature, data, and/or research studies where available.

Response: Please let’s get rid of intrusive hair testing. It is a violation of the dignity of parents.

3. What are the recommended/preferred sample collection, handling, storage, and quality assurance protocols that will ensure high access, reliability, validity and that result are interpreted appropriately?

4. What are the current market laboratory costs: I) by drug panel type (e.g., 5 panels vs. 3 panels); ii) by volume of tests and, iii) by type of tests? What are the current market laboratory costs for confirmation testing? How do bundled and unbundled rates compare and what are the advantages/disadvantages of bundling?

5. What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?

Response: Just see disadvantages. Role clarity is so important, recovery coaches are not there to police or fix problems, and they facilitate recovery by the power of their example. Why jeopardize the future of potential recovery support relationships? Recovery coaches are about non clinical services-this is about promoting recovery, not using that relationship to get DCF’s tests done. Seems like a misuse of the recovery trust relationship. Our lived recovery experience is the skill to be shared and that does not mean serving as DCF’s drug testing police, talking people into stuff etc. Peer relationships become a significant source of support and intimacy with recovery coaching, but there are important boundaries that must be respected.

Peer recovery coaches can help monitor drug use, but tests need to be done by treatment providers. Infractions need to be part of a recovery management plan the coaches work with and support.

Recovery is a lifelong process and recovery coaches are like family, a metaphor for accessibility, respect, interdependence and caring. A place to learn from recovery experience-that is the only authority. Recovery is about so much more than abstinence, how about using other recovery markers and use the coaches to help track those.

6. What recommended standards should be used for chain of custody and what are the market per-test
costs for sample collection? What are the costs per test if dedicated staff and collection sites are implemented? What would be the advantages/disadvantages of a "two-tiered" system (see above) in which high level chain of custody standards are required for child welfare driven testing and lower standards are required for testing in the context of treatment monitoring. How could third party reimbursement of drug testing be maximized?

7. What are the recommended performance measures of drug testing protocols and procedure?

Concept Questions:
Screening, Evaluation and Access to Treatment

8. For those DCF clients that self-identify for treatment through the GAIN-SS or direct report, identify procedures, practices, and policies that would help to strengthen evidentiary support for child welfare practice while enhancing engagement and access into treatment. What might be the advantages or disadvantages of such an approach and what might be done to improve outcomes. What differential practice and policy should be promoted for those clients who are self-motivated and/or self report symptoms to DCF versus those who do not?

Response: Parents who self identify and have a GAIN should not have this used against them. People who are self-motivated and want help should not be punished; recovery is about reunifying and rebuilding lives not taking them apart.

9. How should evaluation be utilized/structured to support child welfare practice and help to engage adults in treatment while reducing costs and maximizing efficiencies. How can evaluation be most effectively utilized to insure timely access to appropriate levels of care and to strengthen linkages to care. Please describe, in detail, the processes that would need to be developed from time of identification, referral to treatment, entry into care, and continuing service. Be specific regarding the administrative functions that would be required to accurately monitor movement through the system and provide reports to the Departments.

10. What standards of practice should be implemented regarding substance abuse evaluations? What is the anticipated fiscal impact of such standards, if any?

11. Describe a method (e.g. hourly fee-for-service, bundled rate, flat grant with performance incentives for improved engagement/retention, etc.) of reimbursement for evaluation that would increase show rates and incentivize retention in treatment.

Concept Questions:
Treatment Services and System Design

12. Identify the practices, procedures, policies, and administrative supports that are most likely to maximize engagement in treatment. Outline a potential treatment system that will enhance Project SAFE families and allow for development of recovery supports in the population we serve.

Response: A treatment system? How about a recovery system instead. There could be several levels of peer relationships and peer intervention that occur, and are possible when considering changes especially in the social and family network. There are complex interrelationships of
parents and peer recovery networks that influence developing recovery supports.

What about peer to peer recovery multifamily group meetings run by families who have been successful with DCF and keeping their children due to sustained recovery helping other families?

13. What best practice treatment modalities will allow for the best treatment outcomes? What are the parameters for proposed treatment programs?

Response: Need to spend some time shifting from a case management model to a true recovery model, and put in the training and structural supports to make it happen. There are biculturally competent treatment and recovery models out there that integrate family traditions and cultural teachings with recovery tracks to support parenting. MIT, outreach and engagement and peer to peer models all work well together.

14. How would you design and incorporate a best practice treatment modality for the family? Residential levels of care should not be included in proposed scenarios.

Response: In the home models are wonderful and multidimensional family therapy is great because it identifies several pathways to recovery changes within multiple systems. The domains linked with the critical challenges and tasks of recovery allows for great treatment and recovery outcomes. Peer relationships in young mom's and dads is very important in building their confidence as parents who are staying sober for their kids.

15. What UM system would enhance treatment provision within Project SAFE? How should Utilization review be conducted? What system should be implemented to determine appropriateness for treatment planning, service intensity and level of care received by the client?

16. Please describe any innovative best practices you are familiar with regarding family-centered approaches with clients who have been identified as having a potential substance use disorder. In addition, what interventions would you suggest or recommend that will help DCF Workers to improve/develop motivational interviewing skills?

Response: DCF needs to increase and expand some of the great pilots they are doing with families, but integrate recovery concepts better.

17. What are your recommendations for models that will help clients develop enhance and/or maintain recovery supports within the community?

Response: There are existing exemplary peer recovery models, CT DCF needs to require traditional providers to formalize agreements with the adult, youth and family recovery communities to help them provide authentic services and share reimbursement dollars for these models. Peer to peer recovery coaching, help from other families/people who live there and have been there themselves works. For example-employment, housing sober-family fun activities, and recovery coping skill building activities exist and are organized but providers don't usually know about them. We need to get rid of the isolation and stigma so parents can discuss issues safely and engage with parents who have been successful.
18. How can substance abuse outpatient services under Project SAFE be made more gender responsive?

Response: Aligning with gender (specific) serving recovery agencies better would help. We need gender specific recovery support groups for parents. Just as gender differences are evident in drug use, so to exist different needs and patterns in recovery. Many of our young parents have considerable environmental sexual trauma and stress during their lifetimes with family members, school, victims of crimes and violence, etc. It is helpful to have a peer coach who has worked through and learned about traumatic life experiences. Do Project Safe’s outpatient and recovery support services support self examination regarding gender specific pain, and do they have referral networks to respond to those needs that impact recovery?

Family dynamics are important in working with LGBT families who especially need increased acceptance and understanding. There have been past complaints from families about unfounded DCF caseworker and Project Safe provider misconceptions about parenting roles. Staff needs to be aware of how to help with referrals to LGBT health and S/A/mental health recovery support networks instead of keeping the cases to themselves in order for reimbursement.

19. How can substance abuse outpatient services under Project SAFE are made more trauma responsive and incorporate components of trauma specific treatments?

Response: More training, more trauma groups. How current is provider trauma training and how do they use it? Trauma informed staff training and that means also matching trauma victims with trauma experts. DCF workers must get help with training and policy changes so they do not add to client’s trauma!

Concept Questions:
Other Service Design Issues

20. How would system communication among all SAFE stakeholders be enhanced? (DCF regional offices, DMHAS treatment providers, court system)

Response: DCF and Project Safe stakeholders need training by youth and families in long-term recovery and what peer to peer is all about to really support its integration operationally.

21. In what ways could the current SAFE system best be evaluated to meet the needs of families and to help sustain recovery?

Response: Family involvement in the design and implementation of evaluation method needs to be central. Is there a functional recovery home environment that will support continued sobriety and safe parenting?

Have you gone back and tracked/surveyed the parents later and tracked if they have sustained recovery? Have you done telephone recovery support?

22. How could data analysis be performed to reduce program costs, create benchmark reporting and report quality?

23. What specific Quality Management Plans should be in place with providers? This should include
specific methods of client engagement and retention and plans for client-centered, gender-specific, trauma-informed and culturally competent programming. (Please provide examples)

24. Can you provide any specific examples of where local or regional Project SAFE processes could be adapted or developed for statewide application?

Response: CTYF call center could link with Project Safe and share referrals, link website etc...

25. What specific steps would be recommended to improve collaboration and communication at the local services level, statewide level and in policy?

Response: More Memorandums of Understandings (MOU) for more service partnerships that include nontraditional recovery supports.

26. What would you recommend be offered to enhance the SAFE network and treatment systems statewide? Be specific regarding: a) the training that should be offered b) for what audiences and c) key topic areas to be addressed.

Response: Natural nontraditional recovery support services need to be reimbursed and exist in the community, more recovery coaches for parents so parents can see other parents making it and see the possibilities. Peer recovery coaches who are real, not recycled case managers who are not in recovery or age appropriate to be culturally matched with the clients. The Project Safe network needs more recovery support services that are actually reimbursed and have relationships with local outpatient providers. The network needs recovery oriented clinicians who really get family recovery and like family involvement.

Concept Questions:
RSVP Services

27. DCF and DMHAS are interested in developing quality assurance and fidelity measures for the RSVP program. What process would be recommended for developing training, quality assurance and fidelity management protocols to replace this model statewide and to maintain fidelity by minimizing and managing program drift?

Response: Need more information about RSVP data, etc.

28. What organizational, management, and supervision structures would be both cost-effective and ensure fidelity of statewide dissemination of the RSVP program? What should the relationship be between the RSVP program and the treatment system?

Response: Recovery coaches are a bridge between the treatment and recovery communities. Recovery coach training and supervision needs to be provided by someone who themselves has years of sustained recovery, and can work effectively with state and provider systems regardless of where they are staff.
29. DCF and DMHAS estimate that Recovery Specialists spend on average XX hours per week with each RSVP client conducting intensive case management activities. What should be the credentials, background and caseloads for each Recovery Specialist? What is the estimated cost per Recovery Specialist?

Response: The credentials for a recovery specialist should include long term sustained recovery, or they are really just case managers with a new name. Do they know about family recovery and how to be effective advocates working across the substance abuse and child custody systems? Do they know the recovery community in their geographic area first hand?

30. What measures of success could be outlined to help DCF measure changes in "recovery capital" among RSVP program participants?

