

ADRC Annual Report – 2008

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President's Report

Ronald C. Fleming, Ph.D., LCSW
President & Chief Executive Officer

Last year at this time I reported that the Senior Staff and Program Directors had committed to a course of education and exploration as part of our Strategic Plan implementation¹. In calendar 2008 ADRC completed the remaining steps in our preparation to fully implement our Strategic Plan.

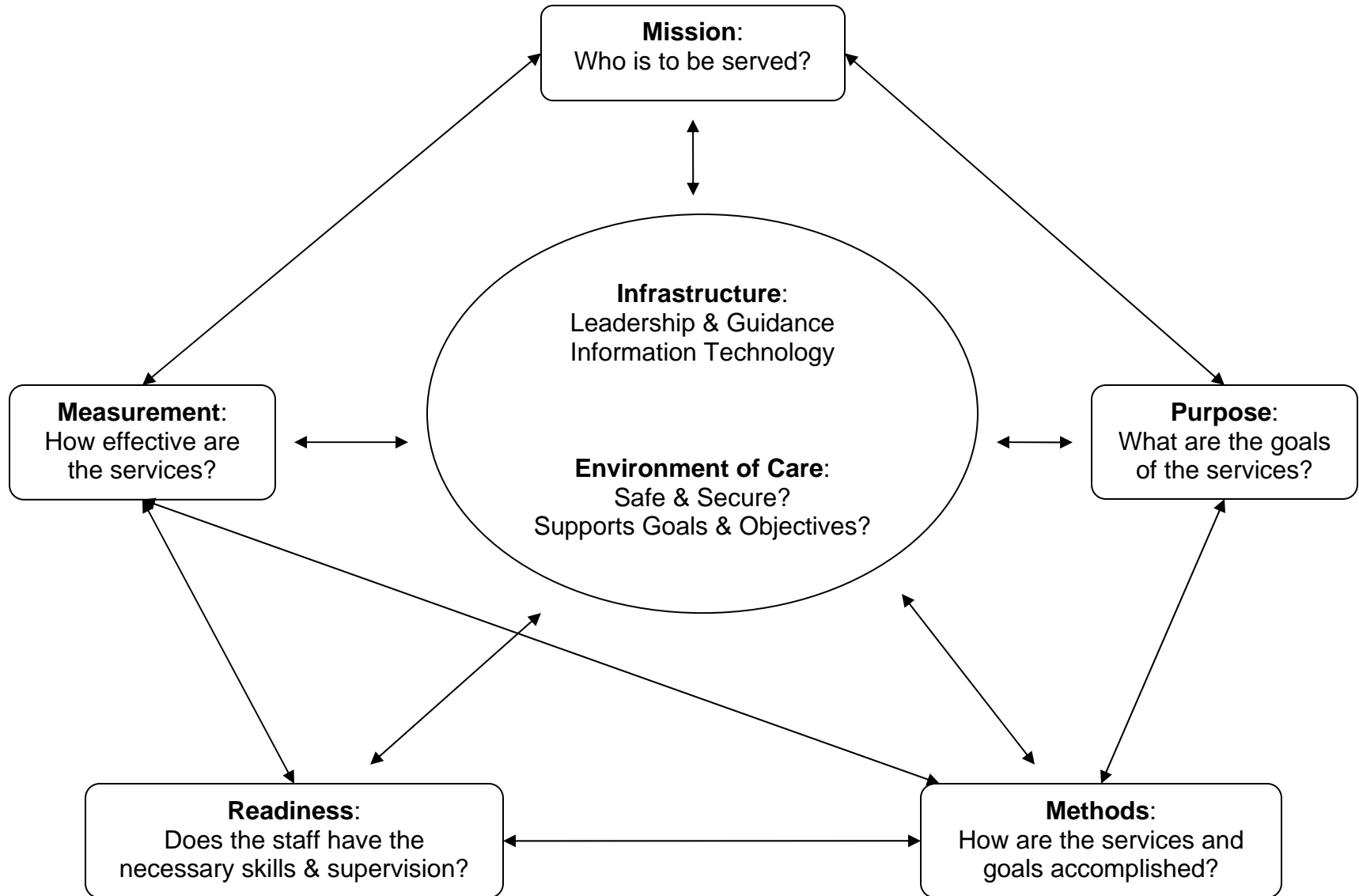
As the accompanying diagram points out, the Agency had divided the implementation process into five distinct operational categories and two additional support structure categories. The operational categories were: 1) mission: who is to be served by any given program, 2) purpose: what are the goals and objectives of any particular program, 3) methods: what means does a program employ to accomplish its goals and objectives, 4) readiness: does the program staff have the necessary skills and supports to utilize the selected program methods, and 5) measurement: how effective are we at accomplishing our goals and objectives. Our two support structure categories involved assuring that the required infrastructure exists to support the strategic plan and that the environment of care is safe, secure, and consistent with the clinical goals of the Agency.

Strategic Plan: Operational Goals & Objectives

Mission

During this calendar year the Agency completed a thorough review of the mission of each major ADRC program. The focus question: who is our client? At each distinct level of care - who is the client as defined by program history, community need, and client need? Each program performed a review of the clients that have presented for care over the years, with particular attention to emergent trends - which may suggest changes in the characteristics or service needs of the clients served. Upon completion of this mission review each program re-wrote their program description in order to fully reflect the current realities of their program. Each program description was written in two forms – one version intended for clients and their families and another, more detailed version, designed for use by other agencies and referral sources.

¹ Much of that effort was guided by the principles found in the book Good to Great: Why Some Companies Make the Leap . . . and Others Don't, by Jim Collins.



Another aspect of the strategic plan implementation, a feature discussed in some depth by Jim Collins², was refocusing the Agency at the programmatic level. This review involved making the decision to not renew two contracts that involved services that were not seen as representing services the Agency was “passionate about” nor services that the Agency could provide in the best way possible. In contrast to these two contracts, the Agency made the decision to pursue, and was privileged to secure, the contract to provide a critical recovery support service – Recovery Oriented Employment Services [ROES] for DMHAS Region 3 and Region 4.

Purpose

The second major feature of the Agency-wide major program review was to revisit this basic question: what are the goals and objectives of each program? What are we attempting to do with and for each client served by our programs? This review was performed with several ideas in mind: 1) the goals and objectives were not intended to be “lofty” and abstract, rather we wanted them to be accessible, measureable, and “down-to-earth”. The ideal goal is one that is observable and measureable by the client, without special outside information. The agency review of our goals and objectives had another important purpose – the goals and objectives of each program are intended to serve as the basis of an implied “contract” – an agreement between the Agency and the client: “if you come to and participate in this program – we believe that you achieve these results”.

Methods

The third feature of our strategic program review was to reassess the intervention methods employed by the program staff in order to accomplish program goals and objectives. Program staff has a tendency to accumulate techniques that they have found useful without regard to how these techniques interlace with the techniques employed by other staff and/or the design of the program itself. In addition, this eclectic approach makes it very difficult to measure which methods actually generate the desired outcomes of care. A critical aspect of the Agency strategic plan is to link intervention methods with outcomes of care – with the intention of selecting out those methods found to be ineffective.

Readiness

The fourth feature of the Agency strategic plan was to evaluate the needs of our staff with respect to their readiness to work with the clients encountered in each program – whatever their presenting characteristics – and to competently employ the preferred intervention methods found in each program. In pursuit of this goal the Agency performed its first ever Agency-wide evaluation of all staff – all

² See Chapter 5, “The Hedgehog Concept”, in Good to Great: Why Some Companies Make the Leap . . . and Others Don't, by Jim Collins.

programs were assessed simultaneously. This assessment allows for three types of training planning – individual needs, program specific needs, and agency-wide needs. This assessment process allows the Agency to prioritize the annual training and development program.

Measurement

The final aspect of the strategic plan is to develop the mechanisms required to measure the outcomes of care delivered by each program. While the Agency has always relied upon a variety of “measures of success”, these measures were not specifically linked to determining whether the intervention methods themselves were responsible for the observed results. This is a demanding challenge but one to which the Agency has committed itself. The intention of this effort IS to “fine tune” our intervention approaches within each program in order to increase the probability of achieving the targeted outcomes of care.

