SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

to the Governor
and the
General Assembly

COMMONWEALTH of VIRGINIA

October 1, 2006

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COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

Patty L. Gilbertson
Chair

P. O. Box 1797
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October 1, 2006

The Honorable Timothy M. Kaine
Governor of Virginia
Patrick Henry Building, Third Floor
1111 East Broad Street
Richmond, Virginia 23219

Dear Governor Kaine:

In accordance with § 2.2-2696 of the *Code* of Virginia, I am pleased to present the ***2006 Annual Report and Comprehensive Interagency State Plan for Substance Abuse Services***.

As chair of the Substance Abuse Services Council, it is my honor and privilege to serve with some of the most professional, highly respected, substance use disorder and prevention experts in the Commonwealth of Virginia. Members of the Council have devoted many hours and resources to the work of the Council.

The 2006 Annual Report contains recommendations in response to Virginia Code requirement (§ 2.2-2697 analysis for each agency-administered substance use treatment program) enacted in 2003.

The 2006 Annual Report also focuses on the lack of state funding dedicated to providing alcohol and other drug prevention services in the Commonwealth. Specifically the report highlights

- The lack of funding for prevention services to address underage drinking.
- The critical need for enhanced and expanded appropriations to utilize Medicaid to reimburse for all substance abuse treatment for all beneficiaries, and
- Information concerning program evaluation to comply with § 2.2-2696 B., and makes recommendations concerning amending this *Code* section.

Finally, the Appendix includes a report on work the Council is addressing with a member agency, the Commission on the Virginia Alcohol Safety Action Programs, as a result of Governor Warner's Task Force to Combat Driving Under the Influence of Drugs and Alcohol.

Everyone - families, friends, and communities - experiences the effects of an individual's substance use disorder. Many people who are addicted attempt to hide their use and deny their addiction as a result of the continuing stigma associated with having a substance use disorder. The stigma regarding addiction also results in individuals who have been successful in their recovery choosing to remain anonymous. Media images invariably focus on people whose

addiction has resulted in serious trouble within one or more of our social or criminal justice systems. Rarely are individuals with substance use disorders portrayed as successful and productive people in stable recovery who are gainfully employed, supporting their children and paying taxes.

Most Virginians have not been given the opportunity to fully appreciate the message of hope that recovery from a substance use disorder is possible. Treatment is usually the first step in the process of recovery for most people. Unfortunately, it has become more difficult to access treatment for individuals with a substance abuse disorder, and recovery is becoming a more distant hope for those who still need treatment.

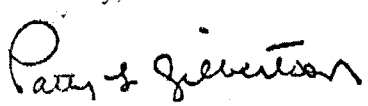
We must commit to shifting our focus on substance use disorders. We must acknowledge the social and criminal justice problems but we must also recognize substance use disorders as a public health issue. No one can deny that substance use disorders affect public safety and social issues. We cannot, however, ignore the compelling evidence that substance use disorders are a chronic, relapsing disease with devastating medical consequences and, as such require ongoing, well integrated treatment and management.

There were numerous additional issues related to substance use disorders that were discussed at great length by members of the Council. All of these affect the quality of life in Virginia for all of its citizens. Many of them have been identified and addressed in the previous Annual Reports.

I also want to recognize the recent appointments of Senator Mark R. Herring, Delegate C. Todd Gilbert, and Delegate David E. Poisson to the Council, and express my appreciation for their participation, as well as that of Senator Roscoe Reynolds, Delegate Beverly Sherwood and Delegate Clifford Athey. Their participation in our meetings has been invaluable.

On behalf of the Council, I appreciate the opportunity to provide you with our 2006 Annual Report, which I hope will contribute in a significant way towards improving the lives of Virginians who are affected by substance use disorders.

Sincerely,



Patty L. Gilbertson, R.N.C.

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SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

TO THE GOVERNOR
AND THE
GENERAL ASSEMBLY
2006

TABLE OF CONTENTS

Executive Summary i

Underage Drinking in Virginia 1

Capacity and Funding: Expansion of Medicaid Coverage 7

Evaluation of Agency Administered Substance Abuse Treatment Programs 15

Appendices:

A. VASAP Report 31
B. Roster of Council Members 43
C. *Code* of Virginia § 2.2-2696 45

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EXECUTIVE SUMMARY

SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

to the Governor
and the
General Assembly
2006

This year's annual report focuses on three issues, selected after considerable discussion and study by members of the Council:

- Underage drinking;
- Expansion of Medicaid coverage for treatment of substance use disorders; and
- Revision to the *Code* requirements related to collection of outcome data by state agencies that provide treatment for substance use disorders.

The Council also worked with a member agency, the Commission on the Virginia Alcohol Safety Action Program, to coordinate substance abuse intervention and treatment programs and services with a high priority on hard core drunk driving and repeat offenders.

PREVENTING UNDERAGE DRINKING REQUIRES ADDITIONAL RESOURCES

The first issue, underage drinking, has received considerable attention at national and local levels, and deserves the attention of the Governor and the General Assembly. The current First Lady of Virginia has already recognized the dangers inherent in underage drinking. A considerable body of evidence indicates that the longer youth delay initial use of alcohol, the less likely the development of alcohol related problems later in life. Unfortunately, research also indicates that, in Virginia, nearly 90,000 youth have a serious alcohol use problem (in addition to violating the law), and nearly 85 percent of those are not receiving any treatment. Over 45 percent of high school seniors in Virginia report using alcohol, and 25 percent who participated in the 2005 Virginia Community Youth Survey indicate that they participate in binge drinking (five or more drinks on the same occasion).

Use of alcohol poses serious risks to young people and has a serious impact on the Commonwealth's budget. For example, each year youth violence associated with alcohol use costs the state over $619.6 million, and fetal alcohol syndrome among infants born to mothers ages 15-20 costs $17.5 million. Virginia's public education system initiated over 1,000 disciplinary actions related to alcohol offenses during the 2004-2005 school year. Clearly, this is an expensive problem.

The Commonwealth has responded using several approaches. The Department of Alcoholic Beverage Control (ABC) has a special enforcement strategy that involves paid underage youth accompanied by an ABC agent visiting businesses to see if they sell to underage youth. ABC retail stores have a compliance rate of 98 percent, while licensees have achieved a compliance

rate of 89 percent. ABC also awards grants from federal funds to localities to address this problem, and has implemented a public education program about the issue.

Virtually all funds that support prevention of underage drinking (or other drug use) are from federal or local sources. The federal Substance Abuse Prevention and Treatment Block Grant, awarded to all states and territories, requires that 20 percent of each state's allocation support prevention services. In Virginia, this amounted to $8,699,974 in Fiscal Year 2005, which was distributed to the 40 community services boards. In order to focus additional resources on this important problem, **the Substance Abuse Services Council is recommending that the General Assembly appropriate $2.4 million annually to support the implementation of evidence-based prevention practices in the 40 community services boards ($55,000 per community services board and $200,000 to the Department of Mental Health, Mental Retardation and Substance Abuse Services to manage the initiative).**

EXPANSION OF MEDICAID COVERAGE FOR SUBSTANCE ABUSE TREATMENT WOULD USE LIMITED STATE RESOURCES EFFICIENTLY

Limited treatment capacity is the second issue of the Council's focus. National studies indicate that about seven percent of all Virginians need, but do not receive, treatment for alcohol abuse or dependence, while approximately 2.5 percent need, but do not receive, treatment for abuse or dependence on other drugs. These rates have remained relatively constant over time. The 2006-2012 Comprehensive Plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services indicates that over 3,000 individuals were on waiting lists for services in 2005, with over 70 percent waiting between one and three months. The number of individuals receiving publicly funded services has declined slightly, due to relatively stagnant funding, increased costs, and longer stays in treatment related to improved treatment methods. Funding for community substance abuse treatment services is almost evenly split between the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and the General Fund. Between 2001 and 2007, General Funds increased from $38,503,482 to $42,470,294 (+ $3,966,812) and the SAPT Block Grant increased from $39,245,298 to 42,930,418 (+ $3,685,120). Since 2005, the amount of the SAPT award has been reduced by over $0.5 million. Other funds, primarily targeted to provide treatment services to the criminal justice population, have declined precipitously, including the elimination of state Substance Abuse Reduction Effort (SABRE) funding and significant reductions in federal Residential Substance Abuse Treatment (RSAT) for Corrections funding.

Localities vary significantly in the amount of funding they contribute, and access to private insurance is limited for a variety of reasons. Many referrals to community substance abuse treatment come from the criminal justice system, but state general funds to support these clients have been curtailed. Nevertheless, the community system continues to attempt to meet these service needs.

Meanwhile, the cost of not providing treatment continues to mount. One national report found that Virginia spent $261.18 per capita to remedy the costs of untreated substance abuse, or 11.5 percent of its budget in 1998. These costs included health, social services, criminal justice, education, mental health and services to the developmentally disabled. However, during that

same period, the Commonwealth spent only $4.20 per capita supporting treatment, prevention or research related to substance use disorders. Of the 47 jurisdictions surveyed, Virginia ranked 33rd in this measure. Furthermore, significant studies conducted by national researchers indicate that at least $1 of every $5 spent by Medicaid on hospital care is attributable to untreated substance abuse or dependence.

If not treating substance use disorders costs money, will treating it save money? Many studies indicate that $1 dollar spent to treat substance use disorders will generate savings of between $5 and $7 dollars in funds not spent on public safety, health, social services and resources generated in employment.

To remedy this lack of resources, **the Council is recommending that Medicaid coverage be expanded to provide any clinically appropriate treatment for substance use disorders for all persons eligible for Medicaid who need treatment.** Medicaid is a federal partnership with the state, in which state dollars are matched (50:50 in Virginia) to cover health care costs for individuals who qualify for Medicaid largely because of low income, or serious disability and low income. The populations most affected by expansion of Medicaid to cover substance abuse treatment would be women with dependent children who receive assistance through the federal Temporary Assistance to Needy Families, and those who are seriously disabled due to a physical or mental impairment. The cost to the General Fund to fully fund the expansion would amount to **$5.5 million per year, and would generate a like amount in federal funds if every Medicaid eligible person who needed services received it.** In addition, because many recipients may already be receiving services in the community services boards, these new funds would "free-up" existing funds to expand capacity.

PROGRAM EVALUATION SHOULD FOCUS ON EVIDENCE-BASED PRACTICES

Finally, this report addresses the requirements in the *Code* [§ 2.2-2697-B] that require the Council to analyze spending and outcomes for the state agencies directly involved in the provision of treatment services, and make funding recommendations based on this analysis. In an effort to assure that public funds are wisely used, most agencies are involved in some level of program evaluation of the services they provide. Generally the emphasis is on using this information to improve services. In substance abuse treatment, reduced use of alcohol or drugs is a common outcome indicator, and might be measured by length of sobriety after treatment. Outcome evaluation, while currently very much the focus of federal and state initiatives, is very expensive. It requires extensive record keeping on each program participant, tracking of the participant once the treatment experience is complete, data collection and storage, and analysis. It also assumes that the effects of the treatment will last once the participant is no longer engaged in treatment, an assumption that is questionable when addressing a chronic relapsing disorder, such as addiction, which may require repeated exposure to treatment at different levels of intensity for a considerable period of time. In addition, outcome measures must be selected that are suitable to the specific treatment environment and population. Another evaluation focus, process evaluation, tends to be more audit focused, but unless the measured processes are highly correlated with good outcomes, it lacks any substantive meaning. Nevertheless, process evaluation can help improve quality and focus limited resources.

