

CREATING OPPORTUNITIES

*a plan for advancing
community-focused services
in Virginia*



**Creating Opportunities for People in
Need of Substance Abuse Services**
*An Interagency Approach to
Strategic Resource Development*

Report to Governor Robert F. McDonnell
October 2011

**The Department of Behavioral Health
and Developmental Services**

in collaboration with the

*Department of Corrections, Department of Criminal Justice Services,
Department of Health, Department of Health Professions, Department of Juvenile
Justice, Department of Medical Assistance Services, Department of Rehabilitative
Services and the Department of Social Services*

**CREATING OPPORTUNITIES
FOR PEOPLE WITH SUBSTANCE USE DISORDERS:
AN INTERAGENCY APPROACH TO STRATEGIC RESOURCE DEVELOPMENT
REPORT TO GOVERNOR ROBERT F. McDONNELL
OCTOBER 2011
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**EXECUTIVE SUMMARY
CREATING OPPORTUNITIES
FOR PEOPLE IN NEED OF SUBSTANCE ABUSE SERVICES:
AN INTERAGENCY APPROACH TO STRATEGIC RESOURCE DEVELOPMENT**

**REPORT TO GOVERNOR ROBERT F. McDONNELL
OCTOBER 2011**

Purpose

This report was prepared in response to a request from Governor Robert F. McDonnell and the Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources, to develop an interagency plan to address the problem of substance abuse in the Commonwealth. The Department of Behavioral Health and Developmental Services (DBHDS) took the lead on this project, building on the momentum of its own Creating Opportunities strategic planning initiative to improve services for people with substance use disorders.

The goal of the report is to provide the Governor with a menu of proposals from which to choose to improve access to substance abuse services for Virginians, with a focus on prevention and treatment for persons involved in the criminal justice system.

In this document, the term *substance abuse* will be used to define the services that are provided by the “substance abuse services” system in the Commonwealth. The term *substance use disorders* will be used as an umbrella term to define the condition/diagnosis of the person who is using the substance. “Substance use disorders” is a clinical term that covers two major levels of severity, *substance dependence* and *substance abuse* as defined in the Diagnostic and Statistical Manual, DSM IV-TR.

Process

This report is the result of a two-stage process. In the first stage, DBHDS solicited the involvement of treatment providers from the public and private sectors, as well as advocates for people with substance use disorders, in its Creating Opportunities strategic planning process. This group met twice in person and its three committees each had three conference calls.

In the second stage, representatives from state agencies that are stakeholders in the issue of treatment for people with substance use disorders (Department of Corrections, Department of Criminal Justice Services, Department of Health, Department of Health Professions, Department of Juvenile Justice, Department of Medical Assistance Services, Department of Rehabilitative Services, Department of Social Services) were brought to the table to provide their state-level perspective. This group met three times and also submitted written information.

Scope of the Substance Abuse Problem in Virginia

The major source of prevalence information about substance use disorders is the National Survey on Drug Use and Health (NSDUH) conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), based on interviews with persons who are at least 12 years old. These data are available for the state and for regions of the state. While Virginia’s statistics are not the worst in the nation, they are cause for concern. NSDUH data for

Virginia indicate that 1,551,487 (22.9%) Virginians age 12 and older have participated in an episode of binge drinking (consuming at least 5 drinks on one occasion). Among this same age group, 331,300 (4.89%) used pain relievers for a nonmedical use. 620,595 (9.16%) Virginians age 12 or older met clinical criteria for either dependence or abuse of illicit drugs or alcohol. Regarding unmet need for treatment, 489,836 (7.23%) Virginians age 12 years old or older needed but did not receive treatment for alcohol use, and 165,989 (2.45%) Virginians needed but did not receive treatment for illicit drug use in the past year.

The Virginia Department of Health Office of the Chief Medical Examiner's Annual Report also provides information about mortality related to substance use, especially the misuse of prescription pain medication. **The number of deaths caused by drugs increased 32% over the period 2003 to 2009, from 563 in 2003 to 735 in 2009, with more than 60% due to prescription drugs in 2009.** In some Virginia communities, the very fabric of the community has been torn due to abuse of prescription pain medication.

The economic impact of substance abuse is also well documented. The Joint Legislative Audit and Review Commission (JLARC) concluded that untreated substance abuse cost the Commonwealth \$613 million in 2006 dollars, mostly in costs to the criminal justice system.

The Department of Corrections estimates that as many as 75% of adults in jails and prisons have substance abuse problems.

Virginia's Substance Abuse Services System

Several state agencies are involved in either providing or financing treatment services for people with substance use disorders, or they provide other types of necessary supports to these individuals.

The DBHDS funds the 39 community services boards and one behavioral health authority (referred to as CSBs) to support their role as the major provider of publicly funded community-based substance abuse treatment. CSBs provided substance abuse treatment to 38,661 individuals in 2010. Fewer than 10% were seventeen or younger. The criminal justice system constituted 42% of referrals.

The Department of Corrections (DOC) provides treatment to even more people than the CSBs. Currently, over 38,000 offenders are incarcerated, and another 53,400 are under active supervision in the community. It is estimated by DOC that at least 75% of them need treatment for a substance use disorder. DOC has put forth considerable effort to provide services to these offenders, utilizing evidence-based treatment practices that are designed to address the needs of offenders.

The Department of Juvenile Justice (DJJ) also provides evidence-based treatment services to the youth under its supervision. In 2010, 5,800 youth were screened using standard risk assessment instruments. The majority of these youth are served in community settings. Of the youth who were committed to the custody of the Department (608 in FY 2010), 85% received evidence-based treatment while in juvenile justice facilities. DJJ has limited funds (\$200,000 statewide) to purchase services for youth under supervision in the community.

The Department of Criminal Justice Services (DCJS), which supports local community-based adult probation and pretrial services, screens and assesses offenders routinely and is also another purchaser of treatment services. In 2010, DCJS drug tested 11,364 offenders and placed 2,858 into counseling.

The Department of Rehabilitative Services (DRS) has a contractual relationship with DBHDS to provide vocational rehabilitation (VR) services in 18 CSBs. Employment plays a key role in recovery from substance use disorders, and these specially trained VR counselors are able to help their clients achieve higher rates of success than those who receive conventional VR counseling.

The Department of Social Services (DSS) provides supports to people who are seeking recovery, and also absorbs the impact of untreated substance use disorders on families. When it identifies a family or individual in need of services, local departments of social services include treatment as a part of the services plan and seek collaboration with the local CSB.

The Department of Health (VDH) provides many health support services and is both a source of referral and a source of assistance for those with substance use disorders. Many health conditions are related to substance use disorders and some local health departments provide clinical treatment services for some health issues, such as sexually transmitted diseases and tuberculosis. VDH is also the base for the Home Visiting Consortium, which provides outreach to at-risk families and provides screening referral for substance use disorders.

The Department of Medical Assistance Services (DMAS) administers Medicaid, a federal program that provides matching reimbursement at about a 1:1 level for eligible substance abuse treatment services for people who meet income or disability eligibility criteria. In 2010, Medicaid paid about \$1.3 million in reimbursement for substance abuse treatment.

The Department of Health Professions (DHP) is home to the Prescription Monitoring Program (PMP), which tracks all filled prescriptions of a certain type, including pain medication, and provides a database that can be queried by prescribers and pharmacists to prevent prescription drug abuse or over-prescribing of certain medications. It also sponsors an online course for prescribers in pain management.

Private providers are a central part of the substance abuse treatment services network in many, if not most communities in Virginia. These organizations provide services across the entire spectrum of substance abuse services, from inpatient detoxification and residential treatment to peer support services. DOC and DJJ provide funding by contract to many of these private providers to support their role in the substance abuse service system. Private providers are an essential part of the system and were represented on the DBHDS Creating Opportunities planning committees.

Services Systems Gaps and Recommendations to Improve Access to Services

Several reports have identified significant gaps and limited capacity in Virginia's treatment system. Consistently, these documents point to a lack of timely access to treatment

services, gaps in capacity in needed services that provide more intensive treatment, and lack of services that have been proven by research to be effective. The result is that **people with substance use disorders wait an average of nearly 19 days for services. Individuals don't always receive services that are intensive enough or that are proven to be effective – and many do not receive the services they need because those services do not exist at all.**

Because the state's capacity to provide substance abuse treatment services falls so far short of the needs that have been documented by this and other studies, a substantial and continuing commitment on the part of the Commonwealth will be necessary to address them adequately. Meeting these needs will require a multi-stage investment plan. Implementing this plan will be a budgetary challenge. Choices will have to be made and priorities assigned in order to make progress within the fiscal limits.

The interagency committees took these challenges into account in recommending the following suggested service improvement initiatives, shown below in brief descriptions with a summary chart of estimated costs. The cost estimates are for annual operating cost. In making the necessary priority and budget-limiting choices, many of these proposals are pilot projects or gradual, staged expansions of capacity. In this step-by-step approach, an initial "down payment" would need to be followed by adding additional pilot sites, expanding coverage, etc. over the years in a sustained effort. More complete information about each proposal and how it might be phased in is found in the body of the report.

Even with this "down payment" approach, it is likely that a feasible step forward, should the Governor and General Assembly wish to move forward in this area, would feature priority selections from among these ideas. Should the Governor and cabinet secretaries so instruct, the state agencies that developed these proposals will submit appropriate funding requests drawn from these or other suggestions as directed.

Proposals to Expand Capacity Needed to Assure Timely Access to Services:

Proposal 1: Enhance Substance Abuse Case Management Capacity. Two-thirds of CSBs report inadequate case management capacity and only one-quarter of persons receiving treatment for substance use disorders receives any case management at all.

Proposal 2: Develop Capacity to Serve Adolescents with Substance Use and Co-Occurring Mental Health Disorders. Although 20% of Virginia's youth are engaged in binge drinking, fewer than 10% of those receiving treatment for substance use disorders at CSBs are younger than 17. Data from the Office of Comprehensive Services indicate that the need for substance abuse treatment for adolescents ranked second only to the need for crisis intervention services.

Proposal 3: Expand Project Link. Pregnant women who use alcohol or other drugs during their pregnancy put their unborn child at risk of Fetal Alcohol Syndrome, learning disabilities, expensive treatment in Newborn Intensive Care Units and lifelong need for supports from the health, education and social service systems. In operation at eight sites,

Project Link provides intensive case management and coordinates services across the CSB, local department of social services, and local health department for pregnant women.