Response: Recovery capital can be measured in individuals, families and in the community. Some ideas:

1. Increase in AOD refusal and coping skills
2. Increase in communication skills
3. Establishment of a sober network in the community
4. Increase in school, work etc, functioning
5. Establishment of a recovery management/relapse prevention plan
6. Decrease in number of dirty urines/positive drug tests
7. Successful interruption in home conflicts
8. Improvement in family functioning, management, communication
9. Improvement in parenting skills
10. Progress in recovery change goals, involvement in recovery community sober activities/peer groups
11. Increase in "giving back" helping others new in the recovery process, providing service and leadership in community sober activities.
SAFE RFI RESPONSE

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Drug Testing

1. **How should drug testing be administered, organized and structured?**

   Drug testing for evidence in child protection court hearings which includes a secure chain of custody and has a high validity rate is essential. The key components that must be considered for drug testing for court purposes are: The testing must be timely to avoid delays in court proceedings and accurate so as to avoid challenges to both the technology used and the results reported in actual court proceedings. Under the current model, individuals required to submit to testing may avoid or manipulate testing to gain results more favorable to them. Testing should screen for both drugs and alcohol, including abuse of prescription drugs. DCF and DHMAS should consider a model that uses existing and emerging methods, such as swab tests and by using breathalyzers, which are observed, truly randomized and reported directly by the individual/organization administering the test. Testing protocols should be established that include whether there is any evidence (either through the GAIN-SS, self-reporting, or other collateral evidence) that an individual warrants drug testing or treatment. Testing should not be done on a routine basis as a “rule out” in every case. Using drug testing in this way exacerbates the adversarial nature of court proceedings and can cause delays in cases in court. When initial testing shows evidence of substance abuse, the randomized testing should be tied to the individual’s progress in treatment, and other recovery factors should be considered and articulated. Testing done by other than an individual’s substance abuse treatment provider should be considered.

   Within the limitation of protections under federal and state law, the frequency of communication of results should be expanded. This is especially critical in cases where the court has ordered “Specific Steps” that include drug testing; as results of both positive and negative drug screens have a significant impact on the outcome of cases and permanency for children. It
is essential that DCF case workers and others have a clear understanding of any established protocols, including how to accurately read and interpret test results.

5. **What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare?**

   The use of Recovery Coaches to oversee the administration of drug testing has several advantages based on observation of their current use in the RSVP program:
   
   - The Recovery Coaches are able to establish an early relationship with their client and with service providers, the court, attorneys and DCF. This relationship enhances ongoing communication and adds credibility to the testing process;
   - Recovery Coaches who receive training and ongoing supervision diminish the likelihood that testing will be administered and interpreted inaccurately;
   - Use of Recovery Coaches makes it possible to perform truly randomized testing;
   - Reporting of test results is timely and appropriate.

   **How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?**

   DCF and DHMAS should consider designing a recovery coach model similar to the Recovery Specialist in RSVP. Recovery Coaches should be tied to the umbrella service provider organization and not to community based treatment providers. However, program guidelines should clearly articulate the role of the Recovery Coach, confidentiality considerations and degree to which information will be shared with others, i.e. DCF case workers, court, and individual’s attorneys. Considerations should be given to use of the recovery coaches in court involved cases where children have not been removed and in non-court involved cases as a prevention strategy to avoid the need to remove children from their homes.
12. Identify the practices, procedures, policies and administrative support that are most likely to maximize engagement in treatment?

Cross system collaboration and communication is essential on a systemic level and can provide needed support and information for agencies and providers. The expansion of the local Substance Abuse Managed Services System (SAMSS) model; which is a joint meeting between DCF, DHMAS and service providers is an effective tool that enhances engagement in treatment.

Early access to appropriate levels of care increases the likelihood that an individual will invest in treatment and be successful. Using a “one stop shopping” approach to assessment for levels of care and provision of services can avoid delays in access to services and can potentially improve case outcomes for court involved children. An electronic referral process should be considered.

Under the current system individuals must navigate multiple delivery systems, especially if they are court involved. Treatment models which are in the community that include provision of other services in addition to substance abuse treatment should be considered. Models that include housing support, education and employment and access to other services such as, medical treatment, domestic violence services, parenting education, child care and transportation etc… should be explored. Natural supports should be identified early and engaged in the treatment and recovery process.

Under current state and federal law, there are significant limitations on the amount of time a parent has to engage in treatment and recovery services. DCF treatment plans should be fully cognizant of these considerations. Child welfare practice should incorporate full disclosure
of the Adoption and Safe Families (ASFA) time frames and in court involved cases, the requirement for filing and court oversight responsibilities for permanency plans.

   Recommended “Specific Steps” which are reviewed and ordered by the court, should articulate not only the services a parent must engage in but also the behavioral aspects and benchmarks expected so as to enable the court to make timely and informed “Reasonable Efforts” findings.

14. **How would you design and incorporate a best practice treatment modality for the family?**

   Currently, substance abuse services for the family are dependent on what area of the state in which a family resides. Issues of availability and access (transportation) often limit a family’s access to treatment. Efforts should be made to make services such as “Intensive Safety Planning” and in home “Family Based Recovery” available regardless of where a family resides. Rather than a linear approach to service provision, planning should center on the entire family’s needs, especially the child’s needs for safety and permanency, as opposed to identifying an individual parent’s treatment needs outside the context of the family. When a family is court involved, the recommended “Specific Steps” should be drafted with specificity as to the programs, providers and treatment goals for the parent who is subject of the treatment.

   The US Department of Health and Human Services, Children’s Bureau recently released a new publication in its User Manual Series about children in substance abusing families which may be informative to the authors of this RFI. It may be found at:

   [www.childwelfare.gov/pubs/usermanuals/substanceuse](http://www.childwelfare.gov/pubs/usermanuals/substanceuse)

   Substance Abuse Treatment providers need to have a better understanding of the child welfare and court system and how substance abuse affects children in drug involved homes.
Training and performance outcomes for these providers should emphasize their ability to engage families in the treatment process.

16. Please describe any innovative best practices you are familiar with regarding family centered approaches with clients who have been identified as having a potential substance abuse disorder.

In the Differential Response System initiative at DCF, the use of Family Team Meetings is being explored. Consideration should be given to this methodology for out of home protective services cases as well. See references at the American Humane Association website at:

http://www.americanhumane.org/protecting-children/programs/family-group-decision-making/

Section 17a-110a of the Connecticut General Status specifies the duties of DCF with regard to use of concurrent permanency planning. While the statutory authority exists, in practice, concurrent permanency planning does not occur. It would be especially helpful to use concurrent permanency planning with substance abusing parents for whom reunification with their children is not possible in a timely manner.

Other Service Design Issues

20. How would system communication among all SAFE stakeholders be enhanced?

Within the rubric of judicial independence and separations of power and authority between branches of government, there is room for enhanced communication between the various system stakeholders involved with Project SAFE. Regular and ongoing communication between DCF, DHMAS and the Judicial Branch and other members of the legal community on non-case specific issues should be encouraged. This can be effectuated through statewide and local meetings, cross system trainings and communications. An articulated, standardized mechanism for problem solving between agencies and the court should be established. A single
point of contact person, for example, the DCF substance abuse consultant and the court services officer, to communicate about case related issues or utilization problems might reduce delays in cases.

Updated/regular information about substance abuse treatment service availability and capacity in each service area would be helpful to clients and their attorneys as well as the court. On a systemic level, data sharing and joint reporting of outcomes should be used to both inform practice and identify trends and gaps in services.

24. **Can you provide specific examples of where local or regional Project SAFE processes could be adapted or developed for statewide application?**

Under the RSVP model, the Substance Abuse Managed Service System Meetings (SAMSS) has proven to be a vital component of the RSVP program. The model should be further examined and considered for replication statewide.

26. **What would you recommend be offered to enhance the SAFE network and treatment systems statewide? Be specific about: a) the training that should be offered b) for what audience and c) key topic areas to be addressed.**

Based on the experience with implementation of the RSVP pilot programs, systemic and local training is needed. There is a lack of understanding of both the child welfare system and the substance abuse treatment delivery system. Both systems can benefit from cross training as well as individualized training.

For court personnel, agency attorneys and lawyers who represent parents and children the following training topics should be considered:

- Understanding substance abuse and recovery;
- Methods and use of drug testing, including current standards for validity;
- Types of assessment and treatment services and where they are available;
State and federal statutes, case law and practice book rules pertaining to confidentiality and communication related to substance abuse treatment information;

- Co-occurring disorders and treatment models for intervention;
- Domestic violence and substance abuse;
- Permanency planning with substance abusing parents.

**RSVP Services**

27. **DCF and DHMAS are interested in developing quality assurance and fidelity measures for the RSVP program. What process would be recommended for developing training, quality assurance and fidelity management protocols to replace this model statewide and to maintain fidelity by minimizing and managing program drift?**

   As a first step in developing quality assurance and fidelity measures for the RSVP program, the agencies and the court should enter into a memorandum of understanding that clearly articulates the goals and proposed outcomes of the program and the commitment on the part of each agency to adhere to established protocols and practices. It should further address interagency training of staff, agency liaison and coordination and a process for resolving interagency conflicts.

   A shared logic model should be developed with input from all system stakeholders. The logic model should include short term and long term outcomes and assign responsibility for monitoring outcomes through a sharing of data.

   Standardization of program guidelines, protocol and forms following completion of the pilot programs would enhance consistency across sites. Use and replication of the Judicial Branch “Standing Order” can ensure adherence to procedures across courts. In considering the fidelity of any model that involves the court, one must consider that each Presiding Judge in
Juvenile Matters locations has the authority to set local “rules” specific to their court. Considerations should be given to discussing program parameters with each presiding judge.

28. What organizational, management, and supervision structures would be both cost-effective and ensure fidelity of statewide dissemination of the RSVP program? What should be the relationship between the RSVP program and the treatment system?

The current method for organization, management and supervision of the RSVP program whereby the Recovery Specialists are employees of an organization, which also has responsibility for the overall management of the Project SAFE network, but maintains the RSVP Program independent from a specific treatment provider organizations appears to be most desirable. From the perspective of the RSVP program, having the Recovery Specialist separate from DCF or DHMAS has increased the program’s autonomy and enhanced the client relationship building capabilities and added a level of integrity for clients, their attorneys and the court. If financial resources were to permit expansion of the program, it should be expanded to those parents who are court involved but have not had their children removed from their care, i.e. parents with pending child protection petitions or those with children under court ordered protective supervision.

Having one organization with oversight responsibility for the treatment system and the Recovery Specialists has enhanced prompt client access to treatment; where in the past parents who have had their children removed by court order have had to wait weeks for an appointment which results in delays in cases.

The RSVP program should be kept separate from the treatment system, but it should be incumbent upon both systems to have a collaborative relationship. DCF and DHMAS should
consider contract specifications with both RSVP and the treatment providers that require cooperation and responsiveness, especially as it relates to communication and access to treatment.

Supervision of the Recovery Specialist by an organization or individual with extensive knowledge of both substance abuse and recovery and the child welfare system is essential.