Mission Supports

The strategic plan described thus far - mission, purpose, methods, and measurement – must operate within the context of appropriate and adequate supports if it is to succeed. The Agency during the last year has made major investments in strengthening the support structures of the Agency. These efforts have occurred in the following areas: information technology, performance improvement, evaluation capacity, and physical plant.

The Agency is increasingly using available information technologies to strengthen our ability to provide high quality care and improve client safety. Recent efforts have included expanding the use of Agency intranet space to increase staff access to educational and performance improvement information. For example, several major aspects of the Agency medication management process rely upon the intranet. Using available software technologies we are beginning to automate those review processes that lend themselves to such procedures. The new ROES program employs portable computers and mobile broadband technology to manage important program information. Our Director of Information Technology has begun to create specialized data flow charts that will allow for the tracking of performance trends. The Agency also committed significant resources to a thorough review of current electronic chart software – and had made a recommendation for upgrading our existing system.

The Agency made the decision in the last year to change from our existing performance improvement approach – which had relied upon part time and/or outside consultant staff – to a model built around the presence of a high level fulltime staff member. We were able to bring on to our team Doris McLaughlin as our Performance Improvement Director. Ms. McLaughlin brings clinical experience in our field, as well as an abundance of performance improvement experience. She has very quickly made her presence known and is having a

substantive impact on those Agency processes that impact the quality of client care.

Late in 2008 the Agency was selected to participate in a special training program offered by the Hartford Foundation for Public Giving called ***Building Evaluation Capacity***. The program requires specific commitment by the senior agency executive as well as at least one additional senior staff member. ADRC has enrolled our Director of Information Technologies – John Pierson – and our Performance Improvement Director – Doris McLaughlin – to participate with me in this two year educational program. This program will enhance the ability of the Agency to monitor the success of the strategic objectives described above.

Physical Plant

The care received by our clients occurs within the specific context of their physical environment. The environment is not merely a place where events occur – the environment is actually part of the event itself. Some years ago when I was working in Boston, I had the privilege to meet a Broadway set designer and costume maker. One indelible memory of that experience was the appreciation that every feature of the physical environment can have an impact on mood and that set designers, of course, purposely manage the environment in order to generate particular emotional reactions in the audience. We have been making a sustained effort to better manage our physical environment so as to improve the likelihood that our services will have the desired impact, and that those receiving and providing care may do so in a place that is also safe, secure, and clinically supportive.

In this last year we have been working to complete substantial renovations at our 56 Coventry Street site – home to three major programs. We have also made alterations and improvements in our Outpatient Counseling Center and our Coventry House Program. At our 56 Coventry Street site we have new beds, new room furniture, new dining room furniture and cabinets, new flooring, new lighting, and a new architect-designed paint scheme. Our Coventry House has a newly redesigned “quiet room” with a new paint scheme and new furniture; the room has been well received by staff and clients. Finally, of course, we dedicated our newly renovated and expanded Outpatient Counseling Center – another triumph of the role an architect can play in improving client and staff satisfaction.

Special Activities

In June I had the opportunity, along with Dr. Thomas A. Kirk [Commissioner of DMHAS] and Philip Valentine [CCAR Director], to participate in the Spring Meeting of the National Conference of State Legislators in Washington, D.C. The three of us constituted a panel discussing the topic “Substance Abuse Treatment for Adults”; with particular emphasis on the concept of a recovery-oriented system of care. The panel presentation allowed providers in Connecticut to share the accomplishments of this model of care to legislative health committee

representatives from across the nation. Late in 2008 I also had occasion to spend many hours, over two separate meetings, with staff members from the Program Review and Investigations Committee [of the State Legislature] – who this year were focusing on substance abuse services rendered to adults in the state of Connecticut.

What's Ahead for 2009

During calendar 2009 the Agency will be focused upon fully implementing the design of our newly integrated model of: mission, purpose, methods, readiness, and evaluation. 2009 will be the year we begin to expand our exploration of the correlations between our selected intervention methods and the outcomes of care. As we pursue this objective the Agency will be mindful of opportunities to further improve our training and staff development program and the overall consistency of the quality of our care.

Some additional goals for 2009 include:

- Expanding the opportunities for ADRC Program graduates to become more involved in our system of care and support. The Agency will continue the effort to offer more ongoing support to program graduates and develop more opportunities for program Alumni/Alumnae to “give back”.
- Increasing the role played by mid-level administrators: In 2008 the Agency began a process to enhance the skills of mid-level administrators; now more opportunities must be found to broaden their role in the Agency – particularly outside of their own program.
- Sponsoring the first ever ADRC Symposium – dedicated to the education of those staff and community persons who provide substance dependence treatment services to persons who are primarily urban, indigent, racially diverse, and without stable housing. Our first symposium is scheduled for May 11 and we have two experts in the field who will be discussing the implications of exposure to violence as a contributing factor to the evolution of substance dependence problems.
- Evaluating the impact of our new buprenorphine detoxification protocol. This protocol was initiated in the summer of 2008 as an alternative treatment intervention for those persons not eligible for methadone detoxification [but in need of opioid detoxification] or who are eligible for methadone detoxification but prefer not to use that method. Our evaluation will be used to make adjustments to the protocol as the evidence warrants.

Program & Operational Reports

2008

Treatment Services – Support Services – Quality of Care

ADRC Client Characteristics – FY 2007-2008

Discharges From Care – Fiscal 2007-2008			
	Discharges	Persons	#Single Admissions (%)
All Programs ¹	4710	2141	2068 (69.3%)

¹Data does not include persons who received a one time service [such as a one time toxicology screen]

Discharge Outcomes – Fiscal 2007-2008			
Favorable Outcome		3623	76.9%
	Completed	3329	70.7%
	Left with Program's Advice	294	6.2%
Unfavorable Outcome		1087	23.1%
	Against Medical Advice	798	16.9%
	Other Non-Compliant Discharges	289	6.1%

Client Characteristics – Fiscal 2007-2008		
Gender	Male	74.3%
	Female	25.7%
Age	Average	38.5
	Median	39.0
Race	African-American	23.7%
	Caucasian	49.2%
	Latino	25.2%
	Other	1.9%
Length of Stay	Average [days]	18.7
	Median [days]	6.0
Legal	History of Arrest	85.9%
	Served Time in Jail/Prison	60.4%
	Case Pending	21.8%
	On Probation	25.3%
Trauma Exposure	One or More Exposures	63.0%
	Average Number of Exposures	2.1
Selected Items	Spanish Speaking (primary)	12.8%
	History of Head Injury	13.7%
	Seeks Family Participation	34.6%
	Contact with Parental Caregivers	68.2%
	Family History of Substance Abuse	49.2%
	Education Level	11.1 years
	History of Emotional Problems	44.2%
	Treatment for Emotional Problems	36.4%
Relationship Status	Currently on Medication	31.8%
	Married	7.9%
	Widow	1.7%
	Engaged	2.9%
	Significant Other	12.3%
	Separated	6.4%
	Divorced	19.4%
Never Married	49.5%	

**Fiscal Year
FY 2007-2008
Selected Client Characteristics & Activity – by Program**
[Data derived from discharges from care]

Program	Gender		Race				Living Situation			Age		Episodes Of Care
	Male	Female	Caucasian	Latino Hispanic	African American	Other	Homeless	Dependent	Independent	Median	Mean	
	%	%	%	%	%	%	%	%	%	n	n	n
Detoxification Center	77.2	22.8	54.4	23.4	20.4	1.9	32.0	14.8	53.1	39	38	2946
Clayton House	48.1	51.9	94.3	3.8	1.9	0.0	44.4	20.4	35.2	39	38	54
Intensive Treatment Program	68.7	31.3	42.9	26.7	28.3	1.7	41.6	19.3	39.1	40	39	518
Intermediate Treatment Program	47.5	52.5	50.8	23.7	22.0	3.4	66.1	20.3	13.6	43	41	59
Coventry House	0.0	100	52.9	29.4	17.6	0.0	50.0	16.7	33.3	24	27	16
Alternate Living Center	100	0.0	50.0	13.5	36.5	0.0	32.7	61.5	5.8	44	43	51
Housing Supports	0.0	100	54.7	17.0	26.4	1.9	66.0	24.5	9.4	45	44	53
Recovery House Programs	68.6	31.4	57.3	20.9	20.3	1.6	58.6	24.2	17.2	40	40	315
Outpatient Counseling Centers	70.9	29.1	24.0	36.9	36.5	2.6	18.9	22.9	58.2	40	39	689

Coventry House

Karen Gardner, MA, LADC
Program Director



Coventry House is a 10 bed, long term, residential substance abuse treatment program for pregnant and parenting women and their children. The majority of our clients remain in treatment for 6-12 months as they progress through the multiple phases of treatment. We provide a safe, nurturing environment that promotes physical, emotional, and spiritual well-being. We provide support through the birth or reunification of a child, and the often challenging period of transition afterwards. In 2008 Coventry House provided these services to twenty-six (26) pregnant and/or post-partum women and their children, from newborns up to 4 years old.