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior. To meet these goals, these agencies have implemented several evidence-based practices (EBPs), practices for which strong research support exists, and consensus-based practices (CBPs), techniques that experts agree to be effective, but for which insufficient research exists to meet the stringent criteria of evidence-based. Given the cost of conducting the extensive outcome-based evaluation currently required in the *Code*, and the dearth of public funding for services, **the Council recommends that § 2.2-2697-B of the *Code* of Virginia be amended, as follows:**

> **B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse program: (i) the amount of funding expended under the program for the ~~prior~~ fiscal year *most currently available*; (ii) the number of individuals served by the program using that funding; (iii) the extent to which *agency programs are employing evidence-based practices; and* (iv) ~~program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person cost and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs, and (vii)~~ recommendations on the funding of programs based on these analyses.**

THE COUNCIL COORDINATES RESOURCES TO IMPROVE VASAP PROGRAM EFFECTIVENESS

Also included as an appendix to the document is a report on the Council's work with the Virginia Commission on Alcohol Safety Action Programs. As a result of Governor Warner's Task Force to Combat Driving under the Influence of Drugs and Alcohol, the Council was assigned the task of assisting the Commission with identifying methods to improve the effectiveness of services to "repeat and hardcore drunk drivers." Funded by a grant from the Department of Motor Vehicles (National Highway Traffic Safety Administration funds), the Council has coordinated training to improve screening and improve knowledge about assessment so that local ASAP programs can enhance contractual services from local providers. Funding for this activity will continue and will focus on provider training.

UNDERAGE DRINKING IN VIRGINIA

"Our children are our nation's most important resource and we need to do all we can to help them make good decisions and stay safe. Preventing childhood drinking is an important part of that effort. A child who begins drinking at nine, ten or even older is at serious risk not only for alcohol abuse later in life, but a host of other dangerous behaviors as well."[1]

Anne Holton
First Lady of Virginia

Research suggests that there is a correlation between the age at which an individual begins drinking and his or her continued use of alcohol. Youth who do not use alcohol before the age of 21 are virtually certain never to do so (CASA 2001)[2]. Individuals who begin drinking before age 15 years are four times more likely to become alcohol dependent than those who do not drink before age 21 years. The likelihood of lifetime alcohol dependence is reduced by 14% with each increasing year of age at first use.[3] A report by the University of Maryland's Center for Substance Abuse Research indicates that 47 percent of persons who began drinking before age 14 were alcohol dependent at some point in their lifetime compared to just nine percent of those who begin drinking after age 20.[4] Joseph Califano, who served as Secretary of Health, Education and Welfare under President Carter and has served as the Executive Director of the Center on Addiction and Substance Abuse at Columbia University for the past 27 years, reiterates that drinking at an early age increases the risk that an individual will develop a substance use disorder associated with alcohol later in life.

ALCOHOL CONSUMPTION BY YOUTH IN VIRGINIA

Underage use of alcohol is the major drug that most affects the youth of Virginia. Ensuring Solutions to Alcohol Problems, an initiative of The George Washington University Medical Center, devised an online calculator that estimates the number of adolescents, ages 12 to 20, that are affected by serious alcohol problems (http://www.alcoholcostcalculator.org/roi/). The estimates are based on two federal government national surveys, the National Survey on Drug Use and Health (NSDUH) and the National Co-morbidity Survey (NCS). The population estimates of adolescents, 12 to 20, were obtained from the 2000 United States Census Bureau. According to the calculator, the impact on the 878,909 young people in Virginia is as follows:

- 88,361 youth have a serious problem with alcohol;
- 84.5% (74,492) are not receiving treatment.

The Virginia Community Youth Survey (VCYS)[5] reports the incidence and prevalence of alcohol, drug and violence-related behaviors, the age of onset of substance use, and perceptions of the health risk and social disapproval for use of alcohol, tobacco and other drugs, of youth in Virginia's public schools, grades 8, 10, and 12. In the most recent VCYS, conducted in the fall of 2005 with over 13,300 public school students in grades 8, 10, and 12, the average age of first use of alcohol was 13.23 years. Almost half of the 12th graders surveyed indicated alcohol use in the 30 days prior to the interview. Other findings are as follows:

- 18.9% of 8th grade students interviewed reported alcohol use;
- 34.5% of 10th grade students interviewed reported alcohol use;
- 45.8% of 12th grade students interviewed reported alcohol use.

"Binge" drinking is classified as having five or more drinks on the same occasion (within a few hours).[6] 2004 NSDUH data indicate that, in Virginia, alcohol use among youth is generally comparable with national averages for alcohol use and binge drinking during the last month, and are just slightly higher in overall use and binge drinking for persons age 12-20. Although Virginia youth perceive a higher risk for binge drinking, they continue to have heavy episodic consumption of alcohol. 2004 NSDUH data indicated the highest prevalence of both binge and heavy drinking was for young adults aged 18-25, with the peak rate occurring at age 21 (48.2%).

The 2005 Virginia Community Youth Survey (VCYS) indicates at least 25% of the youth surveyed reported binge drinking at least one time during the two weeks prior to being interviewed. Binge and heavy alcohol use rates decreased faster with increasing age than did rates of past month alcohol use.[7] The table below illustrates frequency of use among youth in the two weeks prior to the VCYS.

TABLE 1: VIRGINIA YOUTH-BINGE DRINKING, FIVE OR MORE DRINKS IN A ROW, DURING THE LAST TWO WEEKS

FREQUENCY OF USE	8TH GRADE		10TH GRADE		12TH GRADE		TOTAL	
	N	Percent	N	Percent	N	Percent	N	Percent
None	4,369	92.6%	3,667	83.7%	2,899	74.1%	10,935	84.1%
1or more times	282	7.4%	533	16.3%	1021	25.9%	1836	15.9%
	4,651	100.0%	4,200	100.0%	3,920	100.0%	12,771	100.0%

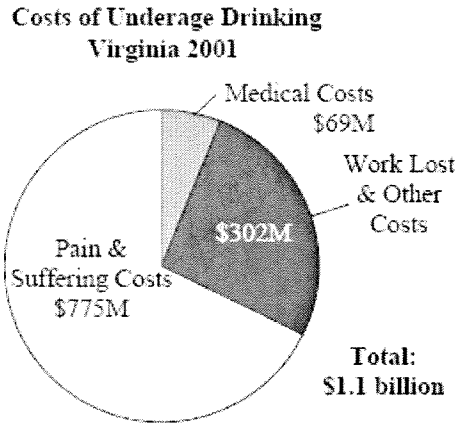
Percentages in the table are weighted and Ns are unweighted.
Source: Survey and Evaluation Research Laboratory, Virginia Commonwealth University 2005-VCYS 2005

ECONOMIC, HEALTH, ACADEMIC, AND SOCIAL CONSEQUENCES

Apart from being illegal, underage alcohol use poses a high risk to both youth and all citizens of Virginia. Underage alcohol use can result in a range of adverse short and long term consequences, including academic and/or social problems, physical problems, memory problems, increased risk of suicide and homicide, high risk sex, alcohol related car crashes, and other unintentional injuries such as burns, falls, drowning, and death from alcohol poisoning.

Binge drinking has been associated with various negative outcomes including drunk driving, accidents and injuries, and other risky behaviors in adults, as well as young people. Binge drinking during pregnancy may contribute to adverse effects on the health of the fetus. Individuals may have an increased risk for stroke or cardiovascular problems, and continued long term binge drinking may cause neurological damage.

FIGURE 1: COST OF UNDERAGE DRINKING VIRGINIA 2001



Underage alcohol use poses significant economic and social costs to the citizens of the Commonwealth, estimated at $1.1 billion in 2001 [8]. This translates to a cost of $1,696 per year for each youth. These costs include medical care, work loss, and pain and suffering associated with the multiple problems resulting from the use of alcohol by youth. Direct costs of underage drinking incurred through medical care and loss of work costs Virginia $371 million each year.

TABLE 2: COSTS OF UNDERAGE DRINKING BY PROBLEM, VIRGINIA 2001

PROBLEM	TOTAL COST (IN MILLIONS)
Youth Violence	$619.6
Youth Traffic Costs	$300.1
High-Risk Sex, Ages 14-20	$84.9
Youth Property Crime	$57.6
Youth Injury	$40.0
Poisonings & Psychoses	$17.4
FAS Among Mothers Age 15-20	$17.5
Youth Alcohol Treatment	$8.8
TOTAL	**$1,146**

Violence and traffic crashes attributable to alcohol use by underage youth in Virginia represent the largest costs for the State. Other problems, as listed in Table 2, contribute substantially to the overall cost. Among teen mothers, fetal alcohol syndrome (FAS) alone costs Virginia $17.5 million.[9]

The impact on the public education system can be significant. The public schools attempt to foster a safe and drug free learning environment that supports academic achievement. In an attempt to provide this environment, during the 2004-2005 school year, Virginia public schools initiated 1,047 disciplinary actions associated with alcohol offenses, including:

- 870 short-term suspensions;

- 148 long-term suspensions;
- 29 expulsions. [10]

The cost of disciplinary actions affects the educational opportunities not only of the offenders, but also of the general school population. Alcohol abuse and dependence among adolescents divert scarce financial resources from school budgets and public safety, as well as time from academic courses and achievement.

ALCOHOL INDUSTRY INFLUENCES ON UNDERAGE ALCOHOL USE

Under-funded prevention resources in State agencies are competing with alcohol companies that are able to spend billions of dollars to influence underage drinking. Companies producing alcoholic beverages spent nearly two billion dollars to advertise alcohol in the media of television, radio, print and outdoor advertising in 2004.[11] Of the estimated $128.6 billion spent on alcohol nationally in 2001, $22.5 billion (17.5%) was attributable to underage drinking. In addition, because underage drinkers are more likely to become adult drinkers with alcohol abuse and dependence - 96.8% of the adult drinkers with alcohol abuse and dependence began drinking prior to the age of 21 years - early initiation also results in a long-term cash value to the alcohol industry.[12]

UNDERAGE ALCOHOL USE AND DRIVING IN VIRGINIA

Underage youth involved in traffic crashes attributable to alcohol use represent the second largest cost ($300.1 million) for the State[13]. According to the Virginia Department of Motor Vehicles:

- 21 youth (ages under 1 to 20) were killed as passengers in alcohol related crashes;
- 26 drivers (ages 15-20) were killed in alcohol related crashes;
- 662 youth drivers were injured in an alcohol related crashes.[14]

VIRGINIA'S RESPONSE TO UNDERAGE ALCOHOL USE

The Virginia Department of Alcoholic Beverage Control (ABC) promotes zero tolerance for underage alcohol consumption as one of its most important messages. The agency has initiated an underage buyer program in an effort to address this issue. Teenage youth are recruited for part-time employment and are accompanied by sworn special agents from the ABC's Bureau of Law Enforcement as they attempt to purchase alcohol at grocery stores, convenience stores, restaurants and other businesses, including state ABC stores. ABC special agents throughout the state complete nearly 400 such alcohol and tobacco compliance checks every month. The youth are instructed not to alter their appearance or mannerisms or mislead clerks in any way while attempting to make a purchase, and carry valid identification. ABC's Compliance Rate as reported in its 2005 Annual Report indicated that the ABC retail stores have reached a compliance rate of 98 percent, while the retail Licensee Community rates have reached a high in recent years of 89 percent.