Proposal 4: Expand Peer-run Support Services. Services provided by people in recovery can offer effective and low-cost supports to people seeking treatment services while they wait for treatment to become available.

Proposal 5: Enhance Uniform Screening and Assessment of Mental Illness and Substance Use Disorders. A substantial number of people who seek services for either mental illness or substance use disorder in fact have both disorders, yet these individuals are rarely appropriately assessed, so treatment only addresses one type of problem. This limits the effectiveness of either type of treatment.

Proposal 6: Implement a Structured Systems Improvement Practice Model such as the Network to Improve Addiction Treatment (NIATx). NIATx is a nationally known approach to quality improvement designed for treatment systems for people with substance use disorders.

Proposals Needed to Fill Gaps in the Services Array:

Proposal 1: Expand Access to Identification and Intervention for Offenders with Substance Use Disorders in Community Correctional Settings. As the JLARC report, *Mitigating the Cost of Substance Abuse in Virginia* (2008) indicated, the Commonwealth spent at least \$613 million in 2006 dollars due to untreated substance use, mostly in the criminal justice system. This initiative would provide funding to DOC, DJJ and DCJS to purchase treatment services from community providers that are best equipped to provide the appropriate intensity and duration of substance abuse treatment services needed to address the clinical level of need for offenders whose offenses are related to substance use, and restore them to productive lives.

Proposal 2: Expand Intensive Outpatient Services. This service involves group counseling at least three times per week and individual counseling, if needed. Only about one-third of CSBs report that they have the capacity to provide treatment services at this level, which is the minimal level needed to help individuals change their behavior and thinking that continue their substance use disorder.

Proposal 3: Expand Capacity for Community-based Residential Medical Detoxification. Detoxification from alcohol and some other drugs can be life threatening and requires some level of medical supervision and support. Half the CSBs lack access to any detoxification capacity. Currently, the public system supports only about 100 beds for this purpose.

Proposal 4: Expand Access to Medication Assisted Treatment (Buprenorphine). Over 400 people per year die due to abuse of prescription medication, usually narcotic pain medication, and this problem appears to be growing. Over half the CSBs lack access to medication assisted treatment, the evidence-based treatment for narcotic addiction. Buprenorphine can

be administered by a specially trained physician and has proven to be an enormous help to people addicted to narcotics.

Proposal 5: Develop Residential Treatment Capacity for Pregnant Women and Women with Dependent Children in Southwest Virginia. A 16 bed facility for women who are pregnant or who have dependent children in the far southwestern region of Virginia would address the needs of this remote area of the state, which has been ravaged by abuse of prescription pain medications, resulting in significantly higher death rates and higher rates of foster care services specifically related to parental drug abuse.

Proposal 6: Re-establish Transitional Therapeutic Communities for DOC. Transitional therapeutic communities (TTCs) are community-based intensive residential treatment programs for offenders who have completed one of three DOC-operated therapeutic communities (bed capacity 1,432), helping ease their transition to the community. Funds for this service were eliminated during 2008, although outcome data indicated significantly improved outcomes. TTCs would provide intensive treatment and assistance with finding employment and housing for approximately 300 offenders per year.

Proposals to Provide Additional Services and Supports Needed to Sustain a Recovery Oriented System:

Proposal 1: Expand Department of Rehabilitative Services SA Vocational Counselors Project. Since 1988, DBHDS has maintained a Memorandum of Agreement (MOA) with DRS to provide vocational rehabilitation (VR) counselors with special training to work with people in recovery at 18 CSBs. These specialty counselors have demonstrated greater success than VR counselors who provide services to similar clients in general case loads, and the costs associated with the substance abuse specialty case loads are also lower. This initiative would expand the funding for this project so that all 40 CSBs would have a specialty counselor.

Proposal 2: Expand Access to Housing Options Available to Adult Offenders in the Community. Stable, safe, sober housing are an important part of supporting an offender in leading a productive, law-abiding, sober lifestyle. However, offenders returning to the community after a period of incarceration often lack the resources to pay deposits on utilities and rent, and do not have supportive friends or family who can help them. Options that would help with these practical issues as well as provide connections to positive social support are available. Funds would be used to help the returning offender with the financial requirements of living in these types of environments for a limited period of time, until he or she can become gainfully employed and self-supporting.

Proposal 3: Establish Capacity for Supported Living Services. Many people seeking substance abuse services in the public system also need a safe place to live that supports recovery. This proposal would distribute funds throughout the state to establish, through lease or purchase, semi-permanent housing for adults in treatment.

Proposal 4: Create a Multi-Agency Work Force Development Capacity Focusing on the Treatment of Substance Use Disorders. A substantial body of knowledge has evolved in the last 20 years concerning effective methods of treating people with substance use disorders. Vetted by research and field tested, these methods are referred to as evidence-based practices (EBPs). Currently, community programs do not use the same or similar EBPs that returning prisoners will have experienced in DOC facilities. Coordination and consistent availability of the same EBPs require staff training and supervision. This proposal would support 1 FTE to collaborate with DOC and DJJ about the types of evidence-based practices needed and to support training events throughout the state to disseminate these EBPs.

Proposal 5: Develop an Ongoing Evaluation Process for Established Drug Treatment Courts. There appears to be ongoing concern about the cost-effectiveness of operating drug courts as a means of providing treatment and diverting incarceration. This proposal includes consideration for existing funding to be held harmless and funds to establish an evaluation function at the Department of Criminal Justice Services to develop an ongoing evaluation process in which every drug treatment court would participate. Evaluation measures would focus on outcomes, especially recidivism.

Budget Summary

The following chart provides the annual operating cost for each of the 17 recommended initiatives to improve access to services that are described briefly above. More detail on these costs can be found in the body of the report.

Project Name	Agency	Annual Cost
Proposals to Expand Capacity Needed to Assure Timely Access to Services:		
1. Enhance Case Management	DBHDS	\$6,400,000
2. Develop Capacity to Serve Adolescents	DBHDS	\$4,080,000
3. Expand Project Link	DBHDS	\$1,455,000
4. Expand Peer-run Support Services	DBHDS	\$1,750,000
5. Enhance Uniform Screening and Assessment	DBHDS	\$250,000
6. Implement NIATx statewide	DBHDS	\$135,000
Proposals Needed to Fill Gaps in the Services Array:		
1. Reinstate Treatment Diversion for Young Non-Violent Offenders	DOC	\$10,000,000
	DJJ	\$3,500,000
	DCJS	\$2,500,000
	DBHDS	\$100,000
2. Expand Intensive Outpatient Services	DBHDS	\$3,000,000
3. Expand Capacity for Community-based Detoxification	DBHDS	\$8,500,000
4. Expand Access to Medication Assisted Treatment	DBHDS	\$4,100,000
5. Develop Residential Treatment Capacity for Pregnant Women in SW Virginia	DBHDS	\$2,000,000
6. Re-establish Transitional Therapeutic Communities	DOC	\$3,000,000
Proposals to Provide Additional Services and Supports Needed to Sustain a Recovery-Oriented System:		
1. Expand DRS Services to CSBs/SA Programs	DBHDS	\$2,230,000
2. Expand DOC Pilot Use of Oxford Houses for Offender Re-entry Housing	DOC	\$160,000
3. Establish Supported Living Capacity	DBHDS	\$500,000
4. Create Multi-Agency Work Force Development Capacity	DBHDS	\$200,000
5. Conduct Cost-Benefit Analysis of Drug Courts	Supreme Court	\$120,000
TOTALS		\$53,980,000

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I. SCOPE AND PURPOSE OF REPORT

This document was prepared in response to a request from Governor Robert F. McDonnell and the Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources, to develop an interagency plan to address the problem of substance abuse in the Commonwealth of Virginia. Coincidentally, the Department of Behavioral Health and Developmental Services (DBHDS), the agency charged by the Code of Virginia [§37.2- 310-1] with acting as “the sole state agency for the planning, coordination, and evolution of the comprehensive interagency state plan for substance abuse services,” had already begun development of a comprehensive substance abuse needs assessment and service development plan as a part of its Creating Opportunities strategic planning process. The interagency planning process, which involved the nine state agencies listed below, expanded on the work that had been initiated by DBHDS.

- Department of Corrections (DOC)
- Department of Criminal Justice Services (DCJS)
- Department of Behavioral Health & Developmental Services (DBHDS)
- Department of Health (VDH)
- Department of Health Professions (DHP)
- Department of Juvenile Justice (DJJ)
- Department of Medical Assistance Services (DMAS)
- Department of Rehabilitative Services (DRS)
- Department of Social Services (DSS)

DBHDS was designated by the Secretary of Health and Human Services as the lead agency in preparing this interagency plan.

The goal of this report is to provide the Governor with a menu of proposals which focus on improving access to services for individuals with substance use disorders across state government. To provide context, the report contains information about the extent of substance use, abuse and dependence in Virginia, including trends in drug-caused deaths. It provides a baseline description of what types of services are currently being offered by the agencies that are part of this collaboration. It examines some recent reports prepared by state entities that identify fundamental issues in the publicly funded treatment services system for people with substance use disorders and delineates some of the gaps in the services system.

In this document, the term *substance abuse* will be used to define the services that are provided by the “substance abuse services” system in the Commonwealth. The term *substance use disorders* will be used as an umbrella term to define the condition/diagnosis of the person who is using the substance. “Substance use disorders” is a clinical term that covers two major

levels of severity, *substance dependence* and *substance abuse* as defined in the Diagnostic and Statistical Manual, DSM IV-TR.¹

The consistent finding resulting from the review of data and information from these varied sources is that Virginia does not have adequate treatment capacity to address the demand for treatment for substance use disorders. The impact is that people who are seeking treatment wait weeks between the time they request services and the time they begin to get help, and often the particular type of treatment that would benefit them the most is not available to them. This lack of capacity results in lost opportunity for these individuals and their families and is costing Virginia money in lost wages, health complications and involvement with the criminal justice system.

The report concludes with a list of budget proposals developed by a team of treatment and interagency experts designed to address some of the identified gaps in services and suggestions for a timetable for implementation.