30. **What measures of success could be outlined to help DCF measure changes in “recovery capitol” among RSVP program participants?**

Given that the current focus of RSVP on court involved parents who have had their children removed because of substance abuse; the definition of “recovery capitol” should include elements that measure capacity for parenting. Some examples may include: Stable housing, recovery support, relapse prevention strategies, economic stability, elimination of behavior that would result in arrest and/or incarceration, ability to parent on a day to day basis, and by minimizing or eliminating foster care reentry or instability in a child’s placement, education and physical and emotional health.
**Cover Page**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Nic Scibelli, LCSW</th>
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<tbody>
<tr>
<td>Affiliation:</td>
<td>Provider</td>
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<tr>
<td>Agency Name:</td>
<td>Wheeler Clinic, Inc</td>
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Concept Questions: Screening, Evaluation and Access to Treatment

10. What standards of practice should be implemented regarding substance abuse evaluations? What is the anticipated fiscal impact of such standards, if any?

All clients would benefit greatly from a comprehensive integrated evaluation prior to placement in treatment. The integrated evaluation should include an assessment of mental health, gambling, violence issues, trauma histories, and educational/vocational information in addition to substance abuse histories. The evaluation should utilize the CAGE-AID (Brown&Rounds, 1995) and the Modified Mini Screen (Sheehan, et al), standardized tools whose use is currently being supported by both DMHAS and CSSD. Project Safe evaluations should be capable of properly screening clients for co-occurring disorders and follow best practices in assessment that are currently being utilized by other state agencies. By broadening the assessment scope, a truer more clinically accurate picture of the client can be captured providing for better treatment recommendations and ultimately better outcomes.

The evaluation should also utilize the Paulhus Deception Scale (PDS: Paulhus, 1998). This scale is useful for identifying individuals who have distorted responses and provides an indication that an individual may desire to appear more socially and morally favorable to others. The PDS when administered concurrently with other instruments is useful in identifying individuals who distort their responses and can be helpful to understand the accuracy of the client’s self-reporting. This is particularly important in child welfare evaluations. In addition, all clinicians should be trained in Motivational Interviewing. Utilization of these skills from the
point of initial assessment by both the DCF worker and the Project Safe clinician would lead to better service planning and engagement.

Implementation of these recommendations would require additional staff time and resources and also require a substantially higher reimbursement.

11. Describe a method (e.g., hourly fee-for-service, bundled rate, flat grant with performance incentives for improved engagement/retention, etc.) of reimbursement for evaluation that would increase show rates and incentivize retention in treatment.

Wheeler Clinic recommends a flat grant with performance incentives for client attendance, improved engagement/retention for Project SAFE providers. The flat grant would allow providers to support staffing positions dedicated to specific functions and would allow for consistency in service delivery. The dedicated staff would have more specialized training to prepare them to best understand child welfare issues and accountability. All staff would also be trained in motivational interviewing to help increase engagement and retention. Wheeler Clinic has had success maintaining clients once they attend their intake evaluation using motivational interviewing techniques.

If FFS rates are considered a thorough rate setting review needs to occur. At their current level (60-70 percent of Enhanced Care Clinic Medicaid) they do not provide adequate reimbursement and may very well jeopardize sustainability of services for many providers.
Concept Questions: Treatment Services and System Design

13. What best practice treatment modalities will allow for the best treatment outcomes?

What are the parameters for proposed treatment programs?

Motivational Interviewing and Motivational Enhancement Therapy skills and tools enhance client motivation and prepare clients for recovery services. Motivational interviewing incorporates a variety of strategies to create a positive atmosphere that is conducive to change and increases the client’s intrinsic motivation. Effective use of motivational interviewing will help identify the client’s position within the Transtheoretical Model stages of change. When motivational interviewing is done well it is the client, not the clinician who gives voice to concerns and intentions to change. The Motivational Interviewing approach is used to enhance and support the client’s level of motivation and to assist the client in moving through the change process. Clients who are resistant to programming benefit from Motivational Enhancement Therapy (MET) in individual sessions prior to attending group services. Clients should be matched to a specific intervention based on their stage of change:

- For many clients we would recommend the recovery model *Group Treatment for Substance Abuse, Stages of Change (SOC)* developed by Mary Valasquez, Gayln Maurer, Cathy Crouch and Carlo DiClemente. The 29-session curriculum can be provided in one group, in two groups (SOCl and SOClII) or as individual modules.

- For clients who have progressed through Pre-contemplation or contemplation, we would recommend the use of *Treating Alcohol Dependence/Addictive Disorders (TAD/D)*. TAD/D is a cognitive–behavioral treatment model whose curriculum was developed...
using research funded by the National Institute for Alcohol Abuse and Alcoholism (NIAAA).

- For clients with co-occurring disorders, we recommend using the *Co-Occurring Disorders Treatment group* (Louis De La Parte Florida Mental Health Institute of South Florida, 2000) as recommended by DMHAS.

- For clients who are experiencing trauma and substance abuse should be offered specialized trauma groups such as the *Trauma Adaptive Recovery Group Education and Therapy (TARGET)* developed by Julian Ford, Ph.D., Karen Mahoney, MA and Eileen Russo or *Seeking Safety*, a gender responsive and trauma informed group for women.

We also recommend the use of the *Working Alliance Inventory – Short Version (WAI-SV)* with all clients in treatment services. Client responses on the WAI-SV allow for open discussion between the client and the clinician on their working relationship. The goal is to openly discuss the therapeutic alliance, its strength at the time of assessment and how it can be improved to better treatment outcomes.

15. **What UM system would enhance treatment provision within Project SAFE? How should utilization review be conducted? What system should be implemented to determine appropriateness for treatment planning, service intensity and level of care received by the client?**

Currently Project SAFE includes a quantitative utilization review examining the number of clients served, services delivered. Project SAFE would benefit greatly from a Utilization Management (UM) system that looked at both quantitative and qualitative measures. Qualitative
measures would include treatment plan content, appropriateness of axis two diagnoses, and evidence that the treatment plan is addressed in treatment sessions. Whenever possible, a standardized tool should be used to determine the client’s progress, such as the OQ-30.1 or the Basis 32. Given at regular intervals and along with the PDS, these tools could be used as a way to inform treatment planning, service intensity and treatment outcome. Since administration of these instruments requires additional clinician time and actual expense of the instrument, they would need to be reimbursable activities in order to be sustainable.

Service coordination and routine, effective communications between the DCF protective service worker and the assessment or treatment provider is critical and supports client engagement and retention. Clear protocols for effective communications should be designed with an emphasis on joint planning to support the client’s meaningful use of service and recovery.

17. **What are your recommendations for models that will help clients develop, enhance and/or maintain recovery supports within the community?**

The establishment and growth of community recovery centers would help Project SAFE clients develop, enhance and/or maintain recovery supports within their communities. Recovery centers are currently located in Windham, New London, Bridgeport, and Hartford. Recovery centers offer supports to community members including peer-to-peer support, telephone recovery support, educational programming, access to sober housing and recovery friendly employment databases, volunteer opportunities, and social activities for individuals to assist in their recovery. New Britain, Waterbury and New Haven Project Safe clients would benefit tremendously from a
recovery center located in their community that are designed to address family needs and are sensitive to individuals that are actively parenting. In addition, the supportive housing program provides the housing and case management supports that allow families to stay together. Resources for these services should be available in a timely manner.

18. **How can substance abuse outpatient services under Project SAFE be made more gender responsive?**

The need for separate gender responsive services is critical. Wheeler Clinic is a leader in providing gender responsive services for women including women who have experienced trauma, exploitation and poverty; women who lack education and job skills, and women with substance abuse, mental health and co-occurring issues. The clinic recognizes the efficacy of gender responsive treatment and has developed a continuum of gender responsive services that are relational and trauma-informed to meet the needs of special populations. Several areas where gender specific programming is particularly important include trauma, chemical dependency, mental health and anger management services.

Gender responsive programming is successful when:

- Staff are trained in gender responsivity to deal with a wide variety of issues
- Services are separate from services for males
- Services take place in a gender-specific room designed for group comfort, safety, and to encourage sharing among group participants
- Models are evidence-based and trauma-informed
- Services employ a strength-based approach, relational interaction style, skill-building and an emphasis on self-efficacy
- All women are provided case management services
- Women with children are provided childcare and are assisted with finding a consistent childcare provider

Wheeler Clinic’s LifeLine program, a gender responsive program for women with substance abuse histories, has been successful in offering childcare and transportation to and from services for women living in New Britain. These services reduce the barriers that may get in the way of treatment and allow women to focus on their recovery.

Providers should demonstrate a high degree of competency as gender responsive providers in order to participate in the Project Safe network. DCF might consider utilizing fewer project safe providers within a defined geographic area in order to guarantee the highest quality service or consider networks that can demonstrate these competencies through competitive bidding. Protocols for communications with child protection, local area and regional DCF staff can better managed through direct coordination with fewer providers that are staffed to meet the demand for services.

Finally, Project Safe grant funding or FFS should include reimbursement for the costs of providing case management, childcare and transportation in order to be more gender responsive.
Concept Questions: Other Service Design Issues

24. Can you provide any specific examples of where local or regional Project SAFE processes could be adapted or developed for statewide application?

The Service Area Management System (SAMS) could be expanded to each area office. This would provide an opportunity for a few number of highly developed project Safe providers to come together weekly with their local areas to review Project SAFE cases and ensure accountability and appropriate service linkage and delivery. A flat grant to fewer providers that includes all aspects of service provision, administrative, utilization review and quality management would better fund the range of services required to delivery a quality product and program to consumers DCF and DMHAS.

Concept Questions: RSVP Services

27. DCF and DMHAS are interested in developing quality assurance and fidelity measures for the RSVP program. What process would be recommended for developing training, quality assurance and fidelity management protocols to replace this model statewide and to maintain fidelity by minimizing and managing program drift?

Statewide all providers must be trained in the model to maintain model fidelity and a streamlined approach. One way to do this would be to require all recovery specialists to complete Connecticut Community for Addiction Recovery’s (CCAR) recovery coach academy.
28. What organizational, management, and supervision structures would be both cost-effective and ensure fidelity of statewide dissemination of the RSVP program? What should the relationship be between the RSVP program and the treatment system?

The case manager positions would be more efficiently placed within the treatment programs than separate. Currently there are three different systems involved with each client: DCF, ABH and the treatment system. As previously mentioned, simplifying the system design will eliminate some of the complexity and provide more resource for direct care.

29. DCF and DMHAS estimate that Recovery Specialists spend on average XX hours per week with each RSVP client conducting intensive case management activities. What should be the credentials, background and caseloads for each Recovery Specialist? What is the estimated cost per Recovery Specialist?

Ideally all recovery specialists would go through CCAR recovery coach academy. Individuals who complete the recovery coach academy’s 40-hour training program become Certified Recovery Coaches. The Recovery Coach Academy trains individuals to promote recovery by removing barriers and obstacles to recovery and serving as personal guides and mentors for people seeking or in recovery. Caseloads should be consistent with the position expectations. Since a significant amount of outreach and client interaction is necessary, caseloads should never go above 25 clients per FTE. Recovery specialists should be reimbursed at a rate consistent with that of a case manager, $39,000 - $41,000 per year with higher salaries available for linguistic competencies. We suggest an allotment of $66,000 per position to include benefit and administrative expense.
Name of Respondent: Marie Mormile-Mehler

Affiliation: Provider – Local Mental Health Authority

Agency Name: Community Mental Health Affiliates, Inc.