Many of these clients successfully completed the program and remain connected to Coventry House through the new alumni group. The alumni group was revived in April 2008 and continues to meet monthly. Attendance at these meetings has ranged from six to ten clients. Clients who cannot attend have maintained contact with staff by stopping in to visit or calling periodically.

This year there were several improvements to the facility, including a new heating system which has greatly improved our ability to maintain a stable and comfortable temperature. We also carpeted and painted the old administrative wing to make a cozy group room and three nice offices for the clinicians. These changes have given Coventry House a more home-like feel. We plan to continue facilities improvement into 2009.

The clinical program has been further enhanced in 2008 as we closely reviewed our treatment methods and put more focus on providing gender responsive and trauma informed treatment. Coventry House also instituted a new point system which makes it easier for clients to earn their pass hours and rewards participation in groups and adherence to rules. ADRC has offered numerous trainings this year which have both developed the clinical skills of the staff and also made all staff more aware of potential safety risks and how to manage them effectively.

Our childcare services have been enhanced with the assistance of Irene Garneau, a consulting childcare educator from Capitol Region Education Council (CREC). She assisted childcare staff in developing a "Mommy and Me" group and in planning age-appropriate activities for the children. One of the clinicians and a childcare worker took part in a research project which involved becoming certified in "The Happiest Baby on the Block" method of preventing shaken baby syndrome.

In 2008 Coventry House clients enjoyed our annual trips to the Recovery Walk in Hartford, The Big E, and numerous recovery events held at the local Connecticut Community for Addiction Recovery (CCAR) center in Hartford. Despite difficult economic times, the clients of Coventry House had joyous holidays thanks to the generosity of the Law Offices of Shipman and Goodwin, the Jaycees, and two local women's spirituality groups. Each of these organizations donated holiday gifts for the clients and their children.

In 2009 we will continue our projects which provide a home-like environment for our clients through painting and decorating. We will also continue to improve the clinical aspects of the program by focusing on further staff training in gender responsive treatment and recovery oriented care.

In February, 2009 Coventry House plans to become a tobacco free treatment facility. We will support current clients through this transition by providing an on-site smoking cessation group.



Detoxification Center

Rose Johnson, RN
Program Director, Director of Nursing



ADRC's thirty-five bed facility is the largest freestanding detoxification center in the State of Connecticut. We offer medically-monitored, inpatient treatment to clients who are experiencing withdrawal from alcohol and other drugs. Those clients seeking admission are screened through our Triage Center, which is in operation twenty-four hours per day. We are staffed by Registered Nurses, Licensed Practical Nurses, Physicians, Medical Assistants, Counselors, and Detox Technicians who work together to provide a safe, caring and culturally competent environment. In December, the Detoxification Center was licensed for another two years by the Connecticut Department of Public Health (DPH).

During the past year, the Detoxification Center has had approximately 3000 admissions with the following ethnic breakdown: African-American (21%), Latino (23%) and Caucasian (55%). The percentage of Latino clients was slightly down from the prior year.



Nancy Hunter, M.Ed., LADC, CCS
Director of Counseling

We encouraged ongoing feedback from clients as a measure of how well we delivered services and to identify areas needing improvement. Tools such as client surveys, informal discussion groups and focus groups enabled us to effectively listen and track client responses. For example, clients repeatedly expressed a need for increased counseling staff on the weekends. In response, we

reconfigured the work schedule and filled positions to provide additional weekend counseling hours to ensure that our clients have increased access to staff to address their clinical concerns during the weekend.

Most recently, the Detoxification Center has been intensely involved in fostering a customer service approach in helping our clients reach their goals. We used part of our monthly staff meetings to introduce elements of customer service development through role playing, conflict resolution and listening skills activities. These sessions have been informative, lively and enjoyed by staff. They contributed to improved staff morale, confidence, and teamwork.

In July, we added a buprenorphine protocol for opiate detoxification. This has gone very well, and we believe that it has resulted in both a desirable detoxification option and improved client retention.

We believe that the results of these and other initiatives were also reflected in a key client outcome measure: the rate of discharges by clients against medical advice (AMA) was below 19% for the year.

The Detoxification Center Counseling Department addressed professional development needs by attending various training events and seminars. One goal has been to continue accumulating training hours and work experience for certification as addictions counselors by the Connecticut Certification Board (CCB). This arduous process will continue into 2009. Skills and information from ongoing education and training were instrumental in identifying and addressing the changing needs of our clients. In particular, age and/or gender-specific groups were conducted whenever warranted by the Detoxification Center client population. Staff also made concerted efforts to further develop the quality of clinical documentation and assessments for aftercare services. As a result, the average referral rate for the year was a record 79%. In addition, much ongoing effort was spent in cultivating relationships with community providers to access needed services.

The Detoxification Center continued to be a primary provider for the Connecticut Department of Mental Health and Addiction Services (DMHAS) Alternative to Hospitalization (ATH) pilot diversion project that identifies substance abuse clients presenting with mental health issues in the Emergency Departments of Saint Francis Hospital and Hartford Hospital. We provided 23-hour medical observation and further screening for detoxification protocols when deemed necessary. The staff worked diligently to quickly yet thoroughly assess these clients and transition them to their pre-designated next level of care.

Our Senior Engagement Program, which promotes good health and well-being physically, socially, psychologically, and spiritually, is designed to assist and address issues of the fifty-five and older population. This program is coordinated by a Senior Engagement Specialist who is primarily concerned with four major components to reach this underserved population: outreach, networking, referrals, and assessments. An age-specific assessment tool is used to identify physical or psycho-social issues that may hinder a client from seeking or maintaining recovery.

Referrals were made to inpatient and outpatient programs, town social service agencies, area agencies on aging, health aides, Visiting Nurses Association, senior job banks, senior volunteer opportunities, family caregiver support groups, Meals On Wheels, senior eye care programs, community mental health organizations, age-specific legal service programs, Access to Recovery programs and Connecticut Department of Social Services. Following discharge from the Detoxification Center, follow-up contacts were made within thirty days through phone calls or home visits. This helped to establish and maintain a recovery supportive environment.

Clayton House

Michael C. Zito, NCC, LPC
Program Director



Now in its twenty-third year of operation, Clayton House continues to provide therapeutic services to persons seeking freedom from substance dependency as they prepare for a return to independent living. As it has from the beginning, Clayton House – a fifteen bed, co-ed therapeutic treatment environment in Glastonbury -- seeks to impart the importance of personal and financial responsibility to those it serves. Each of our clients is required to obtain full-time employment during the day and to then participate in an intensive in-house evening treatment regimen that includes individual and group counseling, as well as active involvement in 12-step and/or other self-help/peer support groups.

In 2008, the staff and clients of Clayton House experienced a great deal of change. Two of our long-time staff members left for personal or health reasons. Although it is never easy to lose important and respected members of the team, we have also learned that it can be an opportunity to bring in new staff members with fresh ideas and enthusiasm. That, I am pleased to say, is precisely what happened at Clayton House with the addition of Counselor Lori Powell. A veteran of substance abuse treatment, Lori joined the clinical team in October and, with the help of two new clinical interns and our new third shift manager, Anthony Ellis, has brought an infusion of new clinical methods and possibilities.