Process and Background of this Report

As part of the DBHDS Creating Opportunities initiative, staff convened two stakeholder groups and conducted interviews with key staff from all 39 community services boards and the behavioral health authority (referred to as CSBs), which are the entities of local government that are charged with providing substance abuse, mental health, and developmental services to member localities. The first stakeholder group consisted of community providers of clinical treatment services for substance use disorders. Public and private entities were represented. The group met face-to-face twice (November 3, 2010 and March 23, 2011) and participated in three subcommittees via three conference calls for each subcommittee.

The second stakeholder group consisted of representatives of state agencies that provide treatment services for substance use disorders, finance treatment, or provide essential support services in the community to people with substance use disorders. This interagency process was very intense and was conducted in three meetings (April 20, May 9 and June 15, 2011). Each agency was asked to submit a narrative describing its system and discussing gaps in services for people with substance use disorders. The text of the report for each agency's subsection was, in some cases, edited or extracted from the information submitted, but the entire text of the submission as it was provided is included in the appendix to this document.

II. EXTENT OF THE SUBSTANCE ABUSE PROBLEM IN VIRGINIA

Substance Abuse Prevalence

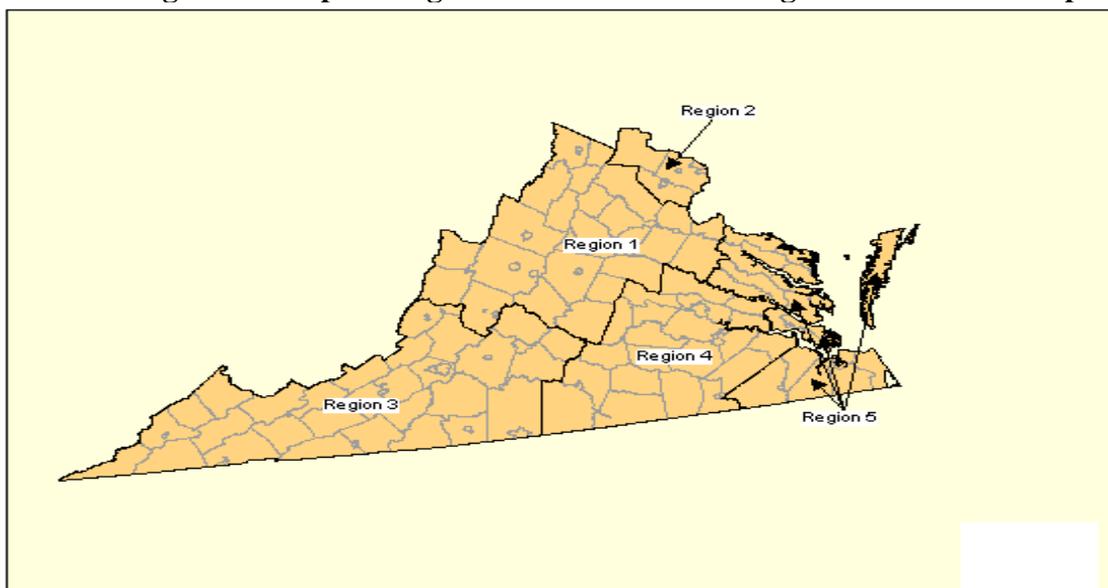
In order to determine the types of programs and services that would make an impact on the harmful use of alcohol and other drugs in Virginia, it is helpful to examine some objective information about the patterns of use and abuse in the commonwealth. The National Survey of Drug Use and Health (NSDUH) is conducted annually on behalf of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), a part of the U.S. Department of Health and Human Services. A representative sample of individuals 12 years of age and older is

¹ American Psychiatric Association. (2000) Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition Text Revision (DSM-IV-TR). Pp. 192-199.

interviewed in every state on an annual basis. SAMHSA makes this information available to the states analyzed by geographic regions within each state. To strengthen the quality of the data, results from three recent years are averaged for each item in the survey.

The most recent NSDUH data available for the states averages results from survey data collected in 2006, 2007 and 2008. Because the source of this information is self-report, it may reflect conservative estimates of use and need for services. In Virginia, data are analyzed by five regions. The map below displays these regions, and a list of the cities and counties within each region is included as Appendix A. This discussion highlights these findings for Virginia, based on estimates of Virginia's 2010 population age 12 and older.

Figure 1: Map of Virginia Divided into Five Regions for NSDUH Report



- **1,551,487** (22.9%) **Virginians** age 12 and older participated in an episode of **binge drinking** (consuming at least 5 drinks on one occasion) **in the month prior to the survey**. The highest rate of binge drinking occurs in Region 1 at 25.22% (264,664), and the lowest rate occurs in Region 5 at 21.5% (329,343).
- **26.42% of Virginia youth** (between the ages of 12-20 years) used **alcohol in the month prior to the survey**, with the highest rate in Region 1 (32.35%) and the lowest rate in Region 2 (21.76%), and **18.2%** participated in at least one episode of **binge drinking** (consuming at least 5 drinks on one occasion) in the past month, with the highest proportion in Region 1 (21.59%) and the lowest proportion in Region 2 (15.86%).
- Statewide, **512,194** (7.56%) Virginians who are at least twelve years old **used illicit drugs in the month prior to the survey**. Regionally, this ranged from 6.52% (120,844) in Region 2 to 8.25% (96,019) in Region 4.
- **666,665** (9.84%) Virginians older than 12 years of age used **marijuana in the year prior to the survey**, with a range of 8.33% (154,391) in Region 2 to 10.92% (128,475) in Region 3.
- **160,569** (2.37%) Virginians older than 12 years of age used **cocaine in the year prior to the survey**, with a range of 2.06% (38,181) in Region 2 to 2.71% (31,541) in Region 4.

- **331,300 (4.89%)** Virginians age 12 and older used **pain relievers for a nonmedical use in the year prior to the survey**, with a range of 5.62% (66,120) in Region 3 to 4.17% (77,288) in Region 4.
- **620,595 (9.16%)** Virginians age 12 or older met clinical criteria for either **dependence or abuse of illicit drugs or alcohol in the year prior to the survey**, with the highest proportion of 9.97% (116,037) in Region 4 and the lowest proportion of 8.04% (149,016) in Region 2.
- **489,836 (7.23%)** Virginians age 12 years old or older needed but did not receive **treatment for alcohol use in the year prior to the survey**, with the greatest number (123,068) in Region 2. However, this represents the lowest proportion among regions of the state at 6.64%. The highest proportion was in Region 1 at 7.67% (80,491).
- **165,989 (2.45%)** Virginians age 12 and older needed but did not receive **treatment for illicit drug use in year prior to the survey**. The actual numbers of people are very evenly distributed among Region 2 (32,064), Region 3 (32,472), and Region 4 (32,937), with the highest proportion of 2.66% (27,915) in Region 1 and the lowest proportion of 1.73% in Region 2.

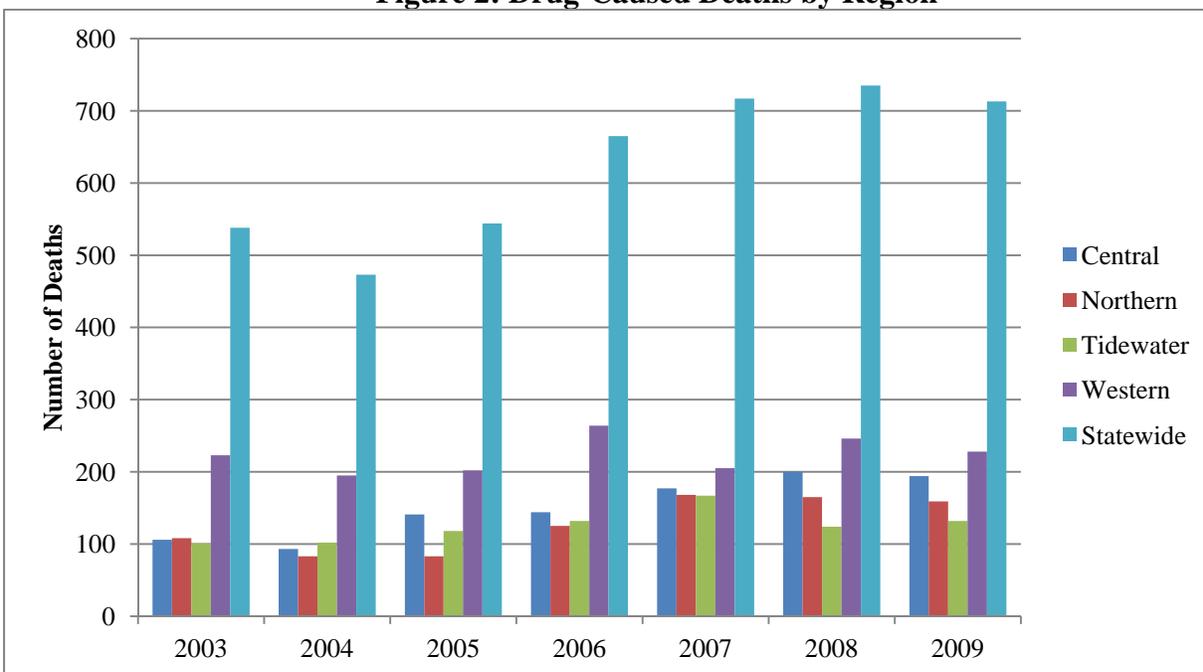
Deaths from Substance Abuse

Data from the VDH Office of the Chief Medical Examiner (OCME) provides information about drug-caused deaths. The OCME uses four regions to analyze the data²; the Western OCME region includes all of the localities included in Region 3 in the NSDUH Western Region, as well as some localities included in Region 1 in the NSDUH data. It is clear the greatest number of deaths has occurred in the Western Region, but it is also evident that the numbers of deaths due to drugs have been increasing in other regions.

There was a slight decline in the total number of deaths in 2009 (the most recent year for which data are available). The peak in total deaths due to this cause occurred in 2008 (735). The total number for 2009 was 713. The number of deaths caused by drugs has increased 32.53% from 2003-2009, with the greatest increase in the Central Region. Over 60% of these deaths are due to prescription drugs, mostly narcotics intended for pain management. In certain parts of the state, the very fabric of the community has been torn because of the high proportion of the population abusing these drugs and the high number of deaths.

² A list of localities by OCME region is included as Appendix B.