Agency Address: 29 Russell Street, New Britain, CT 06052

Respondent’s Phone Number: (860) 826-4985, ext 237

Respondent’s Email Address: mmormile@cmhacc.org

Concept Questions: Drug Testing

1. DCF and DMHAS are interested in service delivery models, utilization protocols and technology that accomplish SAFE program objectives while reducing administrative and drug testing costs in child welfare practice. How should drug testing be administered, organized and structured? What technology can be employed to reduce cost and improve service?

   While we have not researched actual cost and technology, we would like to endorse the concepts included by the Department in the RFI. The drug testing technology should be selected based on the reason for the testing. In cases where the purpose is primarily therapeutic, less expensive testing can be utilized. In cases where there is a mandated forensic rationale for testing, the more elaborate and expensive testing protocols could be routinely used.

5. What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?
The most fundamental role of the Recovery Coach is to help the client develop the motivation and supports necessary to be successfully engaged in recovery. The Recovery Coach will take on many roles from the client’s perspective. From the first efforts to engage the client in ongoing supportive counseling and case management, the Recovery Coach should become an integral part of a client’s daily life. For this relationship to be effective, trust must be one of its cornerstones. The trust implicit in this relationship becomes both the argument for and against the use of the Recovery Coach as the overseer of drug testing administration.

On the positive side, the Recovery Coach should have a good relationship with the client to maximize likelihood of client recovery. The Recovery Coach should not be seen as a threat to the client and the client’s family, but rather, as a supportive resource. To be effective, the Recovery Coach should be available to the client several times a week and be willing to maintain a relationship with client for at least a year after sobriety, according to the client’s wishes. As the Recovery Coach is an integral member of the client’s recovery team, it is feasible to utilize him/her to oversee drug testing. This is especially possible if the drug testing is being conducted within the context of a contingency management treatment approach and the results of the drug testing are being utilized more for clinical purposes (positive reinforcements for clean urines, charting of success for client to see number of days sober) than for punitive or threatening outcomes (e.g. removal of children).

On the negative side, there is the reality of the triangular relationship that brings most clients and families into the care of a Recovery Coach. The referral is most often made by DCF when at least one parent/guardian is suspected or confirmed of
having a substance use issue that significantly impacts his/her parenting abilities.

While there is not a great deal of empirical data, there is some literature that supports using a third party to collect the drug sample if the sample is needed for court or child protection proceedings (Wood, Mattick, Burns & Shakeshaft, 2006). For the Recovery Coach, having a third party administer the drug testing leaves the relationship with the client truly unencumbered. The reality, however, may be that the Recovery Coach and the client gain a false sense of the full dynamics of their relationship. As a mandated reporter, the Recovery Coach is responsible for reporting any concerning behavior on the part of a parent or guardian where the child may be at risk. Thus, the Recovery Coach would need to file a 136 report concerning a parent’s ongoing or binge use of substances, particularly if they lead to compromising or neglectful parenting.

There are several key factors to consider when designing a program that utilizes Recovery Coaches. The most important factor is that no one person (Recovery Coach) or entity (DCF, private provider, etc.), in isolation, will be likely to succeed in engaging and motivating a client to become sober, increasing his/her recovery capital, and maintaining his/her commitment to recovery. It should be a team effort with the client in the lead. It will also take a significant amount of communication and collaboration among numerous systems that focus on the best interest of the client and his/her children. Thus, to be effective, the Recovery Coach should not be beholden to one agency or system. In other words, the needs of the client vs. the needs of the agency which employs the Recovery Coach should come first in selecting treatment programs that are appropriate for the client.
The second key factor is that the Recovery Coach needs to assume two roles (case manager, supportive counselor) but also needs to understand the limitations and boundaries of his/her roles. This will be where the communication with other system partners becomes vital. Weekly meetings such as the Substance Abuse Managed Service System meetings in New Britain are a good venue for partners (DCF, DMHAS, RSVP, ABH, Community Providers) to communicate and to establish roles and responsibilities. These meetings allow for more insightful suggestions for client care and offer new solutions for clients with complicated clinical presentations, limited supports and/or multiple obstacles to recovery.

Concept Questions: Screening, Evaluation and Access to Treatment

8. For those DCF clients that self-identify for treatment through the GAIN-SS or direct report, identify procedures, practices and policies that would help to strengthen evidentiary support for child welfare practice while enhancing engagement and access to treatment? What might be the advantages or disadvantages of such an approach and what might be done to improve outcomes? What differential practice and policy should be promoted for those clients who are self motivated and/or self report symptoms to DCF vs. those who do not?

SAMHSA and DMHAS have identified Integrated Dual Diagnosis Treatment (IDDT) as an evidence-based practice in working with clients who have mental health and substance abuse issues. IDDT’s effectiveness stems, in part, from its use of clinical tools to screen clients for pre-existing mental health and substance abuse issues. The model also requires that the clinician assess the client to determine his/her Stage of Change i.e., Pre-contemplation, Contemplation, Preparation, Action or Maintenance. By using motivational interviewing approaches and a non-judgmental stance, the IDDT
model tailors the treatment according to the client’s readiness for change and Stage of Change.

DCF might consider adopting such a framework for assessing risk and corresponding DCF case action, as parental mental health and substance abuse issues may impact the child’s safety differently, depending on the parent’s Stage of Change. For example, a client in the Action Stage may have identified the consequences of substance/alcohol abuse and be willing to start or become actively engaged in treatment. Since the parent is in the Stage of Action, he/she may try to minimize the impact of his/her substance use on his/her children (e.g., using when the children are not home, using out of the home etc.). In these situations, risk to the children may be lower, and DCF can more readily identify the potential for family reunification/preservation and provide appropriate supports so that the family remains intact/is reunified.

Alternatively, a parent who is in the Pre-contemplative Stage of Change may minimize, rationalize or deny the impact of drugs and alcohol on their children. DCF’s response in this case may be different than in the case of the client who is actively working to make changes to their substance/alcohol abuse. In general, the risk to the children would be greater in the Pre-Contemplative parent as he/she may be using substances in the home or having others who are doing so in the home. DCF work with parents in the Pre-Contemplative stage may involve more immediate concurrent planning during which the parent may receive support/programming to help him/her move to the Action Stage, as well as steps to develop alternative placement(s) for the child(ren) should the parent remain abusing substances.
Working with clients using a Stage of Change approach may be a useful framework for DCF intervention, as it would allow workers to assess risk based on the parent’s Stage of Change and to make treatment recommendations accordingly. Recognizing and working with the client’s state of motivation for change produces better outcomes for client recovery. It also is an approach that realizes risk to children may vary based on the client’s stage of recovery.

The Stage of Change framework also has implications for practice differences in alcohol and substance abuse testing. For example, those clients who self-report substance abuse may be tested less frequently than those who are in the pre-contemplative stages. Varying the frequency of testing according to client stage of change may help reduce testing expenses.

9. How should evaluation be utilized/structured to support child welfare practice and help to engage adults in treatment while reducing costs and maximizing efficiencies? How can evaluation be most effectively utilized to insure timely access to appropriate levels of care and to strengthen linkages to care. Please describe in detail the processes that would need to be developed from time of identification, referral to treatment, entry into care, and continuing service. Be specific regarding the administrative functions that would be required to accurately monitor movement through the system and provide reports to the Departments.

Research indicates that there is a high co-morbidity of anxiety, depression, bi-polar disorder and trauma disorders in clients who have an alcohol or substance dependence issue. Thus, client evaluations should include a comprehensive, integrated assessment of substance abuse and mental health issues.

Agencies that have co-occurring treatment capability and serve adults, children and families across the lifespan and offer multiple levels of care (outpatient, psychiatric, intensive outpatient, residential rehabilitation and in-home treatment) as well as child-
care, transportation, case management, Intensive Family Preservation/Reunification and Intensive Safety Planning) would be ideal for serving clients and families within one integrated system. Smaller agencies will require good linkages to the continuum of other treatment providers and coordinated, facilitated client access to different services. In addition, the ability of agencies to have affiliations/collaborations with primary care physicians would also enhance the coordination and quality of care.

The ability of a multi-service agency to treat both the client and their family “under one roof” has been shown to produce the best client outcomes. In addition, multi-service agencies can more readily track and report on evidence based interventions, incidents and client outcomes for the clients and families in treatment. Utilizing large multi-service agencies offering continuums of care may reduce expenses to DCF and produce better client results.

SAMHSA has developed “Core Consensus Principles for Reform from the Mental Health and Substance Abuse Community” which were presented on 05/26/09. The following Core Principles have particular relevance to this discussion.

a) “Core Principle 3: Achieve Improved Health and Long-Term Fiscal Sustainability”

Successfully coordinated and integrated prevention, treatment and recovery services would not only improve outcomes for people with mental and substance use disorders, but would also reduce costs nationwide. There is a substantial body of evidence to demonstrate that providing adequate levels of mental and substance use disorder prevention and treatment services, as well as integrating these services with primary health care, can: 1) cut and/or control the growth of overall health care costs; 2)
lower the rate, duration, and intensity of disability of many related illnesses; 3) improve productivity; and 4) control the size and growth of other social costs. By including information about preventing as well as detecting mental and substance use disorders in primary health care, institutional, and community settings, we can: 1) provide early, low-cost treatment, thereby avoiding use of expensive, urgent-care facilities and emergency rooms; 2) minimize the impact of the client’s substance abuse on family members, workmates and others; and 3) reduce the likelihood of lasting adverse effects to the client. Further, this approach cultivates a whole-health, person-centered approach that fosters not only recovery but also resilience.

b) “Core Principle 4: Eradicate Fragmentation by Requiring Coordination and Integration of Care for Physical, Mental and Substance Use Conditions”

Complicating the challenges faced by the current treatment system for mental and substance use disorders is the frequent co-occurrence of these disorders, often together with other chronic health conditions. Our current system promotes disconnection among interrelated diseases and conditions leading to fragmentation and frustration among providers and consumers. The presence of multiple concurrent health conditions makes it increasingly difficult to engage consumers successfully in treatment and sustained recovery. Thus, program designs which pair physical and behavioral health services as well as effective client care coordination will reduce service fragmentation, provide holistic client care and produce better client outcomes.