2008 also brought the Connecticut Department of Public Health (DPH) bi-annual operating license renewal process. The unannounced renewal site visit usually lasts an entire day and focuses on all aspects of client care, from the physical plant conditions to client clinical documentation. With the assistance of ADRC's Performance Improvement Director, Doris McLaughlin, I am very pleased to report that the audit was a success and resulted in Clayton House being licensed to operate for another two year period. It is noteworthy that many of the upgrades mentioned in last year's annual report were noticed and appreciated by the DPH inspector. In addition, the Town of Glastonbury Board of Health conducted its own inspection in February 2008 and they too found our facility to be in "outstanding" condition. As 2008 draws to a close, the staff of Clayton House is now preparing for the Joint Commission's unannounced survey which will take place sometime in 2009.

Another significant improvement to Clayton House has come through the assistance of ADRC's Clinical Director, Mary Painter. Mary has made frequent visits to our program for staff meetings, to provide supervision and to facilitate focus groups with our clients and our staff. Mary has taken our staff's requests for further education and used them in a robust training program. With at least

one offering per month, members of the Clayton House team have participated in training dealing with Dialectical Behavioral Therapy, spirituality counseling, problem gambling, suicide assessment, risk management, and Seeking Safety. Each of these trainings not only teaches our clinicians new skills, it also affords Clayton House staff a greater opportunity to network with others throughout ADRC.

The Clayton House annual report would not be complete without mentioning our active alumni group. We continue to host alumni group meetings each Wednesday evening at Clayton House. This year our group of alums worked together to organize the annual alumni picnic and our participation in the 2008 Connecticut Community for Addiction Recovery (CCAR) Recovery Walk in Hartford.

By all standards, 2008 was a very exciting year and, as 2009 begins, the staff of Clayton House looks forward to continuing the mission of helping those who seek freedom from substance dependence by providing support, therapy and fellowship.



The Programs at 56 Coventry Street

Alternate Living Center

Men's Housing Supports

Recovery House I & II

Stacey Johnson, MSW, MBA

Program Director



During 2008 there has been a major focus on the service quality and staff competencies at 56 Coventry Street. These services were provided by long standing staff members as well as new additions to the team, including ADRC program alumni. In addition, a number of individuals completed their internships from both the Manchester Community College Drug and Alcohol Recovery Counseling (DARC) Program and Central Connecticut State University Professional Counseling Master's Degree Program. We have been happy to have hired staff from among both alumni and interns.

There have been some tremendous interior renovations at 56 Coventry Street throughout the past year. All client areas, including bedrooms, have been painted. All common areas on the first floor are now painted in vibrant art deco colors. Floor tile and lighting were both upgraded in 2008. Much new furniture and new beds have also been purchased. In addition, the Recovery House dining area received all new furniture. Both dining areas also have newly installed cabinets and counters.

Men's Housing Support (MHS)

Men's Housing Support is a service of the Substance Abuse Treatment Enhancement Project (SATEP). The program is located directly adjacent to the Recovery House and has a very similar structure. The program includes six male beds, primarily for men who are not currently eligible for State-Administered General Assistance (SAGA). The average length of stay is twenty-four days, though residents are able to stay up to thirty days. The Men's Housing Support program provided transitional housing services to fifty-three (53) men in the last year.

Alternate Living Center (ALC)

ALC is a 15 bed long term transitional housing program for adult men. This program receives no external funding, and is supported by the residents and ADRC. The intent of this program is to assist residents by providing recovery support, stability, access to treatment and community resources. Each client is assigned a case manager to assist in any needs that may arise. In addition, clients have access to an employment specialist to assist with employment needs. Residents within this program are expected to obtain and maintain employment, while also paying rent of \$125.00 per week. This past year there

were some adjustments in ALC staff. ALC is currently managed by Joseph Apanowitch, MSW. The program is taking a strength-based approach and helping all of the men find power within themselves. In addition, ALC is focusing on an enhanced self-governance approach. The clients have been very receptive to this and have embraced the opportunity to interview potential residents.

Recovery Houses I and II

The combined Recovery Houses can accommodate up to thirty adult women and men, for up to ninety days. Recovery House I was established in 2000 with twenty beds primarily for difficult to engage opiate dependent individuals eligible for State Administered General Assistance (SAGA). Recovery House II was established in 2007 with ten additional beds primarily to meet the important needs of those with cocaine and/or methamphetamine dependence who were in need of a period of supervised residential care. The Recovery Houses are designed as engagement and transitional programs for individuals awaiting their next level of care or independent living. This next level of care could be sober housing, a residential treatment program or various other treatment options. While at Recovery House, clients attend local outpatient treatment programs as well as a minimum of three AA or NA meetings per week. In addition, residents are assigned an individual case manager to assist in meeting their current needs and planning for the time after they leave the Recovery House. Residents may access one of the employment specialists for vocational assessment and employment search assistance.

Many of the clients who are served at the Recovery House programs are considered high service utilization individuals and have been assigned a General Assistance Intensive Case Management (GAICM) recovery specialist. All clients who are admitted to the Recovery Houses are referred to appropriate outpatient services, and all outpatient programs are within walking distance or accessible by bus. The average length of stay at the Recovery House programs is approximately four weeks. In 2008, 69% of the residents were male and 31% were female. The racial/ethnic breakdown is as follows: 55% Caucasian, 25% African American and 17% Hispanic. Approximately 300 clients were served in 2008. Importantly, seventy (70) percent of the residents leave the Recovery house and transition to a next level of care.



New Floor Design

Outpatient Counseling Centers

Stephanie Krulewitz, MA, CCDP, CAC, LADC
Program Director



The Outpatient Counseling Centers (OPCC) offer Intensive Outpatient Treatment (IOP), Relapse Prevention and Aftercare services, as well as general outpatient services at two locations in Hartford. Each location is conveniently located on a CT Transit bus line and offers ample parking for our clients' convenience. Clients with limited resources are provided bus tokens to and from treatment; this has aided in the retention of clients in treatment who might otherwise be unable to get to and from their program. Our Main Street program provides Spanish language in a culturally supportive setting.

Treatment is tailored to the individual needs of each client as assessed during the intake/screening process and is re-evaluated continuously throughout treatment by both the client and the assigned primary counselor. Each OPCC location holds an outpatient psychiatric services license, in addition to a substance abuse license. Two consulting psychiatrists (one of whom is Spanish speaking) provide consultation and medication management to ADRC outpatient clients with co-occurring mental health and substance abuse needs – allowing for greatly enhanced continuity of care.

IOP services are offered during both day and evening hours, three to five times per week, three hours each session, Monday through Friday (the Main Street site is open only during daytime hours). IOP services are designed for clients who need highly structured care and frequent contact but do not require the degree of structure and support provided in residential treatment. IOP treatment affords clients the ability to continue their employment or education and to remain in their home environment while participating in treatment. Each OPCC location provides IOP services to selected clients residing at the ADRC Recovery House.

IOP employs a highly structured cognitive behavioral group therapy approach and includes psycho-educational sessions concerning the nature of addiction, the process of recovery, and general life skills. In addition, trauma sensitive programming, such as Seeking Safety, has been added to the IOP this year in order to help clients manage the effects of traumatic experiences while maintaining sobriety. The program's goal is to help clients acquire necessary coping and relapse prevention skills, learn to manage cravings, and to develop sober social supports, including 12-step involvement.

Clients not requiring an intensive level of care, or who need continued treatment following completion of IOP, are offered Relapse Prevention [RP] and Aftercare [AC] services, as well as general outpatient services [such as individual and

family counseling services]. In addition to our primary group counseling services [RP & AC] each OPCC location offers an early intervention group for those clients at high risk for, or in the early stages of, substance abuse. The Coventry Street site has added several “special service” groups to our curriculum this year including Men’s Seeking Safety and Helping Women in Recovery. For all levels of care, during 2008 we added an Art Therapy component to help enhance our clients’ coping skills.