Through a federal initiative, Enforcing Underage Drinking Laws (EUDL), ABC's Bureau of Law Enforcement has continued to offer pass-through grant awards to communities, colleges and universities, and rural law enforcement agencies to address issues surrounding underage drinking throughout the Commonwealth.

These funds have also played a major role in the continuation of the ABC's Youth Advisory Council and targeted enforcement efforts to address high-risk incidents where underage drinking is a key factor. Through several ABC education initiatives, new brochures and posters have been created to address the issue of adults providing alcohol to underage drinkers. Examples include the Sticker Shock program and "Solving the Puzzle of Underage Drinking" best practices guide.

Knowledge about effective prevention services is increasingly sophisticated. Effective prevention programs represent the most significant opportunity to reduce the burden of substance use disorders associated with alcohol. Virginia must commit to a broader prevention effort to stop the use of alcohol before it starts and to spare Virginia families and communities the devastation and economic cost of addiction. Prevention is the first line of defense against the use of alcohol by youth in the Commonwealth. The goal of prevention and intervention strategies directed at the individual, school, and community is to provide knowledge and to change belief systems and social norms in order to reinforce the message that underage alcohol use is unacceptable. In contrast to the critical importance of such efforts, in Virginia, no General Funds are designated for prevention efforts. All current prevention programs are supported by either federal funds or local dollars.

The Substance Abuse Services Council is committed to reducing underage alcohol use and the negative social, health, academic, and economic consequences that accompany substance use disorders associated with alcohol use by incorporating evidence-based prevention practices across agencies, as well as collaboration with community providers, and consumers. Virginia's substance abuse public sector prevention professionals have received extensive training in implementing evidence-based practices and must utilize these evidence-based practices as a condition of continued funding.

The immediate and long-term risks associated with underage alcohol use underscore the need for effective prevention. Research on the personal, social, and environmental factors that contribute to the initiation and escalation of drinking is essential for the development of evidence-based prevention programs. Preventing and identifying alcohol use disorders in youth require different screening, assessment, and, if necessary, treatment approaches. Virginia must acquire and maintain the resources to direct or redirect youth from underage alcohol use.

RECOMMENDATION

That $2.4 million annually be appropriated to the Department of Mental Health, Mental Retardation and Substance Abuse Services to support the implementation of evidence-based prevention programs throughout the Commonwealth. The prevention programs will:

- **Develop local strategy with the Community Based Prevention Planning**

Council to identify specific needs in each locality;

- **Identify specific evidence-based prevention programs and implementation time lines; and**
- **Provide evaluation outcome data for each evidence-based program implemented.**

The 40 community services boards (CSBs) would convene local Community-Based Prevention Planning Councils, as well as provide local administration and implementation of evidence-based programs, data collection, evaluation and reporting. The amount requested will provide $55,000 for each of the 40 community service boards, and $200,000 for the Department of Mental Health, Mental Retardation and Substance Abuse Services to administer the program.

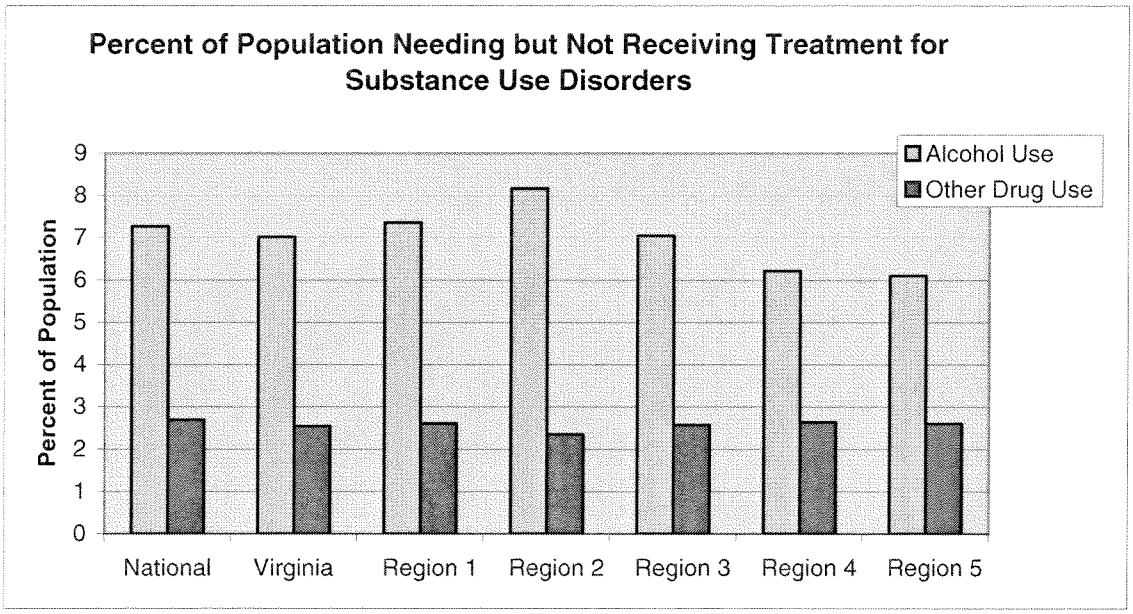
CAPACITY AND FUNDING: EXPANSION OF MEDICAID COVERAGE

In Virginia, community-based treatment and prevention services are provided by 40 community services boards (CSBs), entities of local government that provide mental health, mental retardation, and substance abuse treatment and prevention services. In addition, the Department of Juvenile Justice and the Department of Corrections also provide treatment services within the institutions they operate, and by purchase of service arrangements with CSBs and private non-profit providers in communities. The 29 drug courts operating in Virginia also provide access to treatment for adults, youth and families. However, the need for treatment is exceeding capacity by a significant amount, and the ability to meet this need for individuals who lack private medical insurance is limited.

NEED FOR TREATMENT IS UNMET

Data from the National Survey of Drug Use and Health (NSDUH) conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that 7.02 percent of Virginians need treatment for alcohol abuse or dependence but do not receive it, while 2.54 percent need treatment for drug dependence or abuse but do not receive it.[15] Figure 2 displays the need for treatment for alcohol and other drug use by region of the state. These rates have remained relatively consistent over time.

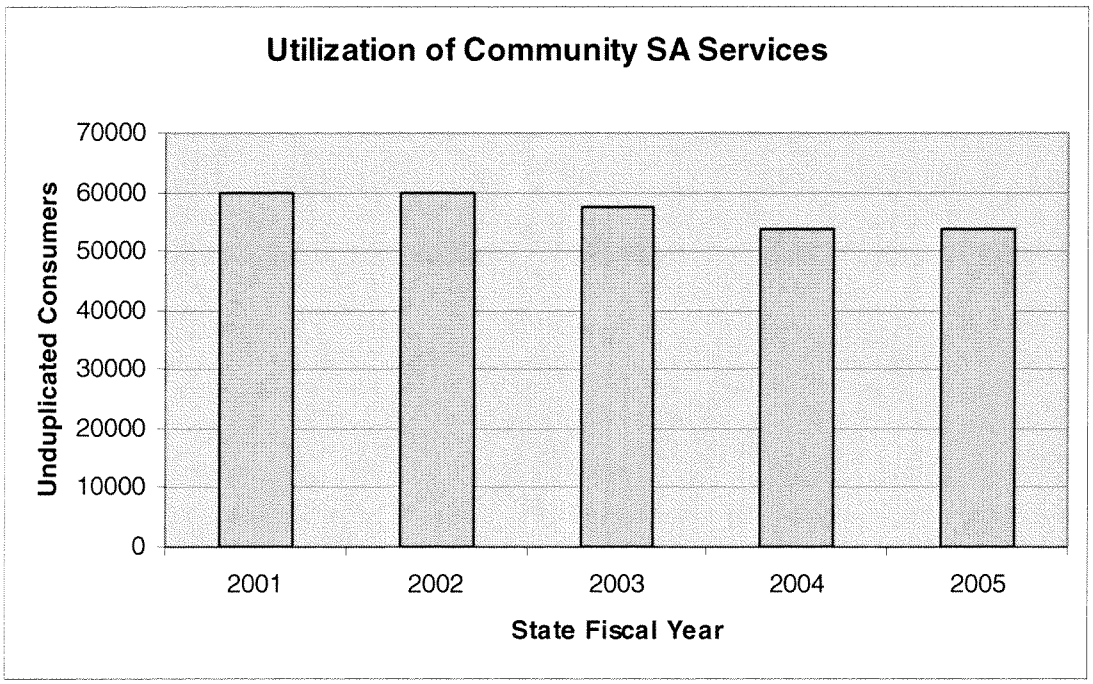
FIGURE 2



The Department of Mental Health, Mental Retardation and Substance Abuse Services, the primary state agency responsible for oversight of substance abuse treatment, collects information from CSBs related to waiting lists for its Comprehensive Plan, published in conjunction with the state's budget cycle. The 2006-2012 Plan indicates that, between January and April 2005, 3,389 individuals waited for services.[16] Of these, 2,386 waited between one and three months for an initial appointment.[17]

Meanwhile, the number of individuals served through CSB substance abuse treatment services has actually declined slightly as Figure 3 illustrates. Reasons for this decline are complex. As science has advanced knowledge about effective substance abuse treatment, this treatment has resulted in longer stays. Because capacity has not been expanded, fewer individuals can be admitted for services. Individuals are presenting with more complex problems, including co-occurring mental illness, which may result in an admission with only a mental health diagnosis, even when they also receive treatment for substance use disorders. Finally, capacity is limited by static funding during a period when the cost of providing services is rising.

FIGURE 3



FUNDING REMAINS STATIC

Funding for substance abuse treatment provided by CSBs comes primarily from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, the state General Fund, and funds from local government and fees. The SAPT Block Grant is allocated to the states by Congress, based on a formula that is primarily population based. Virginia's allocation has actually declined since Fiscal Year 2005, while the General Fund has barely made up the difference, resulting in essentially level funding once inflation is considered. Table 3 displays State General Fund and SAPT funding.

TABLE 3: ALLOCATIONS FOR COMMUNITY SUBSTANCE ABUSE TREATMENT

FISCAL YEAR EXPENDED	GENERAL FUNDS	SAPT BG	TOTAL
2001	$ 38,503,482	$ 39,245,298	$77,748,780
2002	$ 40,202,220	$ 40,929,104	$81,131,324
2003	$ 39,492,092	$ 42,309,094	$81,801,186
2004	$ 39,859,035	$ 42,526,592	$82,385,627
2005	$ 40,460,119	$ 43,461,008	$83,921,127
2006	$ 41,775,873	$ 43,373,280	$85,149,153
2007	$ 42,470,294	$ 42,930,418	$85,400,712

Local governments vary significantly in their allocations to CSBs. Although people receiving services from CSBs are charged fees, based on ability to pay, these fees rarely cover the actual cost of receiving treatment. Few CSB clients seeking services for addiction have any health care insurance, and if they do, it often doesn't adequately cover treatment for addiction, if at all. The *Code of Virginia* § 38.2-3412.1 prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance use, and other physical disorders and diseases. However, larger employers that opt to offer self-funded plans covered by the federal Employee Retirement Income Security Act (ERISA) of 1974 are exempt from meeting the requirements of state law, and these plans do not require coverage for substance use disorders.