Figure 2: Drug-Caused Deaths by Region



Death and injury related to substance abuse also account for a significant number of traffic accidents. In 2009, 316 people died in alcohol-related crashes, and 6,256 individuals were injured. The Department of Motor Vehicles reports that 31,434 people were convicted of Driving Under the Influence in 2009, with an average Blood Alcohol Content level of 0.14, nearly twice the legal limit of 0.08.³

Economic Costs of Substance Abuse Disorders

In addition to the tragedy of lives lost, the economic impact of untreated substance abuse on Virginia is significant. A recent study conducted by the Joint Legislative Audit and Review Commission (JLARC), *Mitigating the Costs of Substance Abuse in Virginia* (2008), estimated a cost of \$613 million (2006 dollars), largely absorbed by Virginia's criminal justice system, related to untreated substance use disorders in Virginia, compared to a total of \$102 million expended to treat substance use disorders during the same period of time.

The JLARC report also indicated that untreated substance use disorders have a negative effect on employment. When large segments of the community are affected, the impact on the economy of the community can be significant. In turn, this can have a destructive consequence on the economy of a region, and ultimately, the commonwealth.⁴ In contrast, the study indicated

³ Virginia Department of Motor Vehicles. Virginia Alcohol-Related Motor Vehicle Statistics (Calendar Year 1984-2009). TSS 02 (6/03/2010).

⁴ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) *Mitigating the Cost of Substance Abuse in Virginia*, House Document No. 19.

that participants in treatment services were less likely to recidivate back to the criminal justice system.⁵

The effect on other aspects of Virginia's budget is also significant. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated that the burden of untreated substance abuse and addiction costs each Virginia resident \$311.21 in 2005 dollars per year, with the largest part of the burden going to the justice system (\$120.95), followed by health (\$72.51) and education (\$60.42). In contrast, in 2005 Virginia was spending only \$5.65 per capita to treat or prevent substance abuse or addiction.⁶ Clearly, this approach to substance use disorders is not cost-effective.

Impact on the Criminal Justice System

Arrest data from the Virginia State Police for 2009 indicate that 44,952 people were arrested for drug/narcotic-related offenses. Among youth under 18, there were 2,526 arrests in this category, and 2,103 arrests for liquor law violations.⁷ The result is that the Department of Corrections estimates that as many as 75% of adults in jails and prisons are incarcerated due, in some measure, to substance abuse.⁸

III. SYSTEMS, SERVICES AND RESOURCES CURRENTLY AVAILABLE TO ADDRESS SUBSTANCE ABUSE IN VIRGINIA

A number of executive branch agencies are involved, either directly or indirectly, with providing services to people with substance use disorders. Three agencies, DBHDS, DOC, and DJJ, provide clinical care to people with substance use disorders. DMAS reimburses qualified providers of substance abuse treatment. In addition, DCJS funds services to adults under the supervision of local correctional boards and administers grant funds to local and state agencies that are used to support substance abuse treatment.

A significant number of people who receive substance abuse treatment at CSBs have a direct involvement with some aspect of the criminal justice system. In addition, DJJ and DOC may contractually purchase community services for individuals under their supervision. Recently, the Governor's Prisoner and Juvenile Offender Re-entry Council released its report which indicated a specific need for mental health and substance abuse services to treat offenders who are re-entering society, thereby lessening the chance that they will re-offend and return to prison or juvenile detention.

Employment is a key part of recovering from a substance use disorder and DRS and DBHDS have been working closely for many years to address this need.

⁵ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19.

⁶ National Center on Addiction and Substance Abuse at Columbia University (2009). Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets, p. 130.

⁷ Virginia Department of State Police Uniform Crime Reporting Section. Crime in Virginia 2009.

⁸ Virginia Department of Corrections Input to Plan System Description (see Appendix for DOC text).

As both DSS and VDH conduct outreach into communities and work with families, there are opportunities to identify families with risk-factors related to substance abuse or dependence, and to offer them intervention. Many families served by DSS are in need due to some circumstance related to a parental substance use disorder. For example, a father or mother has been incarcerated and the children must be placed in foster care; a child must be removed from a home that is dangerous due to parental addiction; a woman seeks shelter for herself and her children because her partner is abusive when he is under the influence of alcohol or another drug, and she may be coping with the stress of living in an abusive situation by abusing alcohol or other drugs. VDH provides services including screening and treatment for conditions for which people with substance use disorders are at high risk.

The DHP collects information about prescriptions written for specific types of drugs that may be abused. It is able to respond to inquiries from qualified professionals about specific individuals who may be attempting to gain access to prescription drugs for abuse, and track prescribers who may be over-prescribing. DHP also provides education to prescribers and pharmacists about addiction and treatment referral resources.

The discussion below highlights services related to substance use disorders for each of these agencies and also provides information about gaps.

A. Department of Behavioral Health and Developmental Services

DBHDS funds CSB treatment and prevention services for substance abuse in the communities they serve. DBHDS allocates state general funds and federal Substance Abuse Prevention and Treatment (SAPT) block grant funds to the CSBs to provide substance abuse services through a performance contract. CSBs also use fees (including insurance and private pay), local government allocations, grants from other sources, and Medicaid to support substance abuse treatment services. In the fiscal year that ended in June, 2010, 38,661 individuals received substance abuse treatment through the CSBs.

Most of those served are between the ages of 23 and 59 (75.83%), and 12.89% are between the ages of 18-22. Only 9.43% are 17 years old or younger, and only 1.77% are older than 59. Regarding ethnicity, 60.3% are white, 29.88% are Black/African American, and less than 1% represents either another or a mixed ethnicity. The gender division is 65% male and 35% female. Forty-two percent of the referrals CSBs receive for substance use disorder treatment services are from some part of the criminal justice system, while 24.3% are self-referred. Alcohol abuse is the most frequent problem presented to CSBs (39%), followed by marijuana (21%), cocaine (11% - including “crack”), followed by heroin (9%) and other opioids (8.8%).⁹

As entities of local government, CSBs develop an array of services to address local needs. All CSBs are required to provide emergency services and nearly all provide outpatient services, which can include individual counseling, group counseling, family counseling, and medication assisted treatment.

- In 2010, 30,632 individuals participated in outpatient treatment services. Typically, people participate in outpatient services once or twice a week for an hour or two each

⁹ From DBHDS CCS-3 database for 2010.

time. However, people seeking substance abuse treatment services usually need to receive evidence-based services at a level that is intense enough to support substantial change in thought processes and behavior. Only about one-third of CSBs are able to provide services at this level due to limited capacity related to staffing.

- In 2010, 2,095 people received some type of medication assisted treatment. Medication assisted treatment uses prescription medication, such as methadone, buprenorphine, Antabuse or other medications to assist the person in addressing the physiological aspects of addiction. Medication must be combined with counseling and other supports to be effective, and is usually provided in an outpatient setting.
- Only 786 people received day treatment services in 2010. Day treatment is nonresidential treatment that is more intensive. In this type of treatment, participants attend treatment more than twice a week and receive between 20-30 hours of services in a week.
- In 2010, 7,826 people received treatment in residential settings. This includes:
 - Community-based detoxification for people who have become so physically dependent that they experience dangerous physical symptoms when they are not using (3,127);
 - Crisis stabilization (283);
 - Highly structured settings that offer intensive therapy and supervision on a 24 hour basis (4,003); and
 - Supportive living, a safe, sober setting where a person may live with some supervision or support services while he or she engages in treatment (413).
- Case management is the service “glue” that helps people in treatment receive supports, such as housing and health care, and helps them move to the appropriate level of treatment. In 2010, 9,458 people received case management services related to substance use disorder treatment.

Costs for services vary by CSB. The table below displays the average statewide costs in FY 2010.

Unit Costs for Selected Substance Use Disorder Services for Provided by CSBs 2010

Type of Service		Unit Cost
Outpatient		\$89.67/hour
Medication assisted treatment		\$68.16/hour
Day treatment		\$40.18/hour
Residential	Community detox	\$433.98/day
	Crisis stabilization	\$521.00/day
	Intensive residential	\$91.74/day
	Supervised	\$88.06/day

Source: 2010 CARS data

DBHDS directly operates nine hospitals that provide inpatient treatment services to people with serious mental illnesses. Staff at these facilities estimate that as many as 70% of admissions are affected by substance use disorders as a co-occurring condition and provide a variety of inpatient substance abuse treatment services, although this is rarely the presenting problem.

Services provided in the community are supported by a combination of federal, state and local funds, along with a limited amount of fees. In 2010, revenues were as follows:

Federal:	\$42,867,676
State:	\$46,678,876
Local:	\$38,310,365
Fees & Other:	<u>\$ 5,947,730</u>
	\$133,804,647 ¹⁰

B. Department of Corrections

As of June 20, 2011, 31,439 offenders were incarcerated in DOC correctional centers. In addition there were 6,789 state-responsible offenders incarcerated in local or regional jails, for a total of 38,228 incarcerated offenders. On average, approximately 13,000 state-responsible offenders complete their sentence each year and return to the community. Of offenders released in 2009, almost 80% had some degree of supervised probation, parole, or post-release supervision. Moreover, in May 2011, DOC probation and parole districts supervised a total of 58,306 offenders. Of that number, 53,700 were being actively supervised. In May 2011, the number of offenders in the DOC totaled 89,749.

Approximately 85% of all offenders have need of some type of treatment service or intervention, and upwards of 75% of offenders have substance use specific treatment needs, which equates to approximately 40,275 offenders out of 53,700 under active supervision. The DOC is cognizant of the enormity of substance abuse occurring within the offender population and is rigorously addressing substance abuse by the integration of evidence-based practices (EBPs) into treatment interventions that have been proven to reduce recidivism. DOC provides a multi-level substance abuse services approach to address varying offender treatment needs based on the severity of the problem. DOC uses a standardized, evidence-based assessment tool that includes a screen for substance abuse designed to assess the correctional needs of individuals in the offender population. Using this tool, DOC has determined that over 70% of offenders screened positive for a substance use disorder. If an offender screens positive for a possible substance use disorder, DOC has recently begun to employ a separate instrument that focuses exclusively on determining the extent of the substance use issue and other information to match the offender to the appropriate level of treatment.

As a part of the DOC Adult Re-entry Initiative, DOC is focused on implementing a comprehensive process that seeks to reduce recidivism by preparing offenders for successful re-entry and transition into the community. Providing the appropriate intensity and duration of treatment for substance use disorders is an integral component of this plan. To address this, DOC has either modified programs already operating to provide treatment for offenders with substance use disorders or has implemented new services and supports.