The Coventry Street site continues to provide Saturday services for clients needing an intake to enter treatment, but who are unavailable to attend an intake appointment during our weekday hours. Saturday hours have proven very successful and have provided evaluation and treatment for clients who otherwise may not have entered care. In 2008, this site added daily “detox slots” which provide clients leaving the ADRC Detoxification Center same day outpatient appointments, as well as transportation to those appointments, in an effort to improve the continuity of care for ADRC detoxification clients.

Each OPCC location participates in the Project SAFE initiative of the Connecticut Department of Children and Families (DCF). Through this program, comprehensive substance abuse evaluations are performed on parents or other caretakers who are in need of a substance use/abuse evaluation. These locations continue to provide random urine drug screening and diagnostic hair testing for DCF-involved clients.

Our Outpatient programs serve a significant population of clients with co-occurring (substance abuse and psychiatric) disorders. These clients receive psycho-education support aimed at helping them address their psychiatric symptoms. The program also provides onsite psychiatric assessment and ongoing medication management through the services of our consulting psychiatrists. This has reduced the necessity of referrals to outside mental health agencies and provides an enhanced continuum of care. In an effort to increase staff competency in the treatment of co-occurring disorders, we have joined the Connecticut Co-Occurring System Integration Grant (COSIG) which, with the help of Dr. Mark McGovern from Dartmouth University, has allowed us to further integrate and strengthen co-occurring programming.

In June, 2008 we held a dedication ceremony for our newly renovated and expanded building at Coventry Street, made possible by the generous funding from the Hartford Foundation for Public Giving and the cooperation of the City of Hartford. The new group rooms and renovated office space have substantially improved the professional appearance, comfort, privacy, flexibility, and size of the treatment spaces. Clients and staff have responded very favorably to their new “home”.

Intensive Residential Program Intermediate Residential Program

Hebe Kudisch, CADC
Program Director



The **Intensive Residential** program is a 28 bed facility designed to provide short-term, residential care utilizing individual counseling, group therapy, family involvement, and psycho-educational groups, as well as regular in-house and off-premises 12-step meetings. During their 14 to 30 days of treatment, clients receive individualized treatment plans, continuing care updates, and discharge plans – commonly oriented to connecting the client to a less intensive next level of care. The Intensive Program is usually preceded by some form of detoxification care.

The **Intermediate Treatment** Program is a 10 bed residential program that involves up to 90 days of treatment, 60 days being the average length of stay. The Intermediate Program is open to individuals who have completed an intensive residential treatment program or who otherwise meet admission criteria. Client referrals to this program must meet the Connecticut Client Placement



Nancy Hunter, M.Ed., LADC, CCS
Director of Counseling

Criteria III.5 level of care. Similar to the Intensive Program, Intermediate Program clients receive individual counseling, group therapy, family involvement, and psycho-educational groups, as well as regular in-house and off-premises 12-step meetings – all tailored to an intermediate level of care. Clients receive individualized treatment plans, continuing care updates, and discharge plans – with more emphasis on re-entry into the community.

Our Intensive & Intermediate (I&I) staff again this year demonstrated its energy, spirit and passion for our clients. We continued and expanded the effort to become a co-occurring disorder capable program [the co-occurring rate exceeds 40%]. Staff participated in multiple in-service trainings, as well as trainings held at the Department of Mental Health and Addiction Services (DMHAS), Saint Francis Academy, and the Connecticut Women's Consortium. Additional staff also received training in the *Seeking Safety* substance abuse/trauma curriculum [at admission, approximately three quarters of our clients report a history of exposure to one or more types of trauma]. Risk assessment and suicide prevention was another major training initiative in 2008; this important training was taken by all I&I staff.

We spent a lot of time in 2008 refining our group schedule and offerings. The daily psychotherapy group, most commonly known as The Feelings Group, has become the most popular one; by all reports, most clients look forward to being there. We divide the community into three smaller “home” groups; clients attend the same “home” group every day during their stay. Health and education groups are also very popular; we established and refined a rotating curriculum of important topics. Also, a new program of activities has been developed for the weekends. Clients particularly seem to be enjoying and benefiting from the co-occurring disorder curriculum used during Saturday’s afternoon group; a masters level clinician and a certified co-occurring clinician are facilitating this group every weekend. I can not leave out the popularity of Pastor James Lane’s twice weekly spirituality groups and Donna Lentini’s poetry groups and talent shows.

One important addition to our range of services this year was our Peer Support Group – known as *Living Life on Life’s Terms*. The group, which meets every Friday afternoon, is open to all I&I alumni, the only requirement is to be clean and sober. The group facilitator is an I&I staff member. Since we started the group in September, the average attendance has been nine. Current I&I clients may also attend this group with the alumni. It is a powerful experience for them to hear from those who are moving forward with recovery after leaving I&I. Alumni also derive substantial benefit from the opportunity to return to I&I both for their own benefit and to help others each Friday.

The rate of unscheduled discharges, including against medical or clinical advice (AMA/ACA), is an important performance measure for I&I. This year we concentrated more on reducing the rate in the Intermediate Residential Program, making some changes to the screening and admissions process, as well as ongoing efforts to promote client engagement. We also assigned a team leader for each shift who is primarily dedicated to Intermediate clients. Staff is constantly brainstorming strategies to address the overall AMA/ACA rate in I&I, and to retain clients for the full duration of their program. Currently, a particular area of focus is improving the retention of young adults, who seem particularly vulnerable to early departures from treatment. As we move into 2009, we will develop additional approaches to help support and retain young adults in their progress on recovery.

We closed out the year with our bi-annual license renewal process with the Connecticut Department of Public Health (DPH), which resulted in a successful site visit and license renewal for another two years. The regulatory readiness of the programs is a testament to the efforts of I&I staff as well as many members of the administrative staff.

We in I&I are very fortunate to have a talented and dedicated staff who successfully supported our clients twenty-four hours a day, every day in 2008. As Program Director, I am very grateful to all of them.

Recovery Support Services

William Young, MS
Chief Operating Officer
Mary Painter, MSW, LADC
Clinical Director



Recovery-Oriented Employment Services (ROES)

Recovery-Oriented Employment Services (ROES) -- inaugurated in 2008 -- is a vocational support program funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS). Begun in July, it provides employment assessment and support services to eligible individuals participating in addiction treatment and recovery support services in North Central and Eastern Connecticut. The ROES program represents a fairly unique collaboration between a traditional non-profit service provider (ADRC) and a community peer service organization Connecticut Community for Addiction Recovery (CCAR).

The ROES client participates in an assessment with an ADRC employment specialist (in English or Spanish) which includes –

- Individual interests, strengths and talents.
- Employment, training and educational history.
- Motivation to engage in job search efforts.
- Risk of relapse and other barriers which may impede progress.
- Transportation capabilities and challenges.
- Individual issues such as medical conditions, motor ability, vision, hearing, literacy, physical endurance and other factors which may effect the identification of best-fit work or education environments.

As appropriate, referrals are made to community and State of Connecticut employment services, educational resources and employers which best match the needs and preferences of the individual. Based on the plan developed with the client and coordinated with the treatment provider, the employment specialist will maintain regular phone and in-person contact with the client.

In addition, clients may participate in the Telephone Recovery Support Program operated by CCAR, and other peer support recovery activities at CCAR. CCAR also offers a weekly recovery-oriented employment support and education group at the recovery community centers in Hartford, Willimantic and Waterford.

In its first six months of operation, ROES has served 151 individuals, 57% male and 43% female. The racial/ethnic mix is approximately 41% Caucasian, 34% Black, and 23% Hispanic. Through December, 72 participants have obtained paid employment while in the ROES Program.

General Assistance Intensive Case Management [GAICM]

The General Assistance Intensive Case Management [GAICM] Program is designed and structured to provide intensive case management services to clients with substance abuse and/or mental health histories who are eligible for State Administered General Assistance (SAGA) and who have been selected as persons in need of improved treatment engagement and coordination by virtue of histories of relatively rapid readmission to treatment services. Six Recovery Specialists based in Hartford work with clients in the North Central Region who most benefit from extended, focused support in treatment and recovery activities. The Recovery Specialists coordinate closely with treatment providers, housing and other recovery supports. In Fiscal year 2008 the GAICM staff provided recovery support services to 262 clients.