The Departments of Corrections and Juvenile Justice refer significant numbers of people to CSBs for services. From FY 2000 to FY 2002, the Governor's Office and the General Assembly established a special fund, the Substance Abuse Reduction Effort (SABRE), to purchase community treatment services for offenders. SABRE distributed $12.3 million to the Departments of Corrections, Criminal Justice Services, and Juvenile Justice for this purpose[18], but the budget crisis beginning with the 2002 fiscal year resulted in the termination of that resource. Criminal and juvenile justice agencies, as well as drug courts funded by the State Supreme Court, continue to be major referral sources for CSB substance abuse treatment services, and CSBs continue to serve them, even without the additional SABRE funding.

Federal Residential Substance Abuse Treatment (RSAT) in Corrections funds, administered by the U.S. Department of Justice through the state Department of Criminal Justice Services has, in the past, been a significant resource for funding treatment for persons in the criminal justice system. These grants supported treatment services in facilities operated by the Department of Corrections, Department of Juvenile Justice facilities and in local jails, and required 1:3 local to federal match. Since 2005, however, these funds have been reduced by 88 percent, from $1,132,011 to $132,560 in federal funds. The reduction in these funds has had a serious impact on the capacity of the criminal justice system to provide rehabilitation to those in its custody.

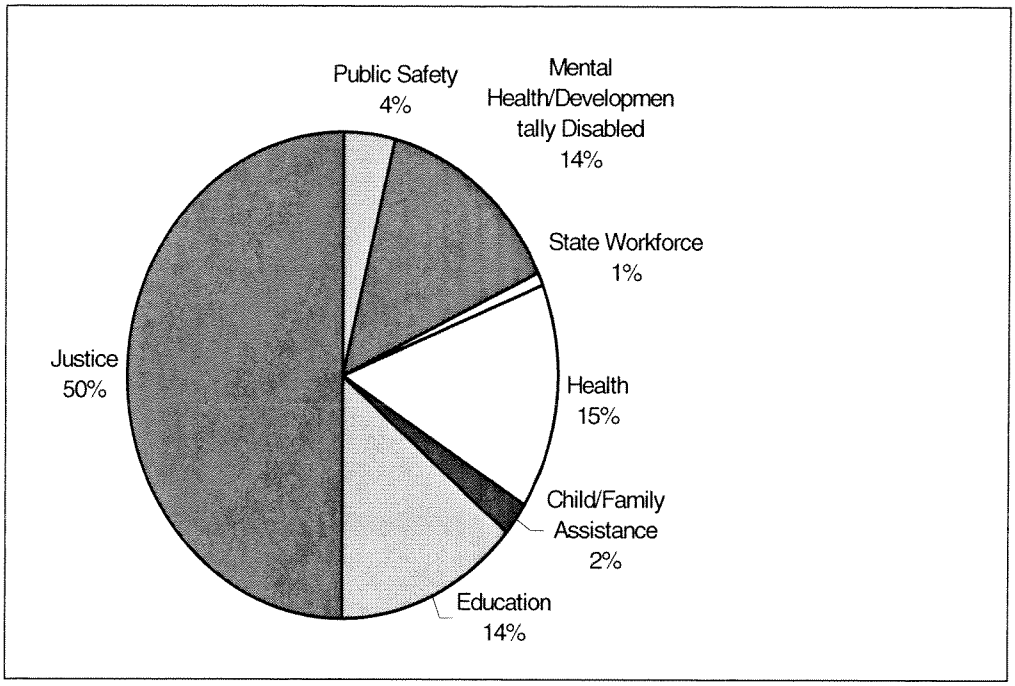
Drug courts also provide avenues to treatment, and are extremely effective in reducing substance abuse and criminal activity. Drug courts operate specialized dockets within the existing structure of Virginia's court system, adjudicating cases involving nonviolent offenders, both juvenile and adult, charged with felony drug possession. Family drug courts work to resolve parental substance abuse and dependence issues, with a goal of keeping families together and insure a safe secure environment for the children in them.

Drug courts offer an alternative to traditional adjudication and sentencing options by providing intensive supervision, drug testing, treatment and frequent court appearances. They rely on a team of judges, prosecutors, defense attorneys, public defenders, law enforcement officers, probation officers, treatment professionals and clerks of the court to assist offenders who have substance use disorders. They accomplish this goal by integrating criminal case processing with comprehensive treatment services and an intensive system of offender accountability under the leadership of the court. Currently 29 drug courts operate in Virginia.

UNTREATED SUBSTANCE ABUSE IS COSTLY

The National Center on Addiction and Substance Abuse (CASA) at Columbia University analyzed the 1998 budgets of 45 states, the District of Columbia and Puerto Rico to identify the impact of untreated substance use disorders on program costs for 16 budget categories. These program categories included health, social services, criminal justice, education, mental health and services for the developmentally disabled. The report found that Virginia spent 11.5 percent of its budget rectifying the impact of untreated substance use disorders, or $261.18 for every man, woman and child in the Commonwealth. For treatment, prevention and research, the Commonwealth spent $4.20 for every man, woman and child, 0.2 percent of the total state budget, or 0.011 percent of what was spent repairing the damage. Figure 4 displays the distribution of these resources. Note that half of what is spent to address the damage of untreated substance use disorders is spent in the justice system.

FIGURE 4: THE FISCAL BURDEN OF UNTREATED SUBSTANCE USE DISORDERS IN VIRGINIA



The average amount spent per capita across the 47 jurisdictions surveyed was $11.20. Virginia ranked 33rd in the amount spent to respond to the impact of untreated substance use disorders, and 33rd in the amount spent to prevent, treat or research substance use disorders.[19]

CASA has also studied the impact of untreated substance use disorders on other health care costs, estimating that nationally at least one dollar out of every five Medicaid spends on hospital care is attributable to substance abuse. Of $21.6 billion Medicaid spent on inpatient hospital costs in 1991, $4.2 billion was associated with substance abuse.[20]

TREATMENT IS AN INVESTMENT THAT PAYS LARGE DIVIDENDS

While failing to provide treatment for substance use disorders costs taxpayers money, providing treatment can save money. Many studies have been conducted that demonstrate that between $5 to $7 dollars are saved for every $1 spent on treating substance use disorders.[21,22] A significant amount is saved due to reduced crime, but benefits also accrue in reduced spending for health and social services and increased employment.[23]

MEDICAID PROPOSAL

Medicaid is a funding resource jointly funded by the federal government and the states. The federal government matches state expenditures at a specific ratio of state to federal dollars, depending on the relative wealth of the state. Virginia receives $1 from the federal government for every $1 of state funds expended. Beneficiaries of the Medicaid program participate as a legal entitlement, and usually qualify due to income or disability. Once services are identified in a state's Medical Assistance Plan, the costs of providing the services must be reimbursed at a rate prescribed in the plan (which may be less than the provider actually spent providing the service). Nearly all states have experienced precipitous growth in Medicaid expenditures.

Currently, Medicaid coverage for substance abuse treatment is very limited. Recently, the Department of Medical Assistance Services began using the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program to reimburse providers for treating youth with substance use disorders. Medicaid may also be used to reimburse for the cost of providing day treatment and residential treatment for substance use disorders to pregnant and post-partum women

In 1999, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services issued a report to the Governor and the Chairs of the House Appropriations and the Senate Finance Committees of the General Assembly recommending that funding be appropriated to utilize Medicaid to reimburse for all substance abuse treatment for all beneficiaries.[24] The cost estimate in 1999 dollars was $3.8 million in State General Funds. This revenue source would directly impact about 10 percent of the population currently receiving services from the community services board system. Most of the people who need treatment for substance use disorders and who qualify for Medicaid are either women with dependent children receiving support from federal Temporary Assistance for Needy Families, or people receiving federal disability benefits due to physical or mental disability.

The cost, in 2006 dollars, is estimated at $5.5 million in State General Funds per annum if every Medicaid eligible person who needed substance abuse treatment sought and received it. It would generate a like amount in federal funds, potentially adding $11 million to the community treatment system to provide a continuum of clinically appropriate and effective treatment of substance use disorders. It is important to note that Medicaid beneficiaries are already receiving treatment for substance use disorders financed by State General Funds, local funds, or federal Substance Abuse Prevention and Treatment Block Grant funds, none of which generate any additional matching funds. The $11 million that could be generated by utilizing Medicaid would release a like amount for expansion of capacity to other non-Medicaid eligible populations, improved infrastructure and quality of care, as well as additional resources for private sector treatment. The federal Centers for Medicare and Medicaid Services (CMS) must approve all additional services, and these amendments to the State Medical Assistance Plan (describing the specific services to be delivered, the qualified providers and the medical necessity requirements) must be promulgated as regulations.

RECOMMENDATION

The Council recommends that the General Assembly appropriate $5.5 million per year to provide General Fund match for Medicaid to fund the full range of clinically appropriate treatment for substance use disorders for all eligible populations. Further, the Council recommends that the Department of Medical Assistance Services collaborate with the Department of Mental Health, Mental Retardation and Substance Abuse Services, as well as public and private providers of treatment for substance use disorders, to draft regulations for the State Medical Assistance Plan.

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EVALUATION OF AGENCY ADMINISTERED SUBSTANCE ABUSE TREATMENT PROGRAMS

OVERVIEW

In an effort to assure that public funds are wisely used, most agencies conduct some level of evaluation of the services they provide. Generally the emphasis is on using this information to improve the quality and management of services. Program evaluation can focus on the process of delivering services or the outcome of those services. For example, process evaluation would address caseload size or treatment planning methods. Outcome evaluation would focus on the impact of the program on the participant. In substance abuse treatment, reduced use of alcohol or drugs is a common outcome indicator, and might be measured by length of sobriety after treatment. Outcome evaluation, while currently very much the focus of federal and state initiatives, is very expensive. It requires extensive record keeping on each program participant, tracking of the participant once the treatment experience is complete, data collection and storage, and analysis. It also assumes that the effects of the treatment will endure once the participant is no longer engaged in treatment, an assumption that might be questionable when addressing a chronic relapsing disorder, such as addiction, which may require repeated exposure to treatment at different levels of intensity for a considerable period of time. In addition, outcome measures must be selected that are suitable to the specific treatment environment and population. Process evaluation activities tend to be more audit focused, but unless the measured processes are highly correlated with good outcomes, they lack any substantive meaning. Nevertheless, process evaluation is important to improve quality and focus limited resources.

In this context, the 2004 Session of the General Assembly passed Senate Bill 304, directing the Substance Abuse Services Council to collect information about the impact and cost of substance abuse treatment provided by public agencies in the Commonwealth. This legislation amended the *Code of Virginia* by adding the following:

> (§ 2.2-2697) Review of state agency substance abuse treatment programs.
>
> A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also

include an assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.

B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse treatment program: (i) the amount of funding expended under the program for the prior fiscal year; (ii) the number of individuals served by the program using that funding; (iii) the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person costs and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs; and (vii) recommendations on the funding of programs based on these analyses.

As required, this section of the Substance Abuse Services Council Annual Report responds to Section B and includes outcome studies from the Department of Corrections (DOC) and descriptions of the substance use disorder services provided by the three state agencies in Virginia that provide these services: the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC).