- DOC currently operates two prisons (one for females and one for males) totaling 1,400 beds in which the entire operation is focused on providing substance abuse treatment, criminal thinking and anti-social behaviors. (DOC is in the process of establishing another women's facility for this purpose.)

¹⁰ FY10 End of Year Reports from CSBs

- Within the standard prison framework, inmates also have access to substance abuse treatment, such as one-to-one counseling, groups, and intensive outpatient therapy, which involves meeting in groups several times per week and utilizing a research-based treatment model.
- Twelve-step anonymous programs and peer supported services are welcome in DOC facilities to provide ongoing support in addition to treatment.
- DOC staff are trained to utilize EBPs that are appropriate to the population it treats. Some are basic to any substance abuse treatment service, and some are specifically designed to address the needs of offenders.
- DOC contracts with community providers for services to offenders who are in the community. DOC requires that providers use specified EBPs and monitors how well the services are provided (e.g., whether or not the services adhere to standards for specific EBPs). DOC utilizes the services of CSBs and other community providers. Services needed by offenders returning to the community vary in intensity, from residential to outpatient.

The cost of providing substance abuse treatment is added onto the cost of incarceration. Depending on the intensity of service, costs can range from \$640 per person per year¹¹ to participate in an outpatient group that meets once a week, to \$3,240 per person per year to participate in an Intensive Outpatient Group that meets for several hours multiple times each week. The cost of participating in an intensive residential treatment setting adds \$2,500 per offender per year to the cost of incarceration.

C. Department of Juvenile Justice

DJJ provides evidence-based, gender specific substance abuse treatment for committed females, with an emphasis on co-occurring mental health disorders. DJJ provided evidence-based treatment programs to approximately 85% of the youth in all juvenile correctional centers in 2010. All youth placed on probation or committed to DJJ are screened for substance use disorders with the Youth Assessment and Screening Instrument (YASI), DJJ's risk-needs assessment tool. In 2010, approximately 5,800 juveniles were screened using standard risk assessment instruments. Youth committed to DJJ are additionally screened utilizing the Substance Abuse Subtle Screening Inventory (SASSI). In 2010, approximately 600 youth participated in this screening.

DJJ develops a transition plan to address the need for continuing care for each committed youth with substance use disorders and utilizes transitional services funds to purchase community-based substance abuse treatment for youth released from a juvenile correctional center, but has limited funding (\$200,000 per year).

DJJ provides on-site, urine and saliva drug testing kits to court service units to monitor substance use for youth on probation and parole.

¹¹ The actual group would meet only 16 weeks, but the cost is spread out over the year.

D. Department of Criminal Justice Services

As the Commonwealth's criminal justice planning agency, DCJS does not provide direct services; however, state and federal funds are utilized to support substance abuse treatment at both the state and local level. These efforts cross a multitude of criminal justice agencies such as juvenile services, adult corrections, local jails, law enforcement, pre-trial, community corrections, local probation and victim services. Programs funded by DCJS utilize evidence-based practices in their implementation. DCJS supports substance abuse services by:

- Providing grant funding to create or enhance residential substance abuse treatment programs in jails, detention centers and adult corrections;
- Providing grant funding for substance abuse prevention and intervention projects for juveniles provided in schools, CSBs, detention centers, universities, nonprofit organizations and local youth-serving commissions;
- Providing training support on substance abuse issues to professionals working in the criminal justice field;
- Participating in interagency committees dealing with many issues, including substance abuse; and
- Convening stakeholders to engage in policy discussions on issues of importance to the criminal justice field.

DCJS provides direct funding and technical assistance to support local community-based adult probation and pre-trial services agencies. This includes assistance for the local agencies' substance abuse assessment of defendants awaiting trial and offenders placed on local probation, and for referral and placement of defendants and offenders in appropriate substance abuse programs. For FY2010, these DCJS funded agencies reported:

- 11,364 offenders were drug tested.
- 4,317 offenders were placed in substance abuse education.
- 3,371 offenders were screened for substance abuse problems.
- 2,880 offenders were assessed or evaluated for substance abuse problems.
- 2,858 offenders were placed in substance abuse counseling.
- 675 offenders were tested for alcohol use.
- 502 offenders were screened, assessed or evaluated for alcohol.

E. Department of Rehabilitative Services

Since 1988, DBHDS and DRS have maintained an interagency agreement under which DRS provides specialized vocational rehabilitation (VR) services to individuals with substance use disorders who meet eligibility criteria for the VR program. The agreement is designed to address issues surrounding job entry and job retention by integrating DRS VR services with a CSB's clinical treatment programs. Currently, dedicated VR counselors provide specialized VR services in only 18 CSBs. For the remaining 22 CSBs, individuals with substance use disorders are served by VR counselors who also serve other individuals with a wide range of disabilities who are referred for VR services from many different sources.

The DRS program manager who provides training and technical assistance to the dedicated VR counselors is also available for consultation with general caseload counselors on issues related to substance use disorders. The generalist VR counselors typically do not have the

opportunity to participate in specialized training, nor do they use the same type of integrated collaborative services model as the dedicated VR counselors.

DRS experience with the integrated service model with dedicated VR counselors has been demonstrated to be more effective with the target population at a lower services cost. Case service costs for clients with substance use disorders served by the dedicated VR counselors are 39% lower than the case service costs for clients with substance use disorders served by generalist VR counselors (\$1,042 versus \$1,700, on average, over the “life” of the case). Also, the typical “life” of a VR case for individuals served by dedicated VR counselors is somewhat shorter which reduces the per-client cost of in-house services. VR clients with substance use disorders served by the dedicated VR counselors are more likely to achieve successful employment outcomes (56%) as opposed to individuals served by generalist VR counselors (45%) and have significantly higher hourly earnings when their VR cases are closed (\$9.98 versus \$9.19, on average) than individuals with substance use disorders served by generalist VR counselors.

The two major types of VR services are core services and purchased services. Core services are services provided by the VR counselor and other DRS staff (e.g., job placement staff, vocational evaluators) to all clients and include: 1) guidance and counseling; 2) vocational evaluation; and 3) assistance with job placement to include 90-day follow up after placement. All VR clients receive counseling and guidance during all phases of the VR process. These core services help clients better understand their potential, set realistic job goals, revise goals when needed, and learn good work habits.

DRS also purchases services, as needed, from a network of providers to help clients reach their vocational goals. These services range from assessments, vocational training and supported employment to medical treatment and assistive technology services. Almost two-thirds of all case service costs for clients with substance use disorders served by the dedicated VR counselors in FY 2010 were for:

- Supported employment and job coach training (24% of total expenditures);
- Training, both vocational and post-secondary (17% of total expenditures);
- “Maintenance,” primarily for room, board, and other costs associated with attending college (14% of total expenditures); and
- Transportation, e.g., for bus tickets and mileage reimbursements to clients (10% of total expenditures).

DRS provides DBHDS with an annual report documenting the services provided and the employment outcomes for individuals served by the dedicated VR counselors through the integrated model described earlier. With additional funding, DRS would significantly increase the number of individuals served with substance use disorders and expand this report to document the additional numbers of clients served and the outcomes of this much-needed service expansion.

F. Department of Social Services

Cooperation, coordination and collaboration within and outside of the social services system are essential to providing the most comprehensive services to families. Individuals and

families face unique challenges that impact their ability to maintain self-sufficiency. DSS values all programs and services that assist individuals and families to regain and maintain self-sufficiency and achieve personal accountability, and is committed to working across programs, divisions, agencies, stakeholder groups, and communities to improve outcomes for the children, individuals, families, and communities it serves. Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and community partners across all programs and services.

DSS, at the state and local levels, has implemented Family Engagement Principles that encourage family participation in service planning. DSS is also embracing a Family Strengthening framework evident in the new DSS Practice Model. Community supports include:

- Inclusion of substance abuse services as part of a service plan.
- Collaboration with CSBs for the provision of community-based substance abuse services. This may vary by locality.

G. Department of Health

VDH provides services including screening and treatment for conditions for which people with substance use disorders are at high-risk:

- Family Planning Clinics provide Sexual Transmitted Infection (STI) testing and treatment to people who may need, or be participating in, services for substance use disorders.
- VDH AIDS Drug Assistance Program (ADAP) provides medications for low-income, uninsured individuals with HIV/AIDS. Due to unprecedented enrollment and increased treatment costs, ADAP is closed to new enrollment except for pregnant women, children 18 years old or younger, and people receiving treatment for an active opportunistic infection. Drug use is a known risk-factor for HIV infection.
- Clinics provide referrals to CSBs. Relationships between local health departments and the CSBs vary by locality.
- Virginia's Home Visiting Consortium is a collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy through age five. The Consortium reports to the Early Childhood Advisory Council and is a partner in Virginia's Plan for Smart Beginnings. VDH and DBHDS are represented on the Consortium and DBHDS has provided funding to support training about screening for substance use disorders.

H. Department of Medical Assistance Services

Medicaid began reimbursing providers for substance abuse treatment in 1998, with the initiation of services limited to pregnant and postpartum women (residential and day treatment). In 2007, the State Medical Assistance Plan was expanded to include an array of services for the general Medicaid eligible population, including crisis intervention, intensive outpatient, day treatment, opioid treatment (methadone), and case management. Federal regulations prohibit the use of Medicaid funding to support residential treatment in facilities that have 16 or more beds for persons between the ages of 18-64, and no residential treatment is covered except for pregnant women in facilities with fewer than 16 beds. Because state general fund dollars spent through the Medicaid program are matched by the federal

government at an approximate 1:1 ratio, Medicaid is a cost-effective approach to funding services for the eligible population. In 2010, Medicaid paid approximately \$1.3 million to providers in reimbursements for substance abuse treatment.

Due to federal and state Medicaid eligibility regulations, the pool of persons currently eligible to have their substance abuse treatment services reimbursed is relatively small and is largely limited to women with dependent children who are receiving public assistance, or people who are disabled due to co-occurring mental illness or physical disability.