Regional Transportation Program

The Regional Transportation Program is a service of the Substance Abuse Treatment Enhancement Project (SATEP). This program provides service to individuals in need of transportation to reach detoxification and other levels of care. Transportation services are available twenty-four hours a day, seven days a week in a safe and courteous manner. Approximately two thousand (2000) transports were provided in 2008.

Senior Outreach Services

The Senior Outreach Services are designed to respond to the special concerns of persons age fifty-five (55) and older in the Greater Hartford region who may be at risk of substance abuse [including inadvertent medication abuse] or who have substance dependence treatment needs. Services tend to be of two particular types: outreach and psycho-education through locations where older adults tend to congregate or seek services (such as senior centers) and case management for persons who are currently or recently involved in substance abuse services. In addition the Senior Outreach worker participates in special assessment and treatment services available in our Detoxification center and the Alternate Living Center. In the most recent annual period the Senior Outreach worker provided services to more than one hundred fifty (150) persons.

Infectious Disease Services [sometimes known as HIV Outreach Services]

The Infectious Disease Services are designed to respond to the special concerns of persons who: may be at high risk to acquire a major infectious illness such as HIV or Hepatitis C, need services for the care of an illness such as HIV, or are

concerned with the risk of transmission of an infectious illness to a partner or family member. Services tend to be of two particular types: outreach and psycho-education at Agency service sites and case management for persons who need to initiate or resume treatment for an infectious illness. In the most recent annual period more than three hundred (300) persons received services and there were in excess of two thousand four hundred (2,400) contacts with persons in need or at risk.

Women's Case Management Services

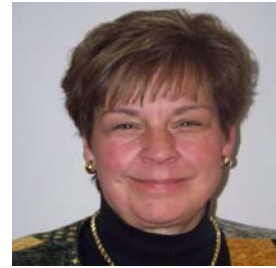
This service is intended to help arrange supportive services to women who are scheduled to be discharged from a local (Region III or Region IV) women's residential substance abuse program. The services are designed to complement and augment those discharge planning efforts made by the host treatment program and facilitate a smooth transition as women move from one level of care to another. In FY2008 Women's Case Management Services were utilized by one hundred (100) women [unduplicated count]. The case manager participated in more than two hundred and forty (240) client case conferences – just one example of her many client support activities.

Innovative Recovery Initiative

ADRC was awarded a one-time DMHAS grant to be used in the first half of 2008 under the Innovative Recovery Initiative (IRI). IRI grants were made to promote creative and efficient development and delivery of recovery support services. ADRC developed and implemented in Hartford and Glastonbury two group curricula, one related to "building recovery capital" and one related to "fatherhood" for those in recovery. Each group series was held twice and was open to both current ADRC clients and others in the community. In addition, eight individuals participated to be coached [mentored] by the group facilitators in preparation for them leading similar groups in the future. The groups were also video recorded for future use by appropriate interested parties.

Performance Improvement

Doris McLaughlin, MS, LADC



During the past year the Performance Improvement (PI) program continued the processes necessary to maintain the high quality of care to which ADRC is committed. This was achieved by maintaining a constant flow of information within all levels of the Agency and through the continuous evaluation of programs utilizing the following processes:

- Monthly chart reviews by each program to ensure that charts meet the required standards.
- Program oriented PI discussions at staff meetings.
- Quarterly PI reports to the PI Committee by all Program Directors.
- Review of all committee activities by the Quality and Outcomes Committee.

The following are examples of 2008 Performance Improvement Activities:

- Continued the implementation of an improved medication management monitoring system throughout the Agency.
- Maintained six outcome measures as required by Joint Commission Accreditation Standards. The six Oryx Measures for 2008 were:
 - Client Satisfaction [including Multi-Cultural surveys]
 - Detoxification Center Against Medical Advice and Non-Compliant Discharge Rates
 - Detoxification Center Referral Rates; During the July-September quarter this measure was enhanced by tracking the referrals initiated and appointments kept on discharge to the Outpatient Counseling Center
 - Intensive Referral Rates; During the July-September quarter, replaced with Medication Reconciliation on Discharge for Intensive and Intermediate Programs
 - Medication Occurrence Reporting – nature and volume
 - Follow through with Client Complaints of Pain: During the July-September quarter enhanced focus on Documentation of Pain > 0 identified on Admission to the Detoxification Program
- Completed a proactive risk reduction activity known as a Failure Mode Effects Analysis (FMEA); the activity focused on client reentry to the Detoxification Program after a visit to the Emergency Department.
- Established an Agency Safety Committee; the committee provides oversight and review of all components of safety within the agency. This includes both client and staff safety.
- Successfully completed the Joint Commission “Periodic Performance Review” (PPR), a self assessment of the applicable standards within the Joint Commission Comprehensive Manual for Behavioral Healthcare. The

self assessment was completed for both the Agency [all accredited programs] and the Opioid Treatment Program. Several “Requirements for Improvement” were noted as results of the PPR process which included enhancing our medication management system through a review of our first dose/first use procedure and our medication reconciliation processes.

- Established a Contracts Review Committee; the committee provides oversight and review of client-related contracted services; utilizing a defined review and evaluation process.
- Incorporated line staff into the “Periodic Performance Review” process.
- Established a monthly Regulatory Readiness Meeting; the meeting focuses on communication and discussion with Program Directors on regulatory issues and changes in accreditation standards.
- Participation in the Building Evaluation Capacity Program (BEC) offered through the Hartford Foundation for Public Giving; our participation in this program evaluation process strengthens the Agency’s commitment to providing quality services to our clients.
- Established an “Accreditation Corner” on our Agency Intranet Site; this is a communication mechanism for pertinent regulatory and accreditation readiness information available to all staff.

Performance Improvement Goals for 2008 include components that have been achieved as follows:

- Agency Intranet Site Utilization:
 - Posted Performance Improvement Committee information (agendas, minutes, findings)
 - Provided all staff with access to program specific outcome data
- Medication Monitoring Process:
 - Improved process of initiation of medication(s) new to clients
 - Increased integration of medication use into client treatment plans
- Mid Level Administrators Group (MLAG) incorporated into specific Performance Improvement processes:
 - Educated MLAG staff on strategic Performance Improvement goals
 - Engaged MLAG Staff in identifying processes needing improvement
- Agency-wide Staff Training and Development Program:
 - Created an inventory of existing staff skills and competencies
 - Implemented routine training and development opportunities with staff input
 - Improved the integration of training and development processes through the provision of external trainers for Nonviolent Crisis Intervention Training and Risk Management Trainings. The trainings were incorporated into staff development requirements this year.
- Program Guideline Review Process:
 - Completed the review of program guidelines
 - Linked program guidelines to specific intervention methods

The Performance Improvement Goals for 2009 include: (components of goals continued from 2008)

- Readiness Preparation: Integration of regulatory initiatives throughout all levels of the Agency
- Agency Intranet Site Utilization: Continue to increase use through:
 - Aggregate and analyze data from client satisfaction surveys
 - Distribute clinical information to direct service staff
- Medication Management Monitoring Process: Continue to evaluate the effectiveness of the process through ongoing review of implemented processes related to:
 - High risk medications
 - Multiple psychotropic medications
 - Initiation of medication(s) new to the client
 - Integration of medication use into the client treatment plan
- Mid-Level Administrators Group [MLAG]: Continue to incorporate into the Performance Improvement Process through:
 - Implementation of initiatives from the PI Committee and/or based on the Agency Performance Improvement Plan
 - Increasing the involvement of direct service staff in the Performance Improvement processes of the Agency
- Agency-wide Staff Training and Development Program: Continue to revise through:
 - Review of “inventory” of existing staff skills and competencies
 - Review of routine training and development opportunities with consideration given to the inventory of staff competencies
- Program Guideline Review Process: Continue to revise through:
 - Distribution of the Program Guidelines to staff members, which includes a thorough orientation process
 - Distribution of the Program Guidelines to clients
 - Evaluation of the intervention methods with respect to how they contribute to the program guideline goals
- Best Practice Initiatives: Continue to stay current on best practices related to the treatment of Substance Use Disorders and increase best practice approaches in the area of co-occurring treatment
- Performance Improvement Initiatives: Continue to integrate activities within the Agency

Information Technologies

John Pierson

Director, Information Technologies



Information Technologies, in the form of databases, electronic clinical records, and internet and intranet solutions, have played an increasing role in ADRC operations ever since the implementation of the CareLogic [Qualifacts] electronic clinical record in 2003. ADRC has employed these various technologies to facilitate the delivery of care to our clients, and has been successful in integrating the use of electronic charting into its system of care. This has helped the agency apply standards of documentation to all programs, has provided a means of communicating those standards, and will provide an on-going means for providing feedback and monitoring of those standards.