11. Describe a method (e.g. hourly fee for service, bundled rate, flat grant with performance incentives for improved engagement and retention, etc.) of reimbursement for evaluation that would increase show rates and incentivize retention in treatment.
In CMHA’s experience, especially with women in the Jail Diversion Program, and with Project LIFE, a federally funded substance abuse wrap around services program for women, we found that giving clients small incentives promotes successful client engagement, retention and treatment compliance. Thus, we recommend that the Project Safe payment structure include client incentive funds to be used at staff discretion to purchase small rewards for women/families who successfully reach key milestones in treatment (kept assessment appointments, meeting a treatment goal or maintaining high attendance at treatment sessions). Items such as gift certificates for haircuts or manicures, bus passes and small children’s gifts are inexpensive and go a long way to promote client engagement, trust and client self-care/self-esteem.

When designing agency incentives to improve client engagement and retention, it is imperative that they be applied not only to volume, productivity or sessions kept, but to actual client outcomes. Offering incentives for client attendance only may result in high client attendance with little client change. Ideally, supportive and productive client sessions should be tied to client attendance, benchmarks for reduced substance use, decreased use of more intensive levels of care, employment, fewer legal charges and improved parental skills. If these variables are built into an incentive plan, the project has the most potential to achieve the desired client results.

It does not seem as relevant to provide agency incentives for client attendance at initial assessments, unless that money is used to support activities that we know would increase the likelihood of initial attendance (reimburse clients for transportation costs; arrange for child care, etc).

**Concept Questions: Treatment Services and System Design**
13. What best practice treatment modalities will allow for the best treatment outcomes? What are the parameters for proposed treatment programs?

While the requirements of this RFI limit a detailed and comprehensive response to this question, some general information regarding the behavior of substance users and addiction treatment can be presented herein. Based on this information, some suggestions for best practices in treatment are offered.

Research shows that for the majority of individuals who are substance abusers, their reliance on substances is often a chronic condition that begins when the individual is young. According to Dennis and Scott (2009), 90% of use and problems begin between the ages of 12 and 20. Unfortunately, the younger an individual is when he/she begins using substances, the longer he/she actually uses substances. These researchers have also found that despite treatment, relapse in this population is very common and is even more likely for individuals who are younger, have been in treatment on multiple occasions and have additional issues such as mental health problems or pain.

Unfortunately, the number of individuals in the United States with co-occurring mental health and substance abuse disorders is significant. According to SAMHSA, the majority of 7.2 million adults who have co-occurring disorders live in households, are between the ages of 18 and 54, and receive no treatment at all, not even from a primary care physician (1997).

Possibly the research of most relevance to this RFI have been the findings around parental addiction. Studies show that 40 to 80% of families who are in the child welfare system as a result of child abuse and neglect have at least one parent who is a substance abuser (Rubenstein, 2003). In addition, children who come from a substance abusing
home are more likely to be placed in foster care and to stay in foster care for longer periods of time than children of parents who are non-substance abusers (HHS 1999).

While research has been very helpful in pointing out concerns, it has been equally helpful in providing potential solutions for effective treatment. Despite professional debate over specific treatments that may be more effective others, there are certain “lessons learned” that seem to be fundamental to assuring positive outcomes in the treatment of substance abuse. These lessons are as follows:

a) **Every individual is unique. There isn’t a “one size fits all” to successful treatment.** Each individual should receive comprehensive, flexible and gender-specific services that are ethnically and culturally sensitive. Comprehensive treatment requires that the focus of care is not just on the individual’s substance use. Instead, the client is treated in a holistic manner that takes into account his or her medical, legal, social, vocational and psychological issues. The most effective treatment is always client-centered and directed.

b) **The path to wellness and abstinence takes time and relapses are likely to occur along the way.** Therefore it is crucial that the client, provider and various systems with which the client is involved recognize the chronic nature of the illness. Relapses should not be viewed as failure. It should be understood and accepted that it may require extended and multiple episodes of treatment for a client to achieve long-term abstinence and restored functioning.

c) **Treatment needs to be easily accessible and offered in the least restrictive environment possible.** Clients enter treatment at various stages of motivation and readiness. Engaging the client at the outset is essential. Therapies that focus
on skill building to resist drug use, replacing drug using activities with more positive and beneficial behaviors and developing better solving problem abilities are crucial to successful outcomes.

d) **Clients who present with co-occurring substance use and mental health disorders should receive integrated services.** Integrated assessment methodology and treatment models should be employed.

e) **Case management services are essential to help the client maintain treatment gains, avoid relapse and improve overall functioning.** The goal is to help the client gain access to self-help and recovery programs and to provide linkages for essential services such as housing, employment and medical care.

f) **Services should be “family friendly” and family inclusive, particularly if the parent’s substance abuse has led to DCF involvement.** This may include providing attachment and parent training with the parent, family therapy and/or counseling services for affected children. Inclusion of a spouse or partner in services should also be strongly considered.

Based on these “lessons learned,” an integrated approach to treatment can be developed to allow for best treatment outcomes. Key components of this approach would include:

a) **Proper Screening and Assessment:** This would include the use of proper drug testing, screening and analysis to assess the need for a referral to treatment as well as assessment which determines the presence of dual diagnosis.
b) **Case Management/Initial Engagement:** This would include pre-treatment engagement by an outreach professional. This individual’s role is to help motivate a client to engage in treatment.

c) **Ongoing Case Management:** As noted above, substance using clients often present with multiple needs and may require varying degrees of support and assistance. It is unreasonable to expect an individual to focus on their own recovery if issues such as the placement of their children, housing and everyday living expenses are prominent concerns. A case manager can provide support and linkages to appropriate services.

d) **Treatment:** Considering the wide range of issues, treatment options must also be varied (inpatient, intensive outpatient, in-home and outpatient) and match the needs and interests of the client. While there are a multitude of approaches that have proven to be promising, especially for clients with co-occurring disorders (NIDA, 1999), and can be delivered in various treatment settings, this response will focus on two such approaches. The first is **Contingency Management,** which is a behaviorally based intervention that reinforces the client for abstaining from substances. It has been found to be very effective with clients who need immediate gratification and have difficulty viewing the long-term impact of their sobriety. The second is **Motivational Enhancement Therapy,** which is a cognitive-behavioral approach that focuses on the client’s ability to make actual changes in behavior. Client change comes after he/she goes
through an internal process where he/she comes to the realization that the negatives for his or her substance abusing behavior outweigh the positives.

e) **Attachment/Parent Training:** One successful in-home program in Connecticut combines contingency management (Reinforcement Based Therapy) with attachment intervention (Coordinated Intervention For Women and Infants, developed by Yale Child Study Center). Interventions are delivered in the client’s home. In addition to the treatment of the parent’s substance abuse, considerable focus must be paid on the parent’s ability to nurture and care for his or her infant (child is usually under the age of two) and other children in the home. Considering that the parent is often referred to DCF due to concerns of neglect or abuse and one of the issues may be impaired parenting due to substance use, participants in this program have had strong motivation to abstain from substances and to learn new ways of parenting.

f) **Continued Case Management:** While many treatments last for specific periods of time (30 days, 8 weeks, one year, etc.), the evidence shows that recovery is often very slow, relapses are common and the transition from treatment to aftercare is often a period that increases the risk for disruption. Extended case management helps clients link to aftercare activities such as support groups (Alcoholics Anonymous/ Narcotics Anonymous) and provides the needed support for parents to take on new life responsibilities such as employment and appropriate child care.
14. How would you design and incorporate best practice treatment modality for the family? Residential levels of care should not be included in proposed scenarios.

As indicated in response to Question 9, SAMHSA indicates evidence-based best practices are co-occurring capable and have the ability to integrate psychiatric/substance abuse and primary care into treatment. In addition, it would be helpful to treat the family with the “whole person” approach within one multi-service treatment agency so that the treatment of the adults and children can occur concurrently and fluidly. Using a multi-service treatment agency with integrated programs and/or insuring that smaller agencies have close collaborative ties with other agencies to facilitate client access is essential.

In addition, many families in treatment have stressors such as poverty, single parenting and/or lack of child care, employment or transportation. The ability to provide a Wrap-Around services model, including in home services, does not “punish” the family due to their poverty or lack of resources. In many circumstances, low-income families are viewed as treatment resistant vs. having a lack of resources to access appropriate services. Families, especially those headed by single mothers, who are told they must stop using substances in order to maintain or regain custody of their children, need intensive support services in addition to treatment. These single mothers, who grapple with the stress of getting their children back or preventing their removal, as well as poverty, homelessness, inadequate child care and legal issues, are expected by DCF to put recovery at the forefront of those issues. Wrap Around supports, including case management, advocacy, child care, entitlement assistance and treatment are essential in order for single mothers to have the emotional space to succeed in recovery-oriented treatment.
18. How can substance abuse outpatient services under Project Safe be made more gender responsive?

Research shows that female substance abusers have a distinct set of issues that suggest the need for substance abuse treatment programming for women. Gender differences in substance abuse include differential treatment barriers, utilization and retention, as well as substance use epidemiology, social context, etiology and physiological consequences. In general, these differences point to disadvantages for women, as most systems and interventions were initially designed for primarily male populations.

The literature shows that female clients have lower educational attainment and employment rates than their male counterparts (Wong et al., 2002). In a study of DATOS data, a national study of more than 10,000 substance abuse treatment clients, women were found to be younger, less educated, and less likely to be employed than men (Wechsberg et al., 1998).

In addition to various medical problems, women substance abusers are at increased risk for psychological problems (Alvarez, Olson, Jason, Davis, & Ferrari, 2004; Brady & Randall, 1999; Chander & McCaul, 2003; Chatham, Hiller, Rowan-Szal, Joe, & Simpson, 1999; Gentilello et al., 2000; Mann, Hintz, & Jung, 2004; OAS, 2004c; Phillips, Carpenter, & Nunes, 2004; Wechsberg et al., 1998; Zimmermann et al., 2004). Psychosocial antecedents more likely to be associated with substance use by females than by males include co-morbid psychiatric disorders, such as depression, anxiety, bipolar affective disorder, phobias, psychosexual disorders, eating disorders, or posttraumatic stress disorder (PTSD) (Boyd, 1993; Brady, Dansky, Sonne, & Saladin, 1998; Denier, Thevos, Latham, & Randall, 1991; Fornari, Kent, Kabo, & Goodman, 1994; Institute of
Medicine [IOM], 1990; Mendelson et al., 1991; Merikangas & Stevens, 1998; Najavits, Weiss, & Shaw, 1997; Nelson-Zlupko, Kauffman, & Dore, 1995; Saxe & Wolfe, 1999). For example, an analysis of the relationship of age at first substance use relative to the onset of affective and anxiety disorders found that the onset of psychiatric disorders preceded the onset of substance use disorders more often in females than in males (Kessler et al., 1997). In addition, substance-dependent females have been found to be more likely to need help for emotional problems at a younger age and to have attempted suicide than substance-dependent males (Haseltine, 2000). Unfortunately, females with co-occurring substance abuse and psychiatric disorders face unique barriers to substance abuse treatment, such as difficulty in obtaining a dual disorder assessment and diagnosis, social stigma attached to both conditions and insufficient knowledge and training among providers of health, mental health, or substance abuse treatment services to manage coexisting disorders (Grella, 1996, 1997).