The 2005 Substance Abuse Services Council report included a section that responded to Section A of the *Code* requirement and included estimates of the large unmet need for treatment and recommendations to address this unmet need. In this discussion, for the purpose of this report, treatment is defined narrowly as those services directed toward individuals with identified substance abuse and dependence disorders and does not include prevention services for which other evaluation methodologies exist. This section provides individual agency responses to Section B of § 2.2-2697.

TREATMENT SERVICES

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Department of Juvenile Justice; and the Department of Corrections. Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior. To meet these goals, these agencies have implemented several evidence-based practices (EBPs), practices for which strong research support exists, and consensus-based practices (CBPs), techniques that experts agree to be effective, but for which insufficient research exists to meet the stringent criteria of evidence-based. EBPs and CBPs used by these agencies include specific types of counseling, post-treatment aftercare, case management and social supports, and medication assisted treatment.

All three of these agencies collect some type of outcome data, although only DMHMRSAS is collecting data on all programs provided by all 40 CSBs. This effort is required by the federal

Substance Abuse and Mental Health Services Administration (SAMHSA) as a condition of receiving the Substance Abuse Prevention and Treatment Block Grant, which provides approximately one-half of the funding for community-based substance abuse treatment. The initiative has required nearly seven years of close collaboration with the federal government and the community services boards, extensive retooling of the agency's and community programs' data systems, and considerable time and effort. The first set of required outcome data will be submitted to SAMHSA in approximately one year (fall of 2007). However, it does not contain the level of detail required by § 2.2-2697.B. *Code of Virginia.*

DOC is systematically collecting and analyzing outcome data on selected programs, and has determined that these have positive impact. DJJ is collecting information concerning re-involvement with the juvenile justice system, and these data are also included. A number of factors limit the ability to collect, analyze and report on outcome measures. These factors include lack of information technology infrastructure and data quality in existing information systems.

The following information provides the agency responses to the seven items in this *Code* section.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

(i) ***the amount of funding expended under the program for the prior Fiscal year (FY 2005):***
Treatment Services Expenditure = $ 132,072,029 (includes General Funds, federal funds, local government funding and fees)

(ii) ***the number of individuals served by the program using that funding:*** 52,441.

(iii) ***the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures:***
Information to address this issue is not available.

(iv) ***identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives:***
Information to address this issue is not available.

(v) ***how effectiveness could be improved:*** Increase the use of Evidence-Based Practices

(vi) ***an estimate of the cost effectiveness of these programs:*** Information to address this issue is not available.

(vii) ***recommendations on the funding of programs based on these analyses:***
Information to address this issue is not available.

DEPARTMENT OF JUVENILE JUSTICE

(i) ***the amount of funding expended under the program for the prior fiscal year (FY 2005)***

- Community Programs Substance Abuse Expenditures = $452,542
- Juvenile Correctional Center Substance Abuse Expenditures = $2,414,181.

(ii) ***the number of individuals served by the program using that funding:***

- Approximately 35 offenders participated in Department-funded treatment programs for youth on probation.
- Approximately 651 offenders participated in programs and services within the juvenile correctional centers.

(iii) ***the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures:***

(a) ***Community: Information to address this issue is not available.***

(b) ***Institutions:*** Data is not available regarding subsequent substance abuse use by youth treated for substance abuse. However, re-arrest rates and reconviction rates are available for these youth.

Most girls in the juvenile correctional centers who had substance abuse treatment needs participated in the federally grant funded Residential Substance Abuse Treatment program. In FY2004, 20% of girls who participated in this program were rearrested for any crime over a 12 month period following release. 10% of these girls were reconvicted.

In FY2004, 53.4% of boys in juvenile correctional centers who participated in substance abuse treatment were rearrested for any crime over a 12 month period following release. 38.3% were reconvicted.

For juvenile correctional center releases as a whole, the corresponding 12 month re-arrest rate was 52.1% and the 12 month reconviction rate was 37.6%.

(iv) ***identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives:*** Information to address this issue is not available.

(v) ***how effectiveness could be improved:*** Information to address this issue is not available.

(vi) ***an estimate of the cost effectiveness of these programs:*** Information to address this issue is not available.

(vii) ***recommendations on the funding of programs based on these analyses:*** Information to address this issue is not available.

DEPARTMENT OF CORRECTIONS

(i) ***the amount of funding expended under the program for the prior Fiscal year (FY 2005): Treatment Services*** Expenditure = $ 3,750,000

Residential Transition Therapeutic Community Expenditure (Please refer to the Community Corrections section)

(ii) ***the number of individuals served by the program using that funding;*** The funding supported treatment for 1,231 institutional participants and 358 Transition Therapeutic Community participants.

(iii) ***the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures:*** Outcome studies are continually in progress for the Therapeutic Community program. Two interim study summaries are being provided with this report. One summary provides outcome information for the 2001 male Therapeutic Community participants and comparison groups. The other summary provides outcome information for the 2002 female Therapeutic Community participants and comparison groups. Three recidivism measures are used with each study: re-arrest, reconviction and recommitment. The findings, thus far, are in keeping with research results in other states. Treatment in an institutional Therapeutic Community followed by appropriate continuing care in the transitional therapeutic community produces the best outcomes for the substance abusing offender population.

(iv) ***identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives:*** Recommitment status checks for five-year outcomes for the 2001 male and female Therapeutic Community participants have just been completed; a cost benefit analysis is underway.

(v) ***how effectiveness could be improved:***
The Department of Corrections has several efforts underway to increase program effectiveness. A two-year pilot study of a risk/needs offender assessment instrument is in progress. One goal of this project is to target appropriate interventions for certain populations based on risk and criminogenic needs. An intensive residential substance abuse treatment program such as the Therapeutic Communities may be more effective with the highest risk offenders.

Secondly, a web-based data collection system for the Therapeutic Communities has been implemented at the largest Therapeutic Communities and is projected to be implemented at all Therapeutic Communities within the next year. This system will provide more timely and detailed data than previously available.

Thirdly, the DOC uses a self-adjusting model. Quarterly management reports are produced and shared with key management staff. These reports address many operational or process issues and highlight any needs for improvements.

(vi) ***an estimate of the cost effectiveness of these programs:***
Research has shown that substance abuse therapeutic community treatment programs when appropriately funded and implemented can reduce offender criminal behavior. The overlay cost for treatment while incarcerated is much lower than the cost for community-based substance abuse treatment. For every year that an offender, who may have been a recidivist without treatment, remains in the community as a law-abiding citizen versus incarceration, there is a cost avoidance of at least $20,000. This figure does not include benefits such as the individual's contributions to society such as tax revenue from gainful employment.

(vii) ***recommendations on the funding of programs based on these analyses.***
The major issues facing the Department of Corrections, Division of Operations include:

- Recruiting and retaining qualified program personnel;
- Improving participant to program staff ratios to more nearly meet levels indicated by research to produce optimum results. National studies show effective participant: staff ratios should be 20:1, whereas the Department of Corrections currently operates programs with staffing ratios of 35:1;
- Clinical supervision resources within the Department are needed to assure program quality and assist with staff development;
- Funding to support evaluation; and
- Allowing judges to sentence certain substance abusing offenders to the Department of Corrections Therapeutic Community program and allow consideration of reducing the length of incarceration upon successful program completion. See Senate Bill 611, carried over to 2007.

RECOMMENDATION

Given the dearth of funding for services for substance use disorders, and the cost of collecting additional outcome data, the Council recommends that the three agencies currently providing treatment focus on expanded implementation of evidence-based practices, and that *Code* of Virginia [§ 2.2-2697.B] **be modified to encourage these agencies to track the frequency with which these practices are implemented in services and programs, as follows:**

B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse program: (i) the amount of funding expended under the program for the ~~prior~~ fiscal year *most currently available*; (ii) the number of individuals served by the program using that funding; (iii) the extent to

which ***agency programs are employing evidence-based practices; and (iv)*** ~~**program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person cost and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs, and (vii)**~~ **recommendations on the funding of programs based on these analyses.**

OVERVIEWS OF TREATMENT SERVICES PROVIDED BY STATE AGENCIES

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Descriptions of substance abuse treatment services provided by CSBs follow.

- ***Emergency Services*** – These services are unscheduled services available 24 hours per day, seven days per week, to provide crisis intervention, stabilization and referral assistance either over the telephone or face-to-face. They may include jail interventions and pre-admission screenings.

- ***Inpatient Services*** – These services provide short-term, intensive psychiatric treatment or substance abuse treatment, except for detoxification, in local hospitals or d*etoxification Services* using medication under the supervision of medical personnel in local hospitals or other 24-hour-per-day-care facilities to systemically eliminate or reduce effects of alcohol or other drugs in the body.

- ***Outpatient and Case Management Services*** - These services are generally provided to an individual, group or family on an hourly basis in a clinic or similar facility. They may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and medication services. Intensive substance abuse outpatient services are included in this category, are generally provided over a four to 12 week period, and include multiple group therapy sessions plus individual and family therapy, consumer monitoring and case management.

- ***Methadone Detoxification Services and Opioid Replacement Therapy Services*** – These services combine outpatient treatment with the administering or dispensing of synthetic narcotics approved by the federal Food and Drug Administration for the purpose of replacing use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

- ***Day Support Services*** – These services provide structured programs of treatment in clusters of two or more continuous hours per day to groups or individuals in a non-residential setting.

- ***Highly Intensive Residential Services*** – These services provide up to seven days of detoxification in non-medical settings that systematically reduces or eliminates the effects of alcohol or other drugs in the body, returning the person to a drug-free state. Physician services are available.

- ***Intensive Residential Services*** - These services provide substance abuse rehabilitation services up to 90 days and include stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.

- ***Jail-Based Habilitation Services*** –This substance abuse psychosocial therapeutic community provides intensive daily group counseling, individual therapy, psycho-education services, self-help meetings, discharge planning, pre-employment and community preparation services in a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Normally the inmates served by this program are housed separately within the jail. The expected length of stay is 90 days.

DEPARTMENT OF JUVENILE JUSTICE

Currently, the Department of Juvenile Justice operates seven institutions. Substance abuse treatment is offered at each. The general treatment design is two-tiered. The first tier, delivered in 16 sessions over an eight week period, is best described as psycho-educational in nature and focuses on:

- increasing knowledge about the effects of substance use,
- the addiction process, the consequences and effects of substance use on the body, family and community;
- AIDS and HIV;
- the connection between thoughts, feelings, and behavior; and
- relapse prevention strategies.

The second tier is more oriented towards providing psychotherapy, with individualized treatment plans, and lasts from three to six months. It includes the basic educational components described above, but is more clinically focused on:

- personal substance abuse history;
- examining defenses and thinking patterns;
- improving decision making;
- increasing preferred social skills;
- exploring family issues; and
- individualized relapse prevention strategies.

For motivated youth with extended lengths of stay, additional services focused on relapse prevention are available. The majority of therapeutic work is accomplished in groups, although, individual sessions are available as needed. All programs operate using evidenced based practices incorporating cognitive behavioral techniques, relapse prevention, and motivational enhancement.