I. Department of Health Professions

DHP has several ongoing programs that are related to substance abuse. The Prescription Monitoring Program (PMP) maintains a database of information on all controlled substances prescribed and filled in Virginia. The information is reported twice a month by all pharmacies and prescribing physicians. Prescribers or pharmacists may check the PMP database to see if patients are receiving multiple prescriptions for drugs that may be abused. Examples include OxyContin, methadone, morphine, Ritalin, Vicodin, Valium and Ambien. The PMP sponsors an online pain management curriculum developed at the Virginia Commonwealth University School of Medicine for prescribers. The PMP has been an active partner with DBHDS and CSBs in educating prescribers about addiction to pain medication, especially in far southwest Virginia where abuse of narcotic pain medication has become epidemic. DBHDS is represented on the PMP Advisory Panel.

Through a contract with Virginia Commonwealth University, DHP also operates the Health Practitioners Monitoring Program, which provides confidential treatment for physical, mental disability or chemical dependency for licensed health professionals.

Finally, DHP certifies substance abuse counselors and licenses health professionals who treat people with substance use disorders and other behavioral health problems. DBHDS monitors these requirements and provides training opportunities to assist professionals associated with community services boards in meeting them.

J. Private Providers.

In many, if not most communities in Virginia, private sector providers are a central part of the substance abuse treatment services network. These organizations provide services across the entire spectrum of services, from inpatient detoxification and residential treatment to peer support services. Private agencies bill private insurance and Medicaid for their services and many are supported by contributions and grants from local, state, and national charitable sources.

State agencies such as DOC and DJJ contract with private providers for services. Many CSBs use state general funds and SAPT block grant funds from DBHDS to contract with private providers. In some CSBs, contracts with private providers constitute the majority of the CSB's substance abuse efforts. Private providers are an essential part of the system and were represented in the DBHDS Creating Opportunities planning process.

IV. SERVICE SYSTEM GAPS AND RECOMMENDATIONS

Several studies have been conducted which identified systemic weaknesses in the substance abuse treatment system. The Office of the Inspector General (OIG) conducted a review of outpatient treatment provided by CSBs for adults with substance use disorders in 2006¹² and conducted a study of community services board services for adolescents in 2008.¹³ As previously mentioned, JLARC conducted a two-year study of the economic impact of substance abuse on the Commonwealth.¹⁴ The resulting report, issued in 2008, also enumerated some systemic deficits of the services system, focusing primarily on the community services system and its linkages with DOC and DJJ. Also in 2008, Senator Hanger introduced Senate Joint Resolution 77 to establish the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention. The study was continued for two additional years and issued three reports.¹⁵ More recently, for its Creating Opportunities substance abuse treatment initiative, DBHDS surveyed the CSBs to obtain a detailed picture of the CSB substance abuse treatment services system.

A consistent theme emerged from reviewing all of these reports: **People who need substance abuse treatment for through the publicly funded system lack *access to adequate capacity of the array of services necessary to support recovery.*** People must be able to get to the service, the service must have capacity to serve them, and the service must provide the intensity and duration needed for recovery. Typically, a person in need of substance abuse treatment will need access to an array of services to match the stage of treatment, medical, psychological or psychiatric, or practical needs they are experiencing. Individuals will begin treatment with different services, depending on their specific clinical and practical needs. One person might begin treatment for alcoholism in a detoxification setting to get the body physically clear of alcohol, then begin psychological aspects of treatment in a day treatment program that provides intensive services, such as group, individual and family therapy services multiple hours per day, multiple hours per week, assuming he or she has a safe living environment to go home to at night and on the weekend. Another person, addicted to a narcotic, might receive medication assisted treatment on a daily basis and participate in group and family counseling on a weekly basis, along with case management.

Services need to be matched in duration and intensity to the person's needs, based on the extent of abuse or dependence, the type of drugs (including alcohol) used, and the level of support available to the person from family and friends. In addition, within the array, the actual services should be based on evidence (research) that they work, and this requires training and ongoing supervision for the counselor.

¹² Inspector General, (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report # 129-06, Office of the Inspector General.

¹³ Inspector General, (2008) Review of Community Services Board Child and Adolescent Services, Report # 149-08, Office of the Inspector General.

¹⁴ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19.

¹⁵ Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

Quality is another essential component of treatment and, in the field of substance use disorders, there is a range of clinical practices and programs that have been vetted by researchers and thoroughly field tested known as evidence-based practices (EBPs). EBPs are tailored to meet the needs of the individual served. Some EBPs are effective for almost every population in every setting and some are designed to meet the clinical needs of a particular population (e.g., criminal justice system, adolescents, women with histories of trauma) or specific clinical issues (e.g., co-occurring mental illness) or diagnosis (e.g., narcotic dependence). Clinicians must be trained not only to know how and when to use an EBP; they also must be coached and supervised appropriately if they are to maintain their effectiveness. Furthermore, if people seeking treatment services in the community have had exposure to an EBP in another setting (such as Corrections), it is important to maintain the continuity of this approach to support the person's progress toward recovery.

Although there are costs associated with providing EBPs, such as training, supervision, manuals, materials, space, or organizational changes, their known effectiveness indicates that it is more cost-effective to apply EBPs than to utilize methods that may have been vetted only through tradition. The OIG report on adult substance abuse treatment in CSBs showed that CSBs varied considerably in their use of EBPs and recommended that particular focus be placed on addressing the training needs of CSB staff.¹⁶ The OIG report on children's services found that few CSBs utilized EBPs for this population.¹⁷ The JLARC report indicated that fewer than half of the CSBs were able to implement EBPs effectively.¹⁸

A. Proposals to Expand Capacity Needed to Assure Timely Access to Services

Working with the Creating Opportunities group and the expanded state interagency group described earlier, DBHDS, at the direction of the Secretary of HHR, took the lead on developing a list of proposals to address this problem. Each state agency contributed its own view of the needs in its area and its priority suggested service development proposals or initiatives. While this list is not exhaustive, it attempts to identify the "fulcrum" services – services that, if funded, would have the most significant impact on addressing gaps in the services system.

Timely access is critical for people seeking substance abuse treatment services. They often struggle with motivation, due to denial or the power of addiction, which has profound effects on the part of the brain that is responsible for decision-making and reasoning, even when the person is not actively under the influence. The lack of timely access to treatment can quickly lead to criminal activity or even death, either by overdose or some other incident, such as fatal traffic accident. DOC has noted in its input for this report that access to treatment for offenders is often problematic. For offenders re-entering the community after incarceration, a significant wait for treatment is a lost opportunity to provide critical support during a difficult transition. Several reports have examined this critical factor in depth:

¹⁶ Inspector General, (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report # 129-06, Office of the Inspector General, p. 36.

¹⁷ Inspector General, (2008) Review of Community Services Board Child and Adolescent Services, Report # 149-08, Office of the Inspector General, p. 7.

¹⁸ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, p. 82.

- The 2006 OIG Study of SA services for adults found an average wait of 25.4 days between the first call for help and engagement in actual services.
- The DBHDS Creating Opportunities substance abuse survey of the 40 CSBs found that individuals wait an average of 18.9 days between the first contact and engagement in a service, with a range of 3-56 days.
- The JLARC study found that the wait time varied depending on the services. The longest wait is for screening and evaluation, the initial service that is critical to participating in other services. For every one person receiving this service, 16 were waiting, which means that capacity for screening and evaluation would need to be expanded 160% to meet demand.¹⁹
- The 2008 OIG study of child and adolescent services found that the average wait for all children and adolescent services from all CSBs that reported was 26 days.

The most significant reason provided by all of these studies for long waiting times is lack of capacity to meet demand for services, and while the need to address capacity is of critical importance, other strategies, such as re-designing the intake process and use of peer-run support services, can also be employed to quickly engage persons seeking services for substance use disorders. People seeking publicly funded substance abuse treatment are often unable to manage time well enough to keep up with appointments and may lack reliable transportation. Scheduling an appointment several weeks away is unrealistic and results in unkept appointments while others are waiting weeks for intakes.

The following proposals represent a carefully selected set of priority programs that the two planning committees agreed were the most cost effective and most immediately needed steps that can be taken to improve access to community substance abuse services. Meeting the full range of needs in this chronically underfunded service area is impossible with anything other than a step-by-step effort over many biennia. The proposals shown below are the first steps, usually employing gradual expansion and use of pilot projects. The costs shown are for the first year of a program's operation or the first step toward a fuller system. Subsequent steps will be multiples of these figures.

Proposal 1: Enhance Substance Abuse Case Management Capacity. According to the 2006 OIG report, two-thirds of CSBs report inadequate case management services²⁰ and utilization data from CSBs indicate that only one-quarter of persons receiving substance abuse treatment services receive any case management services at all.²¹ This is particularly troubling as people with substance use disorders who present to CSBs and other public systems often have practical needs that complicate achieving the goal of recovery. Deserted by family and friends, they lack support systems that could help them and are in need of assistance with housing, employment, access to health care, and other supports which directly impact their capacity to engage in recovery. In addition, they frequently need treatment in varying levels of intensity in subsequent stages. A specialized case manager can

¹⁹ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, p. 80.

²⁰ Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report #129-06, p. 17.

²¹ DBHDS 2010 CSB Fourth Quarter Report.

monitor whether or not treatment intensity is appropriate, as well as access health and other support needs, and then coordinate resources to address them. Persons returning to the community from incarceration or detention also need a person within the treatment system to communicate and plan with their probation officer.

Case management is an essential service for people debilitated by substance use disorders because it assists them in making these crucial connections. As the “glue” that helps the person assemble the community resources necessary to support recovery, case management utilizes the skills of an experienced professional knowledgeable about community and state resources. Quality case management can provide outreach, support ongoing engagement in treatment, and impart practical knowledge to assure that external barriers do not stand in the way of recovery.