To address the above issues, it is imperative that integrated services be provided for women with co-occurring disorders and that the medication management employed utilize the most efficacious treatments for each separate disorder.

Additionally, successful substance abuse treatment programming for women should include child care, transportation, prenatal care, employment services, woman-focused HIV risk reduction and mental health services, linkage to domestic violence shelters/programs and women-only programs that use trauma-informed treatment environment specific to women’s issues.

Brady, T. M., & Ashley, O. S. (Eds.). (2005) note in their study of Women in substance abuse treatment: Results from the Alcohol and Drug Services Study that the
key factors in the etiology of female substance abuse are a history of trauma, family and partner influences and social stigma and discrimination.

a) A Strong Link to Trauma

Substance use by females is linked to traumatic events or stressors, including sexual and physical assault or abuse, sudden physical illness, an accident, or disruption in family life (Grella, 1997; IOM, 1990; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Kilpatrick, Resnick, Saunders, & Best, 1998; Martin, Beaumont & Kupper, 2003; Najavits et al., 1997). Females often use alcohol or other drugs to self-medicate in an effort to cope with these traumatic events (Miranda, Meyerson, Long, Marx, & Simpson, 2002; Teusch, 2001; Young, Boyd, & Hubbell, 2002). Women with substance use problems have been found to be significantly more likely than men to exhibit recent physical, emotional, or sexual abuse (Gentilello et al., 2000), and female substance abuse treatment clients report more problems related to physical and sexual abuse and domestic violence victimization than males (Green et al., 2002; Wechsberg et al., 1998). Unfortunately, some therapeutic approaches, such as confrontational models often used in traditional therapeutic communities, present a special barrier for female substance abusers (Copeland, 1997) because they often "reenact" traumatic experiences and may engender feelings of distress and powerlessness associated with such experiences.

To address the above issues, trauma informed models such as “Seeking Safety” are recommended programs for treating female substance abusers.
b) Family and Partner Influences

Female substance abusers are more likely than their male counterparts to report greater dysfunction in the family of origin (Chatham et al., 1999) and lack adequate role models for parenting (Davis, 1990; Sheridan, 1995). Females often are referred to substance abuse treatment through child protective services as a requirement for retaining or regaining custody of children (Clark, 2001). Poor interactions with children can also be a significant source of stress that interferes with female's treatment efforts (Davis, 1990; Greif & Drechsler, 1993). In addition, female substance abusers are more likely than male substance abusers to enter into dependent relationships dominated by their partner (Woodhouse, 1992), hindering their ability to perform basic life skills, such as managing money and planning for the future. Substance-dependent females are more likely than substance-dependent males to have substance-dependent spouses or partners (Amaro & Hardy-Fanta, 1995; Blum et al., 1998; Henderson, Boyd, & Mieczkowski, 1994; Riehman, Iguchi, Zeller, & Morral, 2003; Tuten & Jones, 2003), who may not be supportive of their seeking treatment. Thus, seeking treatment may create a serious problem for the relationship (McCollum & Trepper, 1995). The partner often not only discourages the woman from entering treatment but also may threaten violence or leave the relationship if the woman seeks treatment (Amaro & Hardy-Fanta, 1995). Also, partner substance use and treatment behavior have been found to be more strongly associated with treatment motivation for females than for males (Riehman, Hser, & Zeller, 2000). In contrast, common reasons for males' entering treatment are family pressure and spousal opposition to substance abuse (Grella & Joshi, 1999).
Given the above discussion, treatment must be sensitive to the demands and changes in the woman’s primary role in the family, her relationship with her domestic partner and role of the family in treatment/recovery.

c) Social Stigma and Discrimination

Substance use among females is more highly stigmatized than among males (Grella & Joshi, 1999), and social stigma, labeling, and guilt are significant barriers for females to receiving treatment (Ayyagari et al., 1999; Copeland, 1997; Dvorchak, Grams, Tate, & Jason, 1995; Finkelstein, 1994; IOM, 1990; Nelson-Zlupko et al., 1995). Stigma and guilt may foster denial of problems by females, creating a further barrier to treatment (Blume, 1997). In addition, females in a variety of treatment settings have been found to be more likely than males to belong to minority racial/ethnic groups (e.g., Hser et al., 2003). As such, women in substance abuse treatment may have experienced racism and may harbor mistrust of the medical and substance abuse treatment systems, which may compromise provider-patient relationships and hinder treatment and recovery.

To address the issues outlined above, wherever possible, treatment should be provided by persons who are culturally and linguistically competent to serve the population in question. Persons who have experience in recovery should also be incorporated into treatment and program designs.

19. How can substance abuse outpatient services under Project Safe be made more trauma responsive?

Clients are often referred to DCF due to incidents involving drugs/ alcohol, domestic violence or illegal activities. Often, parents involved in these types of behavior
have a history of their own physical/emotional or sexual abuse, which can impair or compromise their judgment as parents. Using evidence-based models of trauma treatment for clients with substance abuse and or co-occurring disorders has shown a reduction in recidivism and improvement in outcomes.

Project Safe treatment programs should be encouraged to provide trauma informed treatments such as Seeking Safety, the Trauma Recovery Empowerment Model (TREM) (Amaro, DH, et. Al) and the Men’s Trauma Recovery and Empowerment Model (companion group approach for men: a 24-session group for male trauma survivors). Gender-specific groups have been demonstrated to be more effective, especially with women in recovery. It is less important which model is selected, as there are several with good outcomes; what is most important is that one be selected and followed with fidelity for those women suffering from chronic or acute disorders related to trauma.

Concept Questions: Other Service Design Issues

26. What would you recommend be offered to enhance the SAFE network and treatment systems statewide? Be specific regarding a) the training that should be offered; b) for what audiences and c) key topic areas to be addressed.

The overall success of the Project SAFE should rely on a well-coordinated team effort between child protective and mental health and addiction service agencies (DCF and DMHAS), the selected ASO provider program manager, community providers, the courts and other social service agencies. While the roles of each party may vary, the overall commitment must be the same. Each entity must be invested in the ultimate goal of Project SAFE which “is to engage adults in treatment and support their recovery so
they can more appropriately protect, care for and parent their children” (Project Safe
Redesign, RFI, 2009, p. 7). To be successful in this effort, any training curriculum
should focus on developing interagency team building and collaboration (Chestnut Health
Systems, 2002). Providing the most effective care for the client is a shared experience
best delivered by multiple systems. Child welfare workers should understand and speak
the language of the Recovery Coach. Treatment providers should work with other
members of the system to provide insight and guidance around issues of recovery and
knowledge regarding specific treatments designed to help clients engage and successfully
complete treatment. Chestnut Health Systems calls this effort “cross-fertilization” and
the National Center on Substance Abuse and Child Welfare describes it as “cross-system
collaboration”.

Much of this “cross-fertilization” has already taken place at New Britain’s Project
SAFE. Numerous trainings have been funded by DMHAS and have included DCF
caseworkers and managers, Recovery Coaches, and providers from all points on the
treatment continuum (residential, inpatient, in-home, outpatient) and from all levels of
staffing (case managers, clinicians, coordinators and administrators). The essential
components of training are as follows.

a) Understanding Addictions: Regardless of role, every member of the team will
require a fundamental education about the full complexity of substance abuse and
addiction and the scientific evidence that has emerged over the past decades. This
would include an understanding of the physiological effects of drug and alcohol
abuse and dual diagnosis. Presenting the research findings to the staff should help
eradicate some of the misunderstandings and myths that are still prominent in our
culture regarding the impact of substance use and will lay the groundwork for the advancement of empirically supported treatments. Other topics in the series should include the effects of withdrawal, relapse prevention, maternal substance abuse and the impact of substance abuse on children and families.

b) **Client Engagement:** Regardless of whether it is the DCF child protection worker, the Recovery Coach or the primary clinician who makes the first contact with the family, the most essential aspect of the process will be the initial work around assessing, supporting and engaging the client in work towards his/her recovery. A significant amount of training should be spent on motivational interviewing. Despite successes at various points in the engagement and recovery process, a client’s ambivalence toward change should be taken in stride. It is the goal of any member of the Project SAFE network to help the client rediscover his or her own strengths and competencies.

c) **Evidence-Based Mental Health Treatment:** There is growing evidence that certain approaches to treatment have better outcomes, particularly with the co-occurring population. It is therefore incumbent on treatment providers to have formalized training in empirically supported treatments. While treatment providers should be the experts in these treatments, it is equally important that all members of the Project SAFE cross-system collaboration have a working knowledge of the most widely utilized treatment models and the types of psychotropic medications that are most often utilized to address mental health and addiction disorders. As mentioned earlier in this RFI, there are several outpatient
treatment models that are receiving support in the treatment community (Contingency Management, IDDT).

d) **Specialized Treatment:** While both men and women qualify for Project SAFE services, to date, the majority of individuals admitted have been women. To this end, it is essential that all members within the Project SAFE collaboration understand the issues that are specific to this population. Trainings should be offered that are gender-specific and ethnically and culturally sensitive. Training should include education around physical, sexual and emotional abuse and how an individual’s current behaviors, including the use of substances, may be directly linked to these previous experiences. Often overlooked is the impact of Intimate Partner Violence (IPV) and the significant increase in the number of incidents of IPV when couples are under the influence (Addiction and Family Research Group, 2006). Trauma-specific training would include topics such as communication, developing healthy relationships, emotional regulation, developing safety procedures that address self-harm and boundary maintenance.

e) **Parent Training/Attachment/Family Focused Treatment:** As stated in an earlier response, parents are often referred to Project SAFE due to their substance abuse, which has impaired their parenting abilities. As the RFI points out, the majority are single moms. All Project SAFE participants should recognize the needs of the entire family system, as a healthy family system will motivate the ongoing sobriety of the parent. Emphasis should be placed on child development and parent training. Additional training should be offered in family systems,
healthy family dynamics and communication and the recognition of clinical needs of children and extended family members.

f) **The Role of Recovery Support Groups:** There is a growing emphasis in the literature (Chestnut Health Systems, 2002; Moos & Moos, 2005) that participation in a recovery support group is a key to a client’s ability to sustain stable remission. Thus, all members of the Project SAFE team need to have a solid understanding and knowledge of relevant community based aftercare and support groups. While many people are familiar with the more traditional 12 step groups such as AA or NA, it is important for the partners in Project SAFE to understand and agree that these particular groups are not necessarily the right or only choice for every individual. The goal is client participation in an ongoing activity that will help him or her sustain his or her sobriety. A support group could focus on parenting, life skills, self-care or a variety of other topics. Flexibility and the consideration of culture, gender and ethnicity are essential.
References and Selected Related Readings


Koenig, & W. Pequegnat (Eds.) *From child sexual abuse to adult sexual risk* (pp. 3-10). Washington, DC: American Psychological Association.