A description of services specific to each of the seven institutions follows:

BEAUMONT JUVENILE CORRECTIONAL CENTER

Beaumont houses approximately 250 males. Currently Beaumont has two staff positions and one clinical supervisor designated for substance abuse treatment services. Youth referred for intensive services either receive treatment in a self-contained, residential style program, or within a therapy group in the general population. Youth receiving educational services participate in didactic groups within the general population. Beaumont also houses sex offender treatment units and an intensive services unit, which can access both tiers of services.

BON AIR JUVENILE CORRECTIONAL CENTER

Bon Air houses both males and females with a total population of approximately 250. There are currently three staff positions and one clinical supervisor designated for girls SA treatment, as well as three staff positions and one clinical supervisor for boys SA treatment.

SA clinical services provided to the males are mostly in the form of general population groups (both didactic and intensive).

Services to females at Bon Air are also two-tiered. Girls participating in the intensive program do so in a residential self-contained program, which was previously funded with federal grant monies from the Department of Justice. The staff positions for this program are now financed by the state, beginning FY 2007. This program not only focuses on substance abuse treatment, but also gender specific issues of adolescent girls, as well as co-occurring mental illness. The duration of this program varies from three to twelve months, depending on the severity of clinical need. Individual counseling is also available.

CULPEPER JUVENILE CORRECTIONS CENTER

Culpeper house approximately 140 males aged 18 and older. There are currently two designated staff positions for substance abuse treatment services. Youth receiving intensive services are housed in a 12 bed self-contained unit. The services provided are similar to those provided at Beaumont. In addition, psycho-educational services for youth in the general population are comparable with those offered to the general population at Beaumont and Bon Air. Culpeper also houses sex offender treatment units and an intensive services unit, which can access educational services as well. Individual services are also provided as needed.

HANOVER JUVENILE CORRECTIONS CENTER

This facility houses approximately 140 males. There are currently two designated staff positions for youth receiving substance abuse services at Hanover JCC. Youth receiving intensive services are housed in a 24 bed, self-contained unit and receive services similar to those at Beaumont and Culpeper JCC's. Educational services are offered in group formats to the general population. Sex Offender units are also offered SA educational services when needed.

NATURAL BRIDGE JUVENILE CORRECTIONS CENTER

This facility with a population of approximately 70, houses males. There is one position designated for substance abuse treatment at NBJCC. Currently, both tiers of services are provided within the general population, as well as individual services as needed. In addition, an extended relapse prevention program is offered to accommodate the number of youths transferring from other facilities who will enter the community from this facility.

OAK RIDGE JUVENILE CORRECTIONS CENTER

This center with a population of 40 serves males who have developmental disabilities. An institutional counselor utilizes a curriculum to provide substance abuse treatment services developed for the special needs of these youth.

DEPARTMENT OF CORRECTIONS

The Department of Corrections provides a tiered substance abuse services approach to addresses varying offender treatment needs based on the severity of their problem. Typically, offenders with substance abuse problems also have problems with criminal thinking and antisocial behaviors. It is important to treat both these issues, as treating addiction alone will not change criminal behaviors or reduce recidivism. The Department is structured into two primary operating Divisions: The Division of Operations (prisons) and the Division of Community Corrections (probation, diversion and detention centers). Services will be discussed below in each of these divisions.

DIVISION OF OPERATIONS (PRISONS)

The Division of Operations operates 40 prison facilities across the state. Facilities range in security level from maximum security that house offenders with long sentences and violent crimes to low security facilities and work centers that house offenders with shorter less violent crimes. The state prison system incarcerates approximately 33,000 offenders and releases approximately 10,000 offenders back to the community each year. Approximately 80% of all offenders received into the State prison system have a history of alcohol or drug abuse associated with their criminality.

Within the state prison system, a tiered level of substance abuse programming is offered, with five (5) primary treatment options.

The lowest tier is the substance abuse Orientation Program that prepares offenders for participation in substance abuse groups. The program covers group dynamics and the group process. It introduces participants to the concept of the addictive disease process and acquaints participants to the types of programs available within the Department of Corrections and community-based programs to consider when close to release. The program is set into four (4) modules of two (2) hours in length. These can be offered in any time frame that suits the facility. This program is designed to be offered to all inmates entering the prison system. The Department's case-management Counselors provide this program after completing a 5 day training program.

A second tier is the Substance Abuse Psycho-education Program. This program is primarily education based combined with some group activity. This program operates at 2 hours per week for 15 weeks and provides more extensive information on the addiction process, disease model, and mental and physical effects of drugs or alcohol abuse. Each prison facility operates this program with a limited capacity of 2,900 offenders per year. The Department's case-management Counselors provide this program after completing a 5 day training program.

The third tier of programming is Substance Abuse Counseling Groups. These are on-going counseling groups for offenders that address personal issues related to overcoming addiction. Resources for these groups are very limited, with only about 400 offenders participating each year. Staff are not required to by law to be Certified Substance Abuse Counselors to run these programs but it is encouraged.

The Department does provide through its Academy for Staff Development a six week training program to help staff qualify to become Certified Substance Abuse Counselors by the Virginia Board of Health Professions. Approximately 30 staff attend this training each year.

A fourth treatment option is Support programs. Many prison facilities offender Alcohol and Narcotics Anonymous programs. These programs are voluntary because of the spiritual basis for the approach.

The fifth, most intensive and primary treatment model for offenders in the prison system is the Therapeutic Community (TC). These are the only programs that receive designated funding from the State budget. For that reason, TC programs will be discussed in greater detail below.

THERAPEUTIC COMMUNITY TREATMENT PROGRAMS

The Virginia DOC Therapeutic Community Treatment Model is evidence-based and is the only continuum of care substance abuse treatment program provided in the prison system and also includes a Community Corrections component. As such, participants begin treatment while incarcerated and then transition to the final phase of the program in the community. This final phase of the program is called the transitional therapeutic community (TTC).

Therapeutic Community programs are designed to correct both substance abuse addiction and criminal thinking and antisocial behaviors. The program is residential in that participating offenders live in the same housing unit and are involved in programming every waking hour. The programs use peer pressure and peer role modeling to help offenders learn pro-social ways of interacting and problem solving. Therapeutic Community programs are typically 18 months in duration and are provided to offenders immediately before release, so that treatment effects are optimal when offenders return to the community. As noted, the transitional therapeutic community provides further treatment and transition into free society and employment.

The Therapeutic Communities utilize the following program actions as appropriate to the individual:

1. Individual and Group Counseling
2. Cognitive Behavioral Programming
3. Socialization Training and Practice
4. Urine Screen Monitoring
5. GED Program
6. Employment counseling and job placement
7. Health Services
8. Daily Living Skills (banking, parenting, etc.)
9. Community Living

Institutional Therapeutic Communities

- Botetourt Correctional Center – Capacity 352 beds
- Indian Creek Correctional Center – Capacity 781 beds

- Lawrenceville Correctional Center – Capacity 160 beds *
- Virginia Correctional Center for Women – capacity 274 beds

*Note: this is a private prison and the program model is slightly different from DOC's model.

Transitional Therapeutic Communities:

- Bethany Hall – 8 Women
- Gemeinshchaft Home - 60 men
- Hegira House – 14 men and women
- Serenity House – 63 men and women
- Rubicon – males only (site coming onboard in FY '06)
- Vanguard – males only (beginning FY '06)

SOURCES

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APPENDICES

Report to the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol

Plan to Coordinate Substance Abuse Intervention and Treatment Programs and Services

September 2006

This report was supported in part by the Substance Abuse Prevention and Treatment Block Grant administered through the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, and by National Highway Traffic Safety Administration funds administered through the Virginia Department of Motor Vehicles

Executive Summary
Report to the
Governor's Task Force to Combat Driving under the
Influence of Drugs and Alcohol
Substance Abuse Services Council
Plan to Coordinate
Substance Abuse Intervention and Treatment Programs and Services
September 2006

Executive Summary

In response to a charge from the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol convened in 2002, the Substance Abuse Services Council has prepared the following plan, focused on the requirements set forth in Recommendation 25 of the *Report and Recommendations to the Governor from the Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol*, issued July 2003. Recommendation 25 assigned five tasks to the Council, all related to the provision of prevention, intervention and treatment services provided to Repeat and Hardcore Drunk Drivers served by local Virginia Alcohol Safety Action Programs, which receive oversight from the Commission on Virginia Alcohol Safety Action Program, a legislative body:

- Establish statewide goals and priorities for substance abuse interventions and treatment efforts, placing a high priority on hard core drunk drivers and repeat offenders;
- Identify and promote a standardized assessment tool, such as the Addiction Severity Index (ASI) or Substance Abuse Subtle Screening Inventory (SASSI), that can be used by all service providers to help match individuals to appropriate intervention and treatment programs;
- Establish uniform, statewide substance abuse standards and treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness;
- Identify programs and approaches that have documented success;
- Collect and track data collected from administration of standardized assessment to identify characteristics of at-risk population in order to enhance the design of effective prevention, intervention and treatment programs.

This plan provides information about the work of the Council to address these assignments, as accomplished by the Program Committee of the Council, as well as other as yet to be appointed work groups that will operate within the authority of the Council. The plan identifies four goals: (1) reinforcing the use of the Simple Screening Instrument as the standard approach to screening offenders by all local safety action programs by providing training; (2) identifying an assessment instrument appropriate for Repeat

Offenders and Hardcore Drunk Drivers and recommending that its use be incorporated into service agreements between local safety action programs and local treatment

providers; (3) developing and adopting common definitions of types of treatment and standards for treatment services for uniform application by all VASAP service providers; (4) develop recommendations for data collection to assist in identifying persons likely to become Repeat Offenders and Hardcore Drunk Drivers. The first goal has already been accomplished and progress on goals 2 and 3 are well underway. In addition, the Council addressed several Recommendations listed under Item 32 of the report related to use of third-party reimbursement for BAC blood tests and recordkeeping.

Activities in 2005 and 2006 were supported by National Highway Transportation Safety Action funds granted by the Department of Motor Vehicles to the Department of Mental Health, Mental Retardation and Substance Abuse Services on behalf of the Substance Abuse Services Council.

Report to the
Governor's Task Force to Combat Driving under the
Influence of Drugs and Alcohol
Substance Abuse Services Council
Plan to Coordinate
Substance Abuse Intervention and Treatment Programs and Services
September 2006

Background

On October 4, 2002, at the direction of Governor Warner, Secretary of Public Safety John W. Marshall and Secretary of Transportation Whittington W. Clement convened the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol with the specific goal of reducing offenses by those who have been previously convicted of driving or boating under the influence (DUI or BUI, respectively). In the context of public safety, these persons are referred to as "*hardcore drunk drivers*" and are defined as "*those who drive with a high blood alcohol concentration of 0.15 or above, who do so repeatedly, as demonstrated by having more than one drunk driving arrest, and who are highly resistant to changing their behavior despite previous sanctions, treatment or education efforts.*" The Task Force, which included members from all three branches of government, was divided into three working committees: General Deterrence; Specific Deterrence; and Prevention, Intervention, and Treatment. The tasks for the General Deterrence Committee focused on improving public awareness about the dangers of and penalties for driving and boating under the influence of alcohol and other drugs. The Specific Deterrence Committee focused its work on policy recommendations concerning individual behaviors, including procedural changes to make existing laws more effective and legislation to increase penalties for DUI and BUI. The focus of the Prevention, Intervention, and Treatment Committee was to help those individuals whose DUI or BUI behaviors are not changed by either legal or educational strategies, recognizing that these individuals are either members of at-risk populations or have already developed significant problems with alcohol or other drugs.