The interagency planning committees recommended the gradual addition of two case managers per CSB per year, until each of the 40 CSBs had an average of 6 case managers (1 FTE @ \$80,000 including salary, fringe, equipment, travel, etc.) dedicated to providing services to people with substance use disorders. The first year of this program would add two SA case managers to each of the 40 CSBs:

Funding schedule:	
Year 1:	\$6,400,000

Proposal 2: Develop Capacity to Serve Adolescents with Substance Use and Co-Occurring Mental Health Disorders. Data from the NSDUH indicate that nearly one in five Virginia adolescents regularly engage in binge drinking (consuming at least five drinks on one occasion). CSB utilization data indicate that fewer than 10% of those receiving substance abuse treatment services are adolescents. The FY 2009 Comprehensive Services Gap Analysis reported that among all the services gaps in the state for children and adolescents, intensive substance abuse services ranked second, topped only by the need for crisis intervention and stabilization.²² Information gathered by the OIG indicates that children/adolescents seeking services wait an average of 26 days to access any services. The same source reports that CSBs have inadequate capacity to serve children, rarely perform comprehensive assessments on which to base treatment plans, don’t integrate findings about the child’s substance use into the treatment plan, and have difficulty retaining staff that are knowledgeable about providing services to children and adolescents.²³ Information from a specialized SAMHSA grant-funded project that focused on the needs of adolescents indicated that CSB staff lack the specialized knowledge and skills to provide services to youth with substance use or co-occurring mental health disorders. The leading suggestion from CSBs about how services to children and adolescents could be improved was to provide training on evidence-based services to families and children.²⁴ As a result of their untreated problems, these youths fail to achieve their full potential as adults, and some end up involved

²² Office of Comprehensive Services (2009). FY09 CSA Critical Service Gaps. January 29, 2010.

²³ Office of the Inspector General, (2008) Review of Community Services Board Child and Adolescent Services. Report #149-08. p. 19.

²⁴ Office of the Inspector General, (2008) Review of Community Services Board Child and Adolescent Services. Report #149-08. p. 19.

with the criminal justice system. In addition, the juvenile justice system needs community treatment services for juveniles under community supervision.

Ongoing funds in the amount of \$4,000,000 are needed to support one clinical staff person at each of the 40 CSBs who would be dedicated to providing treatment services to children with substance use and co-occurring mental health disorders (\$100,000 for each of 40 CSBs). In addition, \$80,000 is needed to support, plan and implement ongoing training and coaching of these adolescent specialists to assure that the evidence-based practices being used are true to the model and represent the most current and effective practices. The Adolescent Specialist at each CSB would be knowledgeable and skilled in the use of evidence-based practices and programs that have been found to be effective in working with youth, including integrating the family into treatment services and developing community-based systems of care, such as working with the school and community health and social services professionals.

Funding schedule:

\$4,000,000 (1 FTE per CSB @ \$100,000)

\$80,000 (logistics, materials, curricula, trainers, consultants)

Total: \$4,080,000

Proposal 3: Expand Project Link. Pregnant women who are using alcohol or other drugs during their pregnancy present a special challenge to treatment providers, with complex psychiatric, medical and social needs. These women often have co-occurring mental health issues and are usually severely addicted. However, because of the risk of losing custody of current children or the unborn baby, they may be afraid to seek help. They may also be involved in violent relationships or with addicted partners. In addition, infants born to mothers who are addicted to alcohol are at risk for Fetal Alcohol Syndrome, a type of intellectual disability that is associated with severe learning disabilities and physical abnormalities. Children born to mothers addicted to other types of drugs may experience neurological abnormalities and may suffer from learning disabilities. Untreated, these infants will require treatment in Newborn Intensive Care Units, costing hundreds of thousands of dollars, and requiring extensive educational and social supports, including potential removal to foster care.

Project Link, initially implemented by DBHDS in 1990 with federal funds, provides intensive case management to pregnant women who are either using substances or who are at risk of using substances that harm their unborn children. It utilizes a local interagency team consisting minimally of the local department of social services, the local health department, and the community services board to engage pregnant women who present for services at any of these agencies by providing prenatal care, social services supports, substance abuse treatment and intensive case management. The result is that a healthy infant is born to a mother who is fully engaged in recovery. If the woman has other dependent children, these agencies can also provide services for them as well. If any of the children have special needs, these can be attended to early, through Part C, a federally funded program, when intervention is likely to have the greatest affect. The family can continue to receive services and supports from the local health department, such as Well-Baby Care, and help with other needs, such as WIC (Women, Infants and Children, a federally funded food support program

available to families with young children), federal TANF (Temporary Assistance to Needy Families) benefits, and treatment from the community services board.

Currently DBHDS funds eight Project Link sites that have been highly successful in helping these mothers deliver healthy babies (birth weights and head circumference), treat their addiction, improve their understanding of effective parenting, and provide “wrap-around” services to address the health and social needs of the family. DBHDS uses SAPT block grant funds to support Project Link at six sites that each serves individual CSBs at a cost of \$100,000 each (\$600,000), and general funds to support two sites that serve multiple CSBs at \$125,000 each (\$250,000). These sites have not had an increase in funding since inception. This initiative would increase funding for the six existing sites currently funded at \$100,000 to \$150,000 (additional \$300,000), and increase funding for the additional two current sites from \$125,000 to \$175,000 (additional \$100,000). In addition, 10 new sites will be added, five in FY 2012 and five in FY 2013. In order to provide services to the greatest number of pregnant women, eight of the sites will be implemented as collaborations with two or three multiple CSBs at a cost of \$175,000 each. One site will be a traditional sole CSB site (\$150,000), and one site will serve the metropolitan Richmond area, serving five CSBs, at a cost of \$250,000. Each site, except the Richmond area, will be staffed by a Link Coordinator who will establish and maintain focused interagency relationships with the local departments of social services and health, at a minimum. The Richmond site will be staffed by a Link Manager and a Link Coordinator. In addition, \$30,000 would be used annually to support training and development for all of the new sites.

Funding schedule:

Year 1: \$1,455,000

Proposal 4: Expand Peer-run Support Services. Peer-run support services provide another approach to improving timely access to services, as well as providing supports to persons in need of services. Although peer-run support services can often provide effective and low-cost supplemental supports to treatment, and can tide people over until treatment is available, only half the CSBs report using these services. For instance, after the initial intake, trained peers could facilitate a treatment orientation group for people seeking services that could provide support until the appropriate service was available. Peers can provide other types of support as well. People with substance use disorders need many different types of support, and some types of assistance are more appropriate and more effective when provided by people who are in recovery themselves. These types of support can include emotional support (peer-led support groups); informational support (life skills classes such as financial management, nutrition and wellness, time management, relapse prevention, career planning, leadership development); instrumental support (child care, transportation, housing, clothing, food banks); and social supports (pro-social recreational events, drop-in centers).

Currently DBHDS is funding five peer-support centers, and one center is funded by a federal SAMHSA grant. These centers provide a variety of supports that complement treatment or support people who are either not ready to seek treatment, not able to access treatment, or who are in long-term recovery and seeking additional supports, such as recovery-oriented social events. The DBHDS Creating Opportunities survey indicated that only half of the

CSBs are using these types of services. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that DBHDS and CSBs partner with peer-run recovery organizations in the provision of substance abuse services.²⁵

DBHDS would use a competitive request for proposal process to award five to seven additional projects in the first year based on the organization's ability to address program requirements, quality standards, accountability, and other criteria. Participants in peer-run support services would have improved access to supports that would increase the likelihood of long-term recovery from substance use disorders. Programs would be tailored to address local gaps and needs as demonstrated in its proposal response and would be monitored by DBHDS. In subsequent years additional programs in other communities would be added through competitive grants in amounts of \$250,000 to \$350,000 per program.

Funding schedule:

Year 1: \$1,750,000 to support 5-7 projects

Proposal 5: Enhance Uniform Screening and Assessment of Mental Illness and Substance Use Disorders. Effective treatment begins with a thorough assessment of the issues and problems of the person seeking services. Although three out of four CSBs use a standard instrument to assess the clinical needs of people seeking services, the instruments are not scientifically validated (e.g., they have not been proven to be accurate), and fewer than that are using industry standard criteria for deciding what clinical services are needed to address the clinical substance use disorder problems that are identified in the assessment. Thus, decisions about what services are to be provided are often subjective.

Complicating this lack of a common approach to basic assessment is the fact that many people seeking services for either mental illness or a substance use disorder actually have both disorders, yet often only one disorder is identified. Mental health needs of adults seeking services for substance use disorders from CSBs are under-assessed and under-treated. This is significant because the research literature indicates that a significant proportion of people with substance use disorders also suffer from anxiety and mood disorders, such as depression or bipolar disorder. The risk of intentional suicide among people with substance use disorders is high, and these undiagnosed and untreated mental health disorders are a contributing factor. Apart from the suicide risk, these untreated mental health disorders compound the treatment of the substance use disorder, making it difficult for the person seeking services to maintain the necessary motivation to fully engage in treatment, and undermining the chances that the person will be able to maintain sobriety.

Since the basis of treatment planning and delivery for any disorder is a comprehensive assessment, the lack of thorough assessment and diagnosis severely hampers the effectiveness of treatment. Few community services boards use scientifically valid instruments to assess the clinical needs of people seeking treatment for either mental illness or substance use disorders. Although scientifically validated instruments have existed for some time, many community services boards have developed idiosyncratic approaches to

²⁵ Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

clinical assessment. The lack of a uniform scientific approach to an assessment undermines the treatment planning process so that it is difficult to determine if consumers are receiving the appropriate intensity or duration of treatment that will be effective in addressing their addiction. It also impedes communication between collaborating agencies such as those in the criminal justice system. Many of these instruments are in the public domain (e.g., available at no cost), however training is required to learn how to administer the instruments and use the information they provide to develop effective treatment plans.

Resources needed to address this issue include one FTE (\$100,000 for salary and benefits) plus funds to support regional training events (\$150,000) for a total of \$250,000 in ongoing funds. Use of standardized, validated instruments would help to provide a uniform approach to assessment and treatment planning and would assist communication among treatment providers and between providers and referring agencies. It would help assure that people receive the appropriate intensity and duration of treatment. Ongoing training would assure that, as the work force in CSBs turns over, new staff will be trained in using appropriate assessment instruments.

Funding schedule:

1 FTE:	\$100,000
Training:	\$150,000
Total:	\$250,000

Proposal 6: Implement a Structured Systems Improvement Practice Model Such as the Network to Improve Addiction Treatment (NIATx). A national systems-engineering approach to this issue, originally sponsored by the Robert Wood Johnson Foundation and developed by the University of Wisconsin, resulted in NIATx. This low-cost disciplined approach to continuous quality improvement develops an organizational culture that supports team-based problem-solving for service system problems such as long waiting times for treatment. It provides the organization with a concrete framework for identifying needed changes, such as *eliminating wait times by providing same day intakes*. Organizations learn to measure the impact of small, simple changes to how treatment is made available. Each organization develops a change team that must involve the leadership of the organization as well as practitioners and other key players. They “walk-through” their organization with a volunteer consumer to identify barriers to effective treatment. This exercise enables them to “see” their services system through the eyes of the consumer and identify barriers to services that they would not otherwise have noticed. It helps them to identify a process for removing those barriers in small, simple steps, measuring before and after implementation to test the success of their solution.