U.S. Department of Justice. (2000). *Sexual assault on young children as reported to law enforcement*. Bureau of Justice Reports.


http://www.cdc.gov/nccdphp/ace/prevalence.htm

*ACE Study - Prevalence - Adverse Childhood Experiences*
CONCEPT QUESTIONS
Respondents may respond to any or all of the concept questions.

Concept Questions:
Drug Testing

1. DCF and DMHAS are interested in service delivery models, utilization protocols, and technology that accomplish SAFE program objectives while reducing administrative and drug testing costs in child welfare practice. How should drug testing be administered, organized, and structured? What technology can be employed to reduce cost and improve service?

CSS Test offers a comprehensive management tool which streamlines the collection and reporting processes, thereby allowing for increased efficiencies, which enables significant cost savings over the program lifecycle. CSS will train any personnel that orders drug testing, including: which test to use and when, the pros and cons of each test, windows of detection and sensitivity differences, frequency of testing with various methodologies, results interpretation (what a test does and doesn’t tell you), combining tests, and the value of randomness. CSS will help establish a set of protocols for each type of testing methodology offered based upon best practices while considering the test’s strength and weaknesses, e.g. no need to do a hair test more often than every 90 days since the window of detection is 90 days. Iowa DHS has saved money by employing such training and systems of protocols. Trainers are available to provide in person or web based training.

2. What are the practical, financial, and technical benefits and limitations of each type of testing being considered (urine, hair, saliva, patches, and oral swabs). Base your response on experience, published literature, data, and/or research studies where available.

Urine:

Urine testing is the most widely used and known. It is the standard to which other tests are compared, though each really is unique because of varying sensitivities, windows of detection and vulnerability to tampering.

Urine samples often referred to as urinalyses are the most widely used, cost effective and well researched biological sample for the detection of drugs in adults, older children and youth (United States Department of Justice, 2000). The majority of illicit drugs are excreted from urine within about 72 hours of drug use with the exception of alcohol, which has a 12-hour window of detection. Frequent multiple use of a drug can result in an extended detection period for some drugs. For example, chronic marijuana use may be detected beyond 21 days.

To prevent urine samples from being tampered, replaced or adulterated, a supervised collection method is required.
**Saliva:**

Saliva samples can be obtained by using a swab as one device to collect saliva from the donor’s inner cheek within the mouth. The strengths of testing saliva samples include its ease of administration, confident drug identification of use within the previous hour up to 48 hours and a noninvasive sampling method. Drug test results from saliva sample sources can be provided either through point of collection devices or laboratory testing. The disadvantages of using saliva samples include its inability to detect past use beyond 48 hours, and it is not as effective in detecting marijuana use. Marijuana is detectable for only up to 24 hours following use.

**Sweat Patches:**

Sweat samples are collected by applying a patch, which is similar to a band-aid, directly to the skin. It is placed on the upper arm and typically worn for 7 days prior to removal. A laboratory will test the sample received from the gauze pad on the patch. The advantages of using sweat patches include constant monitoring during the wear period, and its deterrent effect while being worn. It is also good for close monitoring of client. The patch is a 5-panel test which includes monitoring of: marijuana, amphetamine, opiates, cocaine, and PCP.

**Hair:**

The use of hair samples as a method of drug detection has become more common in recent years. Hair sample testing is useful in that it can detect drug use over a period of several months, depending on the length of the hair sample. In addition to having the widest window of detection, other advantages of hair samples include: it is difficult to substitute samples or invalidate the results and that it is a noninvasive sampling method. Disadvantages with using hair samples include the inability to detect recent drug use within the last 7 days or detect instances of a single drug use.

**Breath, Blood and Meconium:** tests may also be used for drug testing but both the blood and meconium would usually be tested within a hospital or other medical setting.
The following tables are an expanded version of the table published by the Office of National Drug Control Policy. It provides additional information on the pros and cons of the various drug testing methods (Office of National Drug Control Policy, 2004).

<table>
<thead>
<tr>
<th>Type of Test</th>
<th>Indications for Use.</th>
<th>Pros</th>
<th>Cons</th>
<th>Window of Detection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>URINE</td>
<td>When a child is removed from an active clandestine meth lab, a urine sample within 4 hours is critical for both medical care and for forensic evidence. When use is suspected in the past few days. Except marijuana which could be in the last several days to weeks. When same gender collector is available for observed collection or collector trained to DOT standards for unobserved collection. When cost is an issue, use for regular, random and frequent testing. To have results that are the most defensible in court. As a deterrent to use or continued use of an illicit substance. To identify those who are using illicit substances. Wide range of possible drug use.</td>
<td>Highest assurance of reliable results. Least expensive. Most flexible in testing different drugs including alcohol and Nicotine. Most likely of all drug testing methods to withstand legal challenge when observed. SAMHSA approved.</td>
<td>Specimen can be adulterated, substituted or diluted. Adulteration and dilution can be detected; Preventing substitution depends upon careful observation of sample collection. Limited window of detection. Tests sometimes viewed as invasive or embarrassing. Biological hazard for specimen handling and shipping to lab.</td>
<td>Typically 1 to 5 days.</td>
</tr>
<tr>
<td>Type of Test</td>
<td>Indications for Use.</td>
<td>Pros</td>
<td>Cons</td>
<td>Window of Detection.</td>
</tr>
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<td>--------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>HAIR</td>
<td>• When a non-intrusive method is necessary.</td>
<td>• Longer window of detection.</td>
<td>• More expensive.</td>
<td>Depends on the length of hair in sample.</td>
</tr>
<tr>
<td></td>
<td>• Children-for presence of drugs in the system.</td>
<td>• Greater stability (does not deteriorate).</td>
<td>• Test usually limited to 5-drug panel.</td>
<td>Hair grows about half-inch per month, so a 1.5 inch specimen would show a 3 month history.</td>
</tr>
<tr>
<td></td>
<td>• To achieve a longer detection window- 1.5 inches of hair equals a 90-day window.</td>
<td>• Can measure chronic use.</td>
<td>• Cannot detect alcohol use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hair is not significantly affected by brief periods of abstinence so it can be</td>
<td>• Collection procedure not considered invasive or embarrassing.</td>
<td>• Will not detect very recent drug use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>used to indicate periodic relapse.</td>
<td>• More difficult to adulterate than urine.</td>
<td>• Most recent use detected may be up to 7 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When invasive collection is an issue.</td>
<td></td>
<td>• Some drugs migrate through the hair, so presence may not indicate recent use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To identify usage that occurred over 7 days in the past.</td>
<td></td>
<td>• Dark hair retains more and longer evidence of use, so there is risk of racial bias.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When there is a suspicion of repeated successful adulteration, dilution,</td>
<td></td>
<td>• Amount detected may vary across samples of hair from the same person.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tampering of urine samples.</td>
<td></td>
<td>• Split sample technique should be used to differentiate environmental exposure from personal use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not SAMHSA approved</td>
<td></td>
</tr>
</tbody>
</table>
| **ORAL FLUIDS** | **Sample obtained under direct observation. Minimal risk of tampering.**  
- **Non-invasive.**  
- **Samples can be collected easily in almost any environment.**  
- **Can detect alcohol use.**  
- **Reflects recent drug use.** | **Drugs and drug metabolites do not remain in oral fluid as long as they do in urine.**  
- **Less reliable than other testing methods in detecting marijuana use.**  
- **Very short detection period is a problem.**  
- **To enhance defensibility must use other methods for marijuana.**  
- **Not SAMHSA approved.** | **Ingestion to 72 hours depending on the substance.** |
| --- | --- | --- | --- |
|  | When a non-intrusive method is necessary.  
- **When observed collection is necessary but no same gender collector is available.**  
- **For recent use (previous hour up to 24 hours marijuana, previous hour up to 72 hours all others).**  
- **Post incident/accident situations.**  
- **When there is a need to know if someone is “under the influence,” shows presence of parent drug.**  
- **When marijuana is not a concern.** |  |  |
<table>
<thead>
<tr>
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<th>Indications for Use.</th>
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<th>Cons</th>
<th>Window of Detection.</th>
</tr>
</thead>
</table>
| SWEAT PATCH | - As a deterrent to use or continued use of an illicit substance.  
- To identify those who are using illicit substances.  
- When a non-intrusive method is necessary.  
- To achieve a longer detection window—drugs are detected up 2 days prior and for as long as the patch is worn. Typically 7-14 days.  
- When there is a suspicion of repeated successful adulteration, dilution, tampering of urine samples  
- When a visible deterrent to using is desirable.  
- When close monitoring is desired, gives 24/7 monitoring while worn.  
- When "shy bladder" is an issue.  
- When head hair has been shaved off. | - Longer window of detection.  
- Sample obtained over 7 or more days.  
- 24 hour a day monitoring  
- Minimal risk of tampering, if removed by donor can't be reapplied.  
- Non-invasive, no same gender issues  
- Difficult to adulterate, attempts and tampering are evident to collector.  
- Not considered a bodily fluid/hazard, as is urine.  
- All positive screens are confirmed by GC/MS.  
- Positives are confirmed for parent drug and drug metabolite.  
- Can detect occasional use.  
- Recommended by DHHS for approval for use in federally mandated testing programs.  
- FDA approved.  
- Gives client good reason to refuse using opportunities. | - Is a storage device, can't tell if use was once or multiple times.  
- Collector needs to be attentive to condition of patch upon removal to detect tampering.  
- Chain of custody form needs to be completed.  
- Possibility of contamination via mishandling by collector. Need to follow application and removal protocols.  
- Not as court tested as urine.  
- More labs doing urine, hair and oral fluids, less choice in who to work with.  
- Tests only for 5 substances: cocaine, PCP, opiates, marijuana, and amphetamine/methamphetamine.  
- Not SAMHSA approved. | - 1-2 days prior to application of patch and while being worn, typically 7+ days |
3. What are the recommended/preferred sample collection, handling, storage, and quality assurance protocols that will ensure high access, reliability, validity and that result are interpreted appropriately?

Current CLIA and CAP certifications/endorsements for all labs being used. SAMHSA approval insures even greater standards are met.

4. What are the current market laboratory costs: i) by drug panel type (e.g., 5 panel vs. 3 panel); ii) by volume of tests and, iii) by type of tests? What are the current market laboratory costs for confirmation testing? How do bundled and unbundled rates compare and what are the advantages/disadvantages of bundling?

Bundling allows for more accurate budgeting. Secures set costs for a test. Also allows those with less knowledge of testing and the nuances involved with testing to gain the ability to test effectively and efficiently.