To that end, ADRC has decided to continue its relationship with Qualifacts, the vendor of its electronic clinical record. After a thorough review of available products, it was determined that the new version of its CareLogic offering will continue to provide ADRC with a high level of usability and improved functionality, most notably improved reporting capabilities.

Throughout 2008, ADRC continued its drive to take the information accumulated in quotidian operations and transform it into intelligent reports which can be used by the various programs and the Agency as a whole to monitor various indicators of performance. An example of this is a new system of reporting client satisfaction data based on actual client responses. This system will provide monthly data to all programs on how well they are performing on twelve areas of client satisfaction. This report will show a rolling twelve months of data so that trends and patterns can be detected and responded to in a more timely manner. Over time, in coordination with the new Performance Improvement Director, similar reports will be generated for most major indicators.

One key tool which will continue to play a major part in Agency-wide communications and information delivery is the ADRC Intranet site, which has been expanded to encompass certain Facilities processes and various standing committees. The Intranet will be used to disseminate all of the previously mentioned Performance Improvement reports.

Other ongoing efforts include the redesign of the ADRC external website and the development of a new Access Line website. Information Technologies will also continue to work with Human Resources to facilitate communication with Program Directors by developing reporting tools relevant to training, certification, competencies, and core requirements.

Staff Training & Development

Mary Painter, LADC, LCSW
Clinical DIRECTOR



ADRC provides accessible, timely, responsive, and high quality care to persons seeking to recover from the effects of addictive disorders. The ADRC vision includes being a center for the training and development of persons who want to work in the field of addiction services. This year's staff training and development activities focused on clinical documentation, cultural competence, patient safety, and specific methods of treatment intervention.

In 2008, ADRC offered over 20 different trainings on such important and relevant topics as: Buprenorphine, Cultural Competence, Dialectical Behavioral Therapy (DBT), Spirituality, Problem Gambling, Group Therapy, & Medication-assisted Treatment. There were over 400 slots filled by our ADRC employees for these various trainings. Almost all of the trainings offered were approved by the Connecticut Certification Board, Inc. (CCB) for continuing education credits applicable towards credentialing and licensing requirements. All of these trainings were provided to the staff at no cost to the employee. The training topics were determined based on staff and manager input on agency training needs.

In addition to these trainings, ADRC implemented an agency wide **Risk Management Training** for all ADRC employees. To date, nearly all employees have received this important training on ensuring client physical and emotional safety. Furthermore, the agency made a decision to have all employees trained in Nonviolent Crisis Intervention (NCI) skills. ADRC is also near its goal of having all its employees trained in non-confrontational interventions with clients [the Agency has achieved the interim goal of no less than one staff member per shift in each program]. The Agency has a comparable goal with respect to CPR training – which is provided every year to staff members in need of certification or renewal. The following table summarizes the principal training activities offered during 2008.

The training of interns at ADRC has also flourished in the past year. This year there are a record number [12] of interns at the Agency, representing a variety of teaching institutions and degree programs. There are students from: University of Connecticut School of Social Work, Central Connecticut State University, Manchester Community College, and Lesley College in Boston, MA. We are training students working on their Associates degree in Drug and Alcohol Counseling, Master's level students, and nursing students.

In 2009, the Agency will maintain its efforts at providing the necessary training to provide excellent quality service to the persons we serve. In December of 2008 the Agency performed a comprehensive competencies and skills survey of all staff that has direct contact with clients – regardless of role. This survey will provide the basis for prioritizing the training plan for 2009.

Staff Training & Development Primary on Site Training Activity – 2008

Training Focus & Title	Trainer(s)	Number Trained & Hours
Anger Management Treatment Strategies when working with clients with addiction and co-occurring disorders	Marvin Douglas & Sweets Wilson, PhD	31 attendees 3 hours
Boundary Issues & Professionalism Minding the Boundaries: Taking Care of the Helping Relationship	William Fisher, LCSW	13 attendees 3 hours
Buprenorphine Buprenorphine Protocol for Opiate Detoxification	Dr. Danilo Pangilinan	48 attendees 1 hour
Childhood Development Creating a Curriculum for Mommy and Me Group	Irene Garneau, MA, Director SYCAAH	4 attendees 1 hour
Art Therapy Creative Arts Therapy	Jayne Dean, LMFT, LADC	14 attendees 3 hours
Cultural Competence Multi-cultural issues in Treatment	Robyn Anderson, LPC, LADC	52 attendees 6 hours
Dialectical Behavioral Therapy DBT Skills with Substance Abusers	Lisa Maruccio, PhD	14 attendees 8 hours
DSM-IV Assessing & Diagnosing for Substance Abuse and Mental Health	Stephanie Krulewitz, MS, CCDP, CAC, LADC	23 attendees 8 hours
Group Therapy Introduction to Group Treatment	Stephanie Krulewitz, MS, CCDP, CAC, LADC	Multiple sites 1 hour
Group Therapy Group Counseling Skills	Stephanie Krulewitz, MS, CCDP, CAC, LADC	14 attendees 4.5 hours
Medication Assisted Treatments Medication Assisted Treatment for Substance Abuse	Dr. Patricia Mulready	24 attendees 3 hours
Nursing Assessment Part I-Cardio	Dr. Patricia Mulready	14 attendees 8 hours
Personality Disorders Personality Disorders	Steven Moore, PhD	23 attendees 2 hours
Problem/Compulsive Gambling Why do we need to talk about this?	Pat Devendorf, MS, LADC	16 attendees 4 hours
Compulsive Gambling –Part II	Pat Devendorf, MS, LADC	8 attendees 2 hours
Etiology of Pathological Gambling	Jeremiah Weinstock, PhD	7 attendees 2 hours
Risk Management Risk Management Training for ADRC	Mary Painter, LCSW, LADC; Stephanie Krulewitz, LADC; Rose Marotta, MSW; Bill Young, MS; Stacey Johnson, MSW; Mike Zito, LPC	Mandated for all staff 3 hours
Seeking Safety Utilizing the Seeking Safety Model	Martha Schmitz, PhD	11 attendees 14 hours
Spirituality & Substance Abuse Treatment Spirituality & Recovery in Substance Abuse Treatment	Marcus McKinney, D.Min	21 attendees 3 hours