Participation in NIATx is free, but does require dedicated focus. The amount of \$135,000 would support 1 FTE at DBHDS who would coordinate NIATx efforts across the state, coach CSB leadership and staff in implementing the process, and facilitate learning cooperatives so that CSBs could benefit from each others’ experience. Funds also would support travel around the state to conduct meetings and purchase technology needed to facilitate electronic communication among participating CSBs.

Funding schedule:

1 FTE:	\$100,000
Travel and meeting support:	\$10,000
Technology equipment and support:	\$25,000
Total:	\$135,000

B. Proposals to Fill Gaps in the Services Array

The JLARC study noted that “the demand for services consistently exceeds the supply that can be provided with existing resources, and more intensive forms of treatment are often not available at all.”²⁶ The same study found that CSBs tend to offer more lower-intensity services and refer people needing more intense services to private providers, which is often too expensive.²⁷ The 2006 OIG study of outpatient substance abuse treatment for adults in CSBs found that the range, variety and capacity of substance abuse services are not adequate to meet the needs of consumers in the majority of Virginia communities.²⁸ Less than 50% of CSBs have access to any residential treatment, only a quarter of CSBs have long-term residential treatment, and almost all have inadequate capacity to meet needs.²⁹ The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that “Funding should be made available to support a full range of substance abuse treatment and prevention services in the Commonwealth, including services offered and coordinated by the Department of Behavioral Health and Developmental Services, community services boards, public and private agencies and organizations, and anonymous recovery community organizations.”³⁰ This shortage in capacity becomes even more critical when addressing the needs of special populations, such as women who are pregnant or who have dependent children, adolescents, and those with severe physical dependence on alcohol or certain sedatives.

The lack of access to an array of services results in people not receiving the appropriate intensity or duration of treatment they need to successfully attain recovery. While nearly all CSBs offer outpatient services, the intensity of this service—meeting with a counselor once a week—is not enough to have impact on the person’s behavior, thinking, or other aspects of the person’s substance use disorder. People with substance use disorders are experiencing serious psychological and emotional issues and need consistent and frequent support to change their behavior and their ways of thinking about how to approach their substance use issues and other related problems. Meeting for an hour or two a week simply is not a significant “dose” of treatment for many people with significant substance use disorders.

²⁶ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008)Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, p. v. Also see Chapter 4.

²⁷ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008)Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, pp.73-74.

²⁸ Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report: #129-06, p. 17.

²⁹ Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report #129-06, p. 17.

³⁰ Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

Proposal 1: Expand Access to Identification and Intervention for Offenders with Substance Use Disorders in Community Correctional Settings. The JLARC report found that Virginia expended \$613 million dollars in 2006 due to untreated substance abuse, with much of the expense occurring in the criminal justice system. DOC and DJJ provide significant substance abuse treatment services to people who are either in or emerging from institutional care. In addition, many adults supervised by local probation and pre-trial agencies funded by DCJS also have substance abuse problems. As the JLARC report indicates, it is costly to incarcerate these individuals. Further, incarceration has a lifetime impact on people as they seek to re-establish themselves in the community.

This initiative is targeted at providing services to offenders whose criminal offenses are related to substance use. The Report on the Status and Effectiveness of Offender Drug Screening, Assessment and Treatment to the General Assembly of Virginia (2010) reports that similar efforts in the past were very effective when they were funded. The 2008 OIG report acknowledges that state Probation and Parole offices across the state report long wait times for services from CSBs and that the array of services needed by these individuals was often not available. Funds for this project would be allocated to DOC, DJJ and DCJS to purchase services from any qualified provider of the services needed by the individual. Provision of these services would be supervised by local offices of these agencies or, in the case of DCJS, local community corrections. These funds would insure that these individuals received needed services.

Potentially eligible offenders would be screened by staff at DOC, DJJ and local community corrections agencies, just as they are now under the current arrangement described in the Report on the Status and Effectiveness of Offender Drug Screening, Assessment and Treatment to the General Assembly of Virginia (2010). Funds would be used to purchase clinically appropriate services, including additional psychological assessments, case management, and treatment services of the proposer clinical intensity and duration, based on the clinical assessment. Community treatment providers would be contractually required to meet rigorous professional standards, including the use of evidence-based practices and achievement of outcomes, including employment or educational gains.

Funding schedule:

DOC:	\$10,000,000
DJJ:	\$3,500,000
DCJS:	\$2,500,000
Total request:	\$16,000,000

Proposal 2: Expand Intensive Outpatient Services (IOP). Persons seeking substance abuse treatment need to receive evidence-based services at a level that is intense enough to support substantial change in thought processes and behavior. Many people seeking treatment have significant involvement with the criminal justice system, and may be re-entering the community after a period of incarceration or detention. They require an initial period of strong clinical support that could be provided by IOP services. Providing treatment services in an IOP modality will be a more efficient use of resources because individuals will be receiving services that are more likely to be at an effective intensity.

IOP services include intensive individual and group experiences (more than an hour, or more than twice per week) facilitated by professionals, utilizing positive peer supports as well as evidence-based counseling practices that are appropriate for the individual. By providing services at a more intensive level, individuals are able to engage in the recovery process more quickly and be more productive in the treatment process. Currently CSBs do not have the capacity (work force) to provide IOP services. Only about one-third of CSBs report that they provide services at the level of intensity offered by IOP services. Services provided by the remaining CSBs are at a frequency of once per week or less, which does not provide the intensity required to support or sustain recovery.

Graduated ongoing funding over a three year period would support the addition of 30 dedicated positions per year, until all 40 CSBs have IOP services (90 FTEs). Treatment would be age appropriate and gender specific. Individual and family counseling would also be available and services would be offered at staggered hours so as not to interfere with employment or school. Services would be provided by qualified professionals. The following funding amounts would support the addition of IOP services at 10 additional CSBs per year, until all 40 CSBs are using this modality.

Funding schedule (1 FTE = \$100,000 for salary and benefits):
Year 1: \$3,000,000

Proposal 3: Expand Capacity for Community-based Residential Medical Detoxification.

Detoxification is often the necessary first step for a person who is physically dependent on alcohol or other drugs. Detoxification from alcohol and certain other drugs can be life threatening, and can be complicated by psychiatric and other health issues, such as heart conditions, seizure disorders or diabetes. For detoxification to be safely conducted, the person should be in a safe, clean, medically supervised residential setting that has access to an on-call physician 24 hours a day, and where care is supervised by a registered nurse and provided by qualified health professionals. The physician can order medications to assist in safe withdrawal, and the health professionals provide constant monitoring of the patients progress. Detoxification usually lasts 3-7 days, and the patient is ideally discharged to another level of care so that actual substance abuse treatment can continue. Currently, half the CSBs lack local social detoxification services, and a quarter lack local medical detoxification services.³¹ There are only about 100 beds for this purpose in the state. The DBHDS Creating Opportunities survey of CSBs indicated that CSBs ranked the need for additional detoxification capacity as the second highest needed service in the next five years. Funds in the amount of \$8.5 million in first year would support expansion of detoxification capacity by 100 beds in the state (\$160,000 per bed X 100 beds). The bed capacity for this service would be integrated into existing services, such as Crisis Stabilization Units, whenever possible, and would be geographically distributed to improve access around the state.

Included in this amount is \$500,000 to be appropriated to The Healing Place at the existing Richmond site (\$250,000) and for a new site in Lynchburg (\$250,000), to be used to support

³¹ Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report: #129-06, p 17.

community-based detoxification services. This initiative was suggested by representatives of the Governor's Housing Outcomes Advisory Group.

Funding schedule:

Year 1: \$8,500,000

Proposal 4: Expand Access to Medication Assisted Treatment (buprenorphine). The 2006 OIG report indicates that half of CSBs lack any access to opiate maintenance treatment, yet opiates are frequently seen in 65 % of communities and they lead the list of all drugs considered by CSB staff to be increasing in use.³² The survey conducted for this report indicated no significant change in this capacity. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that “Funding should be made available to allow community services boards to provide medication assisted treatment and required wrap-around and support services to all persons for whom such treatment is appropriate.”³³

Data from the VDH Chief Medical Examiner indicated significant increases in abuse of narcotic prescription pain medication. Although this problem began in rural far Southwest Virginia, data indicate that the problem is spreading across the state. (See Figure 2.) In addition, anecdotal reports from treatment providers indicate increasing numbers of young people abusing heroin. Until recently, people addicted to opiates had two treatment choices. They could either withdraw without the use of any medication, which results in extreme flu-like symptoms and does not address the anxiety and physiological craving, or they could be treated with methadone, a medication that can only be administered in clinics regulated by the federal and state governments. Although methadone treatment is very effective in terms of preventing people from relapsing to illegal drug use and helping them to stabilize, engage in employment, and become productive citizens, treatment with methadone requires that the patient report to the clinic on a daily basis which requires daily transportation and can interfere with employment and other productive pursuits. Currently there are 19 methadone clinic sites in Virginia (only four are operated by CSBs). The private clinic in Lebanon (Tazewell County) is the largest in the state, dosing over 1,000 patients daily, and many people in need of services are more than one hour away.

This project will expand the capacity of CSBs to provide evidence-based treatment for people addicted to opiates, including pain medication, and reduce the number of deaths from drugs. Buprenorphine is a medication that can be initiated under the supervision of a specially-trained physician in the physician's office or other outpatient setting.

Buprenorphine cancels the craving of the addicted person for opiates and prevents the person from feeling the euphoria of the narcotic. Once the physician determines the correct dosage for the patient, the person receives a prescription and manages his or own medication under

³² Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report #129-06, p. 17.

³³ Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

supervision while continuing to participate in counseling. When combined with counseling and other supports, it has proven to be an extremely effective component of treatment. Many people are able to taper off the medication over time and live independently of any additional medication, while others find it helpful to continue the medication.

Ongoing funding in the amount of \$4.1 million would support expanded use of buprenorphine at the 21 CSBs currently using this medication, and would also