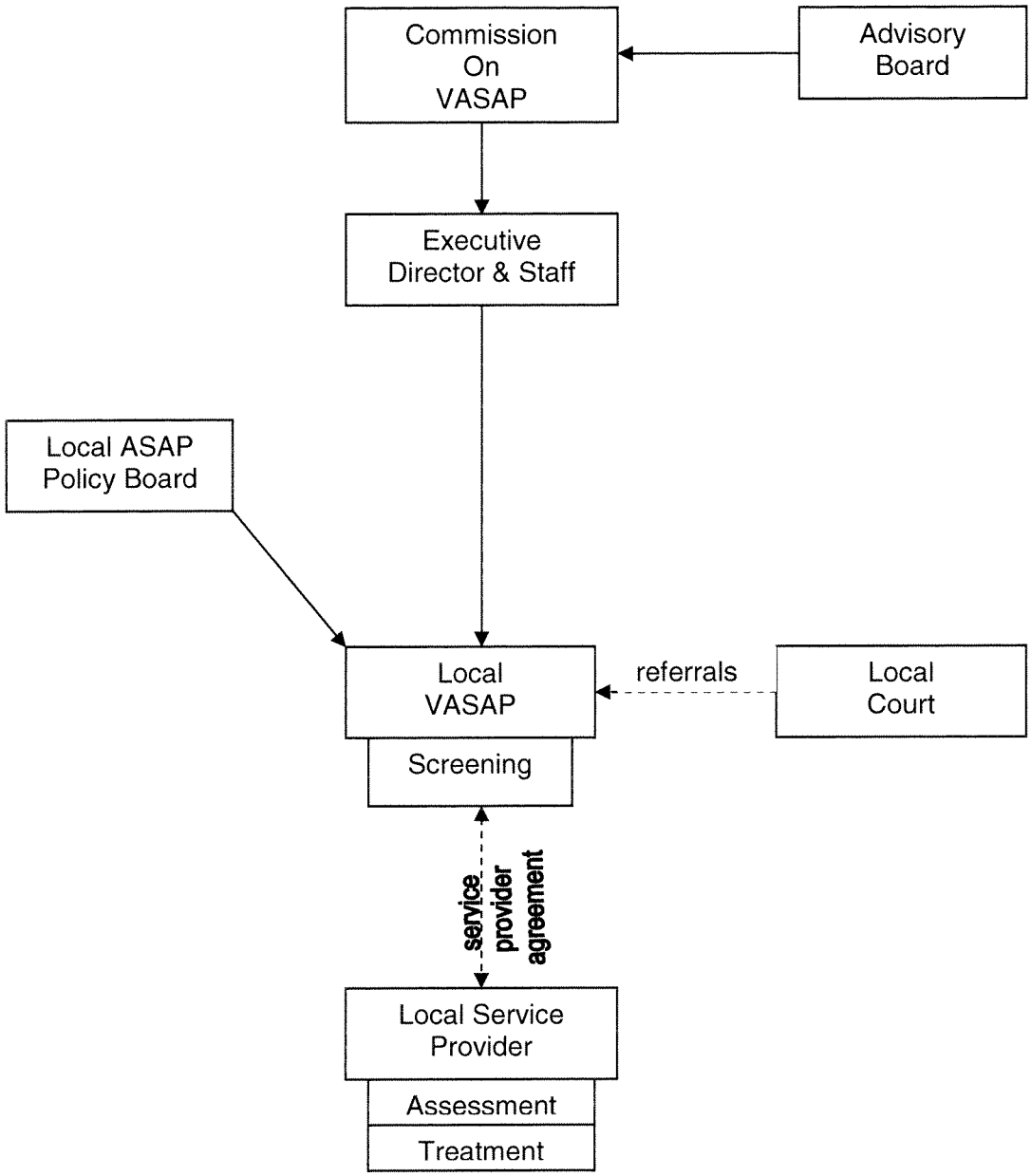
To inform its work, the Prevention, Intervention, and Treatment Committee learned about the programs and practices of local Virginia Alcohol Safety Action Programs (VASAP), current treatment approaches for individuals participating in VASAP, the continuum of publicly funded treatment available in Virginia for substance use disorders, and the gap between the number of people in need of treatment and the existing capacity. The Commission on Virginia Alcohol Safety Action Program (VASAP) is a legislative commission comprised of members of the General Assembly, judges, representatives of local alcohol safety action programs, law enforcement, the Department of Motor Vehicles, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Commission also appoints an advisory board that includes representatives of local safety action programs, the state or local boards of mental health, mental retardation and substance abuse services, and other community mental health organizations.

The Commission is supported by an administrative staff, and provides oversight to local ASAP programs, each of which is responsible to its own policy board. [*Code of Virginia* § 18.2-271 *et seq*]. Local courts refer offenders to local safety action programs, where they are screened using the Simple Screening Instrument (SSI), a standardized instrument developed by the Center for Substance Abuse Treatment (CSAT) at the federal Substance Abuse and Mental Health Services Administration to screen for alcohol and other drug abuse in at-risk populations Figure 1 displays these relationships.

One of the key issues the Committee identified was the inconsistent range of treatment services available from community to community. One of the effects of this variability was that assessment practices varied from community to community, so that a common assessment tool and communication about the results of the assessment are not standard. Another effect is that a complete array of services is not available in every community. As Repeat Offenders and Hardcore Drunk Drivers are likely to need intense services, such as residential treatment or outpatient treatment that occurs several times a week for several hours each session, this lack of access seriously affects the outcome of the treatment experience. This is especially critical for Repeat Offenders and Hardcore Drunk Drivers as their clinical needs are often more complex, frequently involving abuse of or dependence on multiple substances, as well as mental illness. The local alcohol safety action programs are certified to meet standards established by the Commission and treatment referrals are made to licensed individuals or professional programs. In summary, systematic assessment procedures and standards for acceptable treatment practices based on the assessment are being recommended.

To address these issues, members of the Prevention, Intervention, and Treatment Committee provided several recommendations to the Task Force that were subsequently adopted, two of which were specifically assigned to the Substance Abuse Services Council in the Report and Recommendations of the Task Force issued July 2003. The following report concerns the Council's progress addressing Recommendation 25, stated below. The report on Recommendation 26 is due 2008, and will be presented at the appropriate time.

Figure 1: State and Local Reporting and Referral Relationships



Recommendation 25:
The Substance Abuse Services Council, in partnership with the Virginia Alcohol Safety Action Program, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and other partners, should develop a plan that coordinates substance abuse intervention and treatment programs and services, no later than 2005. Nominal administrative costs are anticipated.

In particular, this plan should address and recommend ways to:

- Establish statewide goals and priorities for substance abuse interventions and treatment efforts, placing a high priority on hard-core drunk drivers and repeat offenders;
- Identify and promote a standardized assessment tool, such as the Addiction Severity Index (ASI) or Substance Abuse Subtle Screening Inventory (SASSI), that can be used by all service providers to help match individuals to appropriate intervention and treatment programs;
- Establish uniform, statewide substance abuse standards and treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness;
- Identify programs and approaches that have documented success;
- Collect and track data collected from administration of standardized assessment to identify characteristics of at-risk population in order to enhance the design of effective prevention, intervention and treatment programs.

Plan
The Program Committee of the Substance Abuse Services Council (SASC), chaired by Rudi Schuster, representing the Department of Criminal Justice Services (DCJS), a member agency, consisted of representatives from the Commission on Virginia Alcohol Safety Action Program (VASAP) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), both member agencies, as well as representatives from local VASAP programs, and the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC) at Virginia Commonwealth University. The Program Committee met several times to develop the following plan to address the requirements of the Task Force. This plan includes certain goals, objectives and action steps to coordinate VASAP substance abuse intervention with treatment programs. In addition, working on behalf of the Council, DMHMRSAS applied for and secured a grant from the Department of Motor Vehicles (DMV) using National Highway Safety Action Funds to support the costs incurred in developing and implementing the plan. DMV awarded the grant to DMHRSAS for a second year and the funds were used to continue to meet the requirements of the Task Force.

Priority Consideration: Screening, intervention, referral, assessment, and treatment services for Repeat Offenders and Hardcore Drunk Drivers.

Issue 1: Reinforce the use of the Simple Screening Instrument. Screening and assessment are separate activities with separate goals. Screening indicates whether or not the

individual has a significant substance abuse problem, and screening results provide the local VASAP with information to determine whether or not the person would benefit from education or would require treatment to address the substance abuse behavior that preceded the arrest. Screening activities generally require limited training or time to administer or score.

Assessment instruments provide detailed information about the nature, duration and severity of the substance abuse problem and usually require some sophistication to administer and score. In addition, sound assessments are crucial to designing or matching treatment services to the individual needs of the DUI/BUI offender, including ancillary issues that may affect the offender's capacity to remain drug or alcohol free, such as attitudes towards authority, mood disorders, or social supports. Assessment instruments are also important in measuring outcome, as they can provide measures for baseline behavior and behavior after participation in treatment. In the VASAP system, assessments are conducted by contract treatment providers, not by the VASAP case managers. However, understanding the measures utilized by specific assessment instruments provides the case manager with context about the treatment in which the offender participates and helps the case manager assure that the offender is receiving the appropriate intensity and duration of treatment.

Goal 1.0: Reinforce the use of the Simple Screening Instrument, and identify and promote a limited selection of assessment instruments to be used by all service providers to help match individual service needs to treatment programs.

Objective 1.1: Provide training to local ASAP case managers in the Simple Screening Instrument to reinforce its use as the standardized screening instrument.

Progress: VASAP case managers participated in one-day review training on the Simple Screening Inventory at the 2005 Virginia Summer Institute for Addiction Studies. They also received overview information about the Addiction Severity Index (ASI) as many community services boards that provide treatment services to local VASAPs utilize this assessment instrument. The grant from the Department of Motor Vehicles (National Highway Transportation Safety Administration funds) supported scholarships to the entire weeklong institute for case managers from each of the 24 local VASAP programs.

Objective 1.2: After a standard assessment instrument has been identified, staff will explore methods of training that will be helpful to treatment staff from around the state to develop the skills to use the standard assessment instrument.

Plan: Using grant funds from the Department of Motor Vehicles (National Highway Transportation Safety Administration funds) the Department of Mental Health, Mental Retardation and Substance Abuse Services will contract with the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC) to identify assessment instruments most suitable for assessing the Repeat Offender and Hardcore Drunk Driver population and for administration in treatment

environments that vary significantly in infrastructure. Mid-ATTC will produce a report that will include, at a minimum, the following information: the clinical utility for diagnosis, treatment placement, treatment planning, treatment outcome; the types of measures reported; the amount, intensity and estimated cost of training required to administer and interpret the results of the assessment; the cost of the instrument (if proprietary); the accuracy (validity, reliability, cultural, language or gender issues, cut-off scores); complexity of and time required to administer, score and interpret; and the suitability of the instrument for the general service delivery system utilized by local VASAPs. The report will also recommend a limited number of assessment instruments and provide rationale for selection using the information specified above. The Substance Abuse Services Council will make a recommendation to the Commission and Mid-ATTC will provide training about the instrument to local VASAP case managers to assist them in using the information produced by the assessment to incorporate into service agreements with local treatment providers, and to assist them in monitoring services to assure that offenders referred for treatment receive services that are appropriate in intensity and duration. This may include training to provide familiarity with patient placement criteria of the type developed by the American Society of Addiction Medicine.