5. What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?

Recovery coaches have good access to clients which should mean testing is done with desired frequency. To have recovery coaches do collections puts the responsibility on the coach to insure testing occurs vs. client holding that responsibility. Recovery coaches should only serve as collectors and not determine test type, frequency, or randomness. This prevents compromise of the testing system by an overinvested coach. CSS Test offers a random testing system that works well for urine or saliva testing. Consider constant monitoring using patches for those new in recovery. This would be similar to what KC federal probation does. First 3 months constant patches.

6. What recommended standards should be used for chain of custody and what are the market per-test costs for sample collection? What are the costs per test if dedicated staff and collection sites are implemented? See what Iowa DHS has done as an example of dedicated collection staff and sites. What would be the advantages/disadvantages of a "two-tiered" system (see above) in which high level chain of custody standards are required for child welfare driven testing and lower standards are required for testing in the context of treatment monitoring. Cost is an advantage. Disadvantage –may create a more complex system to administer and more training could be needed if collectors are doing collections for clients from both tiers. How could third party reimbursement of drug testing be maximized? By creating a system that verifies payment source at the time of testing being authorized. Communicating this to collector, who would then, do/use the appropriate chain of
7. What are the recommended performance measures of drug testing protocols and procedure? See the Iowa RFP (.pdf listed below) which contains a good example of performance measures. Iowa also has established frequency and use protocols based on the type of test and best practices for achieving both useful and economical drug testing in the child welfare arena. They have a guidance manual that is pending release as well. Manual was developed as part of a technical assistance grant that involved the NCSACW.

Iowa RFP for DHS Iowa
The reference number for this RFP is DCFS-07-002. The RFP can be found on the General Services web site at: http://bidopportunities.iowa.gov/

Concept Questions:
Screening, Evaluation and Access to Treatment

8. For those DCF clients that self-identify for treatment through the GAIN-SS or direct report, identify procedures, practices, and policies that would help to strengthen evidentiary support for child welfare practice while enhancing engagement and access into treatment. What might be the advantages or disadvantages of such an approach and what might be done to improve outcomes. What differential practice and policy should be promoted for those clients who are self-motivated and/or self report symptoms to DCF versus those who do not?

9. How should evaluation be utilized/structured to support child welfare practice and help to engage adults in treatment while reducing costs and maximizing efficiencies. The use of collateral information solicited from entities that the parent may be involved with such as child welfare or court system in conducting the evaluation and not completing eval until collaterals have been contacted. A universal release of information used by every entity is of value. So too is a process for early identification of those individuals that are common to one or more systems,(courts, child welfare, treatment). A standardized form providing the type of information available from a collateral source is of value, should be sent with every referral made to treatment program. Engagement is best achieved by using motivational interviewing techniques, and working to incorporate ideas from NIATx https://www.niatx.net/Home/Home.aspx. How can evaluation be most effectively utilized to insure timely access to appropriate levels of care and to strengthen linkages to care. Please describe, in detail, the processes that would need to be developed from time of identification, referral to treatment, entry into care, and continuing service. Be specific regarding the administrative functions that would be required to accurately monitor movement through the system and provide reports to the Departments.
10. What standards of practice should be implemented regarding substance abuse evaluations? What is the anticipated fiscal impact of such standards, if any?

11. Describe a method (e.g. hourly fee-for-service, bundled rate, flat grant with performance incentives for improved engagement/retention, etc.) of reimbursement for evaluation that would increase show rates and incentivize retention in treatment.

Concept Questions:
Treatment Services and System Design

12. Identify the practices, procedures, policies, and administrative supports that are most likely to maximize engagement in treatment. NIATx again would be a great resource to investigate. Outline a potential treatment system that will enhance Project SAFE families and allow for development of recovery supports in the population we serve.

13. What best practice treatment modalities will allow for the best treatment outcomes? Matrix model of outpatient treatment for stimulant abuse. What are the parameters for proposed treatment programs?

14. How would you design and incorporate a best practice treatment modality for the family? Residential levels of care should not be included in proposed scenarios.

15. What UM system would enhance treatment provision within Project SAFE? How should Utilization review be conducted? What system should be implemented to determine appropriateness for treatment planning, service intensity and level of care received by the client?

16. Please describe any innovative best practices you are familiar with regarding family-centered approaches with clients who have been identified as having a potential substance use disorder. In addition, what interventions would you suggest or recommend that will help DCF Workers to improve/develop motivational interviewing skills?

17. What are your recommendations for models that will help clients develop, enhance and/or maintain recovery supports within the community?

18. How can substance abuse outpatient services under Project SAFE be made more gender responsive?
19. How can substance abuse outpatient services under Project SAFE be made more trauma responsive and incorporate components of trauma specific treatments? Seeking Safety is a good model to take a look at regarding clients with trauma issues. http://www.ncsacw.samhsa.gov/

Concept Questions:
Other Service Design Issues
20. How would system communication among all SAFE stakeholders be enhanced? (DCF regional offices, DMHAS treatment providers, court system) SAFER manual addresses some how-to’s in this area found at NCSACW http://ncsacw.samhsa.gov/

21. In what ways could the current SAFE system best be evaluated to meet the needs of families and to help sustain recovery? Contact Lisa D'Aunno National Resource Center for Family Centered Practice She coauthored the Illinois Recovery Progress Matrix found in the SAFERR (Screening and Assessment for Family Engagement, Retention and Recovery) manual from National Center on Substance Abuse and Child Welfare

Lisa D'Aunno.vcf

22. How could data analysis be performed to reduce program costs, create benchmark reporting and report quality? The CSS Total Quality Management System includes various metric tracking capabilities, specific to drug testing, which can delineate between multiple cost centers, thereby allowing for increased cost efficiencies. The CSS system also allows for real-time, dashboard level viewing of all testing events, and is able to show positivity rates by location and individual drug type. In addition, the CSS management reports are highly customizable, and allow for specific data mining based upon stated organizational needs.

23. What specific Quality Management Plans should be in place with providers? This should include specific methods of client engagement and retention and plans for client-centered, gender-specific, trauma-informed and culturally competent programming. (please provide examples)

24. Can you provide any specific examples of where local or regional Project SAFE processes could be adapted or developed for statewide application?
25. What specific steps would be recommended to improve collaboration and communication at the local services level, statewide level and in policy? Cross training on drug testing and all other issues.

26. What would you recommend be offered to enhance the SAFE network and treatment systems statewide? Be specific regarding: a) the training that should be offered b) for what audiences and c) key topic areas to be addressed. Drug testing uniformity and consistency on all training. State-wide, with easy result access on the CSS Total Quality Management System.

Concept Questions:
RSVP Services

27. DCF and DMHAS are interested in developing quality assurance and fidelity measures for the RSVP program. What process would be recommended for developing training, quality assurance and fidelity management protocols to replace this model statewide and to maintain fidelity by minimizing and managing program drift? Recovery Specialists should be trained like anyone else working with clients.

28. What organizational, management, and supervision structures would be both cost-effective and ensure fidelity of statewide dissemination of the RSVP program? What should the relationship be between the RSVP program and the treatment system?

29. DCF and DMHAS estimate that Recovery Specialists spend on average XX hours per week with each RSVP client conducting intensive case management activities. What should be the credentials, background and caseloads for each Recovery Specialist? What is the estimated cost per Recovery Specialist?

30. What measures of success could be outlined to help DCF measure changes in "recovery capitol" among RSVP program participants?
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203-503-3358
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Concept Questions:
Drug Testing

5. What are considered to be the advantages and disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare? How should a program utilizing Recovery Coaches be structured and what key factors should be considered in program design?

Utilizing Recovery Coaches to oversee the administration of drug testing in child welfare can be advantageous when it occurs within the context of a collaborative relationship between client, treatment provider(s), DCF worker and ancillary agencies involved in the client’s care. The ability of a Recovery Coach to arrive at a client’s home after treatment hours or on the weekends to request, supervise, and collect a urine sample for testing can help further randomize the drug testing protocol, a critical component of the treatment process. The involvement of Recovery Coaches could prove to be advantageous in providing support for successful treatment outcomes, and helping to improve linkages between the client, the court in which the client’s child protection case is located, DCF workers, treatment providers, and community based support systems. The RSVP can also help in the implementation in providing regular monthly reports to the court, attorneys of record, the DCF social worker, as well as the substance abuse treatment providers on the client’s engagement in treatment, case management and community support groups. This may help increase the rate of client engagement in the recommended services, which will, in turn, help support successful client treatment outcomes.

Disadvantages of utilizing Recovery Coaches to oversee the administration of drug testing in child welfare could arise if the client’s support system were totally dependent on the RSVP. There would be time constraints to just utilizing Recovery Coaches to collect specimens in the home. Also, this may decrease the number of interactions between the client and treating clinician which would then impede the therapeutic process. Furthermore, the administration of drug testing by Recovery Coaches at a client’s home does not allow for confirmation testing, such as GC-MS (Gas Chromatography/Mass Spectrometry), the “gold standard” of confirmation results.

A program utilizing Recovery Coaches must be structured in such a way that the RSVP is a supplement to the services offered by the treatment provider. A collaborative relationship is key. The treatment program must offer individual and group therapy, urine sample administration that allows for GC-MS confirmation, breathalyzer screenings, treatment modalities addressing substance abuse and mental health issues, case management services, and medical screenings. Critical factors that should be considered in the program’s design is a collaborative relationship between treatment provider(s), DCF, and community agencies. Provision of on-site child care for clients is also important for the treatment program to consider. Transportation is another crucial element that should be taken into account when discussing program design. Some of these tasks can be provided as a result of a shared effort between the RSVP and treatment provider.
8. For those DCF clients that self-identify for treatment through the GAIN-SS or direct report, identify procedures, practices, and policies that would help to strengthen evidentiary support for child welfare practice while enhancing engagement and access into treatment. What might be the advantages or disadvantages of such an approach and what might be done to improve outcomes. What differential practice and policy should be promoted for those clients who are self-motivated and/or self report symptoms to DCF versus those who do not?

Procedures, practices and policies that would help strengthen evidentiary support for child welfare practice while enhancing engagement and access into treatment include, but are not limited to, incentive-based programs. While an incentive for treatment engagement often includes individuals regaining custody of their children, building sobriety and gaining motivation for treatment often involves positive reinforcement at the early phases of treatment/recovery. Offering life skills, job skills and employment readiness training are also important services that would enhance a client’s engagement in treatment. Having the RSVP assist in such areas as transporting clients to and from treatment would help increase a client’s engagement and help ensure participation in treatment. Furthermore, having the RSVP transport clients to their Project Safe Evaluation appointment and to their initial intake appointment would maximize the client’s potential for lasting recovery. Utilizing similar policies for clients who are self-motivated would also be beneficial.