Fiscal Reports

2008

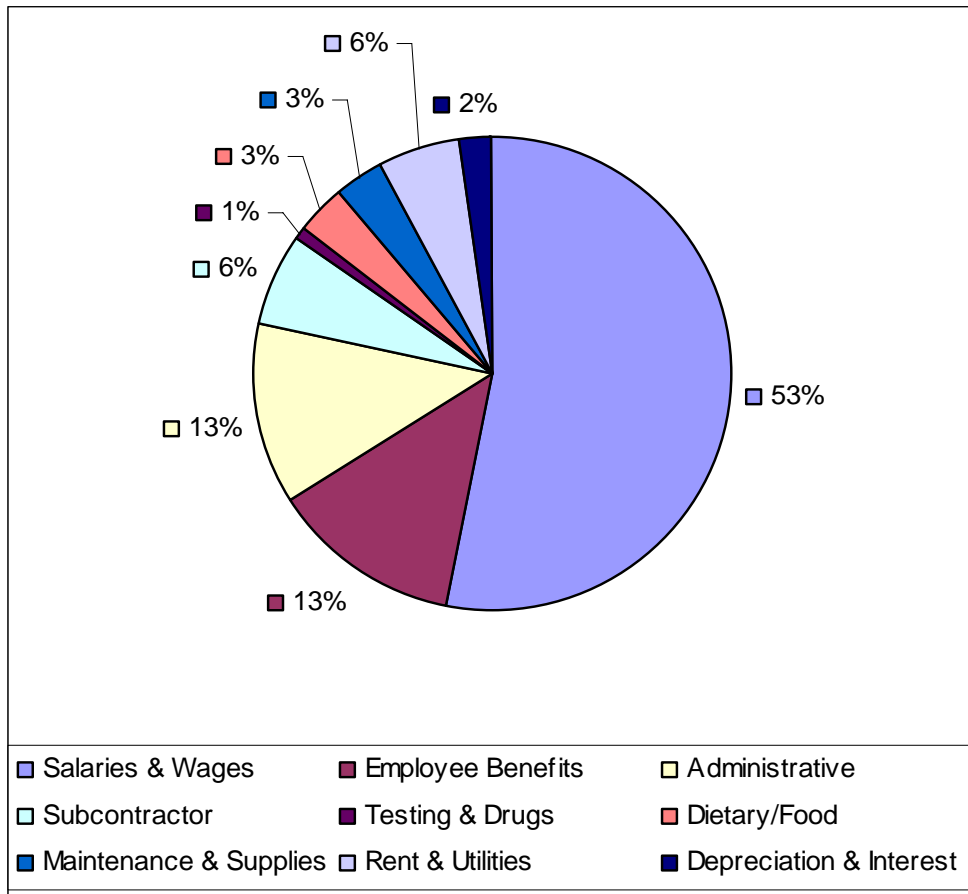
Revenues & Expenses

Fiscal Report

Natalie Cummings
Chief Fiscal Officer

ADRC FY 2008 Operating Expenses

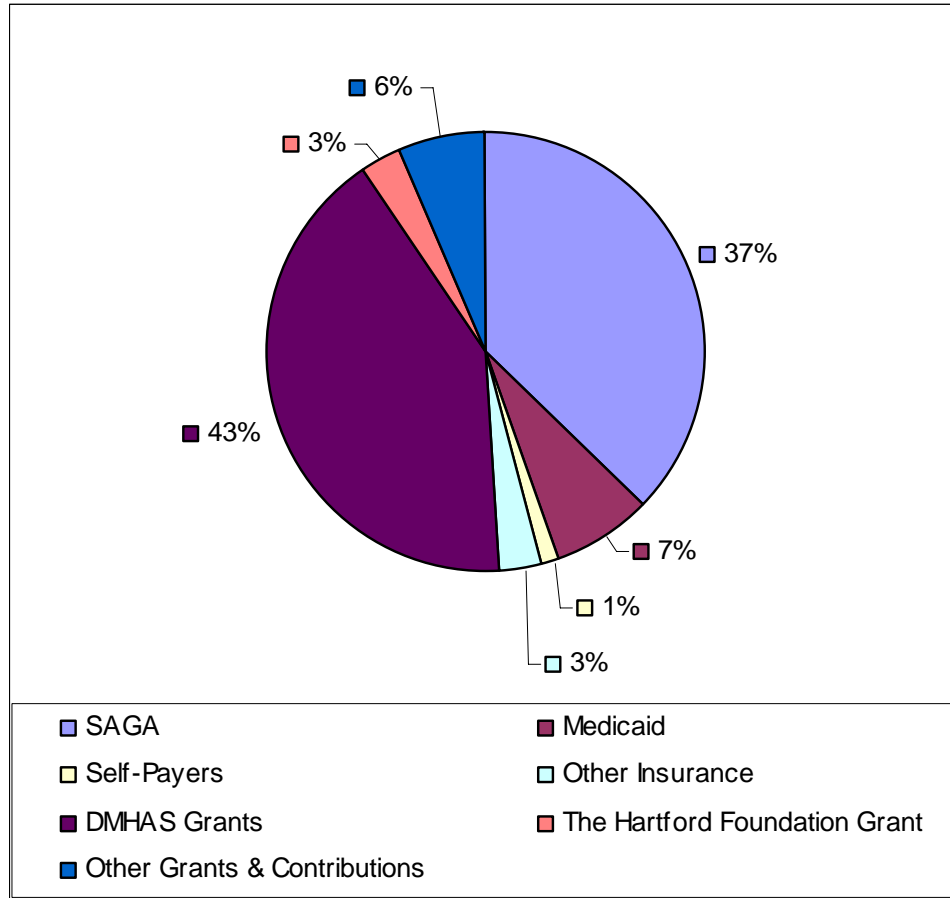
Salaries & Wages	\$	5,635,901
Employee Benefits		1,371,210
Administrative		1,335,281
Subcontractor		682,255
Testing & Drugs		81,405
Dietary/Food		345,460
Maintenance & Supplies		359,077
Rent & Utilities		598,938
Depreciation & Interest		227,490
Total Expenses	\$	10,637,017



ADRC FY 2008 Operating Revenues

SAGA	\$	4,075,722
Medicaid		773,830
Self-Payers		144,897
Other Insurance		346,409
DMHAS Grants		4,550,312
Hartford Foundation for Public Giving Grant ³		329,341
Other Grants & Contributions		691,888

Total Revenues	\$	10,912,399
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³ The Hartford Foundation for Public Giving funds represent a generous, non-recurring grant to cover the costs of renovating and expanding the 16 Coventry Street Outpatient Counseling Center site.

Agency Information

2008

**Mission Statement - Board of Directors
Senior Staff Roster**

MISSION STATEMENT

Alcohol & Drug Recovery Centers, Inc. provides accessible, timely, responsive, and high quality care to persons seeking to recover from the effects of addictive disorders.

VISION STATEMENT

Alcohol & Drug Recovery Centers, Inc. will be an influential leader in the provision of services to persons with addictive disorders by virtue of:

- Maintaining an array of comprehensive and integrated services which support the restoration of lives and the principles of recovery;
- Being an innovator in the design and implementation of additional services as our partnerships in the community and with those in recovery indicate are necessary;
- Being a center for the training and development of persons who want to work in the field of addiction services, especially persons in recovery who feel called to such a vocation; and,
- Supporting research into the causes of addictive disorders.

ADRC PRINCIPLES

As a provider of high quality care to persons seeking to recover from the effects of addictive disorders we are committed to the following principles:

- Recovery is the legitimate hope for all those who seek help with the effects of an addictive disorder.
- Everyone – those we serve and those who are our colleagues – has the right to be treated equitably and with dignity and respect.
- Recovery is best accomplished and maintained when we develop and nurture lasting partnerships with others in recovery, our community, and, when possible, our families.
- Persons in recovery from addictive disorders must be provided with safe and supportive opportunities to learn and practice the skills of living with a chronic illness.
- Services, to be effective, must be accessible, welcoming, empathic, hopeful, culturally-competent, comprehensive, continuous, integrated, responsive, and tailored to the need of the individual.
- The advancement and diffusion of knowledge is prompted both by the training and development of agency staff members and by research into the causes and treatment of addictive disorders.

Board of Directors

New Officer Terms Begin January 15, 2009

Chairperson

Edward Johnson, D.D.S

Vice-Chairman

Timothy Cooley

Treasurer

Donald Straceski

Secretary

James Kelly

Members

John Farrell [retiring on January 15, 2009]

R. Amalia Castillo

Paul Pendergast

Raymond Sailor

ADRC Senior Administration

President & Chief Executive Officer

Ronald C. Fleming, Ph.D., LCSW

Medical Director

Danilo Pangillinan, MD

Chief Operating Officer

William Young, MS

Clinical Director

Mary Painter, MSW, LCSW, LADC

Chief Financial Officer

Natalie Cummings

Human Resources Director

Cooley M. Wrenn, MS, PHR