Progress: During 2005 and 2006, the grant from the Department of Motor Vehicles supported research on assessment instruments conducted by Jill Russett, MSW, CSAC and doctoral student at the College of William and Mary. This research yielded a number of assessment instruments appropriate for providing services to the Repeat Offender. The Comprehensive Drinker Profile was selected and training was provided to local ASAP staff at the 2006 Virginia Summer Institute for Addiction Studies. The grant given by the Department of Motor Vehicles supported attendance at this training for VASAP case managers and directors. This training also included information on best practices for the Repeat Offender and Hardcore Drinking Driver. Finally, recommendations of appropriate assessment instruments will be submitted to the Commission on VASAP.

Issue 2: Uniform, statewide treatment definitions and standards are needed to provide a shared understanding about the continuum and quality of treatment necessary to improve treatment outcomes for DUI/BUI offenders. Standards, in the nature of clinical benchmarks, should be based on evidence or consensus based practices, and should be incorporated in treatment programs modeled after those that have proven successful for this population.

Goal 2.0: Develop, disseminate and adopt uniform definitions and standards for treatment of DUI/BUI offenders.

Objective 2.1: Establish uniform treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness.

Progress: The Substance Abuse Services Council recommends that service definitions adapted from Taxonomy 6 of the Department of Mental Health, Mental Retardation and Substance Abuse Services be utilized. Many VASAPs contract with local community services boards, which already use this taxonomy. In addition, the taxonomy offers a broad array of services and defines services by intensity and duration, two key issues in the successful treatment of substance use disorders. A copy of the adapted taxonomy is attached as Appendix A.

Plan: These definitions will be distributed to VASAP staff via upcoming training planned regarding evidence and consensus based practices (See Objective 2.2). They will also be utilized as a guide in the development of standards and service agreements between local VASAPs and local service providers.

Objective 2.2: Establish uniform, statewide standards for substance abuse treatment for service providers to improve implementation of treatment programs and evaluations of effectiveness.

Plan: The Chair of the Substance Abuse Services Council will establish a work group with the assigned task of developing recommendations for clinical quality benchmarks for use in VASAP contracting and monitoring of treatment services. These benchmarks will be based on evidence and consensus-based practices, and will address outcome measures identified in the Council's report on outcomes as required in §2.2-2691 of the *Code of Virginia*. The work group will also identify programs that have proven to be effective with the Repeat Offender and Hardcore Drunk Driver. The work group will include representatives from state agencies currently providing treatment services (DMHMRSAS, DOC, DJJ) and a representative from VASAP. The work group will report its recommendations by 2007. The Mid-ATTC will provide training "on line" to VASAP case managers to assist them in determining which programs are evidence or consensus based, as well as training specifically pertaining to evidence and consensus based treatment practices for Repeat Offenders and Hardcore Drunk Drivers at the 2006 Virginia Summer Institute for Addiction Studies. In addition, Mid-ATTC will provide training to VASAP providers. The cost will be addressed by the DMV-NHTSA grant to DMHMRSAS.

Progress: During the 2006 Virginia Summer Institute for Addiction Studies, training on best practices was presented to the VASAP case mangers, in addition to staff from community services boards and private treatment agencies under contract to provide services to VASAP clients. This training was prepared and

administered by staff from the Mid-ATTC with assistance from staff from the Commission on VASAP. Additional training to providers will be contingent upon continued grant awards from DMV. The work group will utilize this training as a base for its work on identifying programs that are proven effective with Repeat Offenders and Hardcore Drunk Drivers. A final report on the recommendations of evidence-based practices will be presented at the appropriate time.

Issue 3: There is presently no mechanism established to identify characteristics of populations at risk of becoming Repeat Offenders or Hardcore Drunk Drivers so that programs providing prevention, intervention and treatment for this population can be targeted. This information could be used to inform service design regarding age, gender and other characteristics to improve effectiveness and to assist in identification for earlier intervention.

Goal 3.0: Develop recommendations for data collection that will assist in identifying the characteristics of Repeat Offenders or Hardcore Drunk Drivers so that prevention and intervention programs can be developed that target these individuals to prevent repeat offenses and high blood alcohol concentration levels while driving or boating.

Objective 3.1: Collaborate with other state agencies, to include the Department of Motor Vehicles and the Department of Mental Health, Mental Retardation and Substance Abuse Services, to collect data by augmenting existing data collection and analysis initiatives that will provide information about the demographic and clinical characteristics of Repeat Offenders and Hardcore Drunk Drivers.

Plan: The Commission on VASAP will collaborate with the Department of Motor Vehicles in the design of its database to incorporate data collection and analysis on individual DUI/BUI offenders, tracking those with BAC at arrest of 0.15 or higher, or those arrested more than twice in a five year period. The Commission on VASAP will examine its own data for characteristics of recidivists, as well.

Progress: The Commission on VASAP has been working with DMV and other state agencies on enhancing data collection and exploring methods to integrate data into a central database. In preparation for comprehensive data collection, the Commission on VASAP has been updating and strengthening its hardware at the state office and support systems at the local programs.

Abbreviated Taxonomy for Providers of Substance Abuse Treatment Services to Virginia Alcohol Safety Action Programs

INPATIENT SERVICES include:

- hospital-based 24 hour detoxification
- other hospital-based 24 hour substance treatment
- use of medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

OUTPATIENT SERVICES include:

- outpatient counseling with individuals, groups and families
- opioid detoxification and maintenance services
- case management
- intensive outpatient (services provided multiple times per week for less than six hours per day, less than five days per week)

DAY SUPPORT SERVICES include:

- day treatment (coordinated, comprehensive, multi-disciplinary treatment for at least six hours per day, at least three to five days per week)

RESIDENTIAL SERVICES include

- highly intensive residential services for individuals with co-occurring mental health and substance abuse services
- intensive residential services that include
  - detoxification in a nonhospital, community-based setting (less than 30 days for intensive stabilization, daily group therapy, individual and family therapy, case management, and discharge planning)
  - intermediate rehabilitation (up to 90 days for supportive group therapy, individual and family therapy, case management, community preparation)
  - therapeutic community (90 or more days in a highly structured environment where residents, under staff supervision, are responsible for daily facility operations; services include intensive daily group and individual therapy, family therapy, development of daily living skills and readiness for or engagement in community employment)
  - halfway houses (90 days or more for 24 hour supervision, training in daily living functions such as meal preparation, personal hygiene, laundry, budgeting, transportation)
- jail-based habilitation services (at least 90 days)
  - highly structured environment where residents, under staff supervision, are responsible for the daily operations of the program;
  - services include intensive daily group and individual therapy, family therapy, development of daily living skills and readiness for employment, and discharge planning (daily living skills in conjunction with the therapeutic milieu structure);
  - inmates participating in the are usually housed separately from the general population

- supervised residential services include supervised apartments that are directly operated or contracted programs that place and provide services to individuals, with an expected length of stay exceeding 30 days, and includes

  - subsidized as well as non-subsidized apartments;
  - staff support and supervision
  - usually provided in conjunction with outpatient services.

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CODE OF VIRGINIA

§ 2.2-2696. (Effective October 1, 2005) Substance Abuse Services Council.

A. The Substance Abuse Services Council (the Council) is established as an advisory council, within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the Council is to advise and make recommendations to the Governor, the General Assembly, and the State Mental Health, Mental Retardation and Substance Abuse Services Board on broad policies and goals and on the coordination of the Commonwealth's public and private efforts to control substance abuse, as defined in § 37.2-100.

B. The Council shall consist of 30 members. Four members of the House of Delegates shall be appointed by the Speaker of the House of Delegates, in accordance with the principles of proportional representation contained in the Rules of the House of Delegates, and two members of the Senate shall be appointed by the Senate Committee on Rules. The Governor shall appoint one member representing the Virginia Sheriffs' Association, one member representing the Virginia Drug Courts Association, one member representing the Substance Abuse Certification Alliance of Virginia, two members representing the Virginia Association of Community Services Boards, and two members representing statewide consumer and advocacy organizations. The Council shall also include the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services; the Commissioner of Health; the Commissioner of the Department of Motor Vehicles; the Superintendent of Public Instruction; the Directors of the Departments of Juvenile Justice, Corrections, Criminal Justice Services, Medical Assistance Services, and Social Services; the Chief Operating Officer of the Department of Alcoholic Beverage Control; the Executive Director of the Governor's Office for Substance Abuse Prevention or his designee; the Executive Director of the Virginia Tobacco Settlement Foundation or his designee; the Executive Director of the Commission on the Virginia Alcohol Safety Action Program or his designee; and the chairs or their designees of the Virginia Association of Drug and Alcohol Programs, the Virginia Association of Alcoholism and Drug Abuse Counselors, and the Substance Abuse Council and the Prevention Task Force of the Virginia Association of Community Services Boards.

C. Appointments of legislative members and heads of agencies or representatives of organizations shall be for terms consistent with their terms of office. All other appointments of nonlegislative members shall be for terms of three years, except an appointment to fill a vacancy, which shall be for the unexpired term. The Governor shall appoint a chairman from among the members.

No person shall be eligible to serve more than two successive terms, provided that a person appointed to fill a vacancy may serve two full successive terms.

D. The Council shall meet at least four times annually and more often if deemed necessary or advisable by the chairman.

E. Members of the Council shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the cost of expenses shall be provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

F. The duties of the Council shall be:

1. To recommend policies and goals to the Governor, the General Assembly, and the State Mental Health, Mental Retardation and Substance Abuse Services Board;

2. To coordinate agency programs and activities, to prevent duplication of functions, and to combine all agency plans into a comprehensive interagency state plan for substance abuse services;

3. To review and comment on annual state agency budget requests regarding substance abuse and on all applications for state or federal funds or services to be used in substance abuse programs;

4. To define responsibilities among state agencies for various programs for persons with substance abuse and to encourage cooperation among agencies; and

5. To make investigations, issue annual reports to the Governor and the General Assembly, and make recommendations relevant to substance abuse upon the request of the Governor.

G. Staff assistance shall be provided to the Council by the Office of Substance Abuse Services of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

(1976, c. 767, § 37.1-207; 1977, c. 18; 1978, c. 171; 1979, c. 678; 1980, c. 582; 1984, c. 589; 1990, cc. 1, 288, 317; 1998, c. 724; 1999, c. 614; 2005, cc. 713, 716.)

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§ 2.2-2697. (Effective October 1, 2005) Review of state agency substance abuse treatment programs.

A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also include an

assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.

B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse treatment program: (i) the amount of funding expended under the program for the prior fiscal year; (ii) the number of individuals served by the program using that funding; (iii) the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person costs and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs; and (vii) recommendations on the funding of programs based on these analyses.

C. All agencies identified in the Comprehensive Interagency State Plan as administering a substance abuse treatment program shall provide the information and staff support necessary for the Council to complete the Plan. In addition, any agency that captures outcome-related information concerning substance abuse programs identified in subsection B shall make this information available for analysis upon request.

(2004, c. 686, § 37.1-207.1; 2005, c. 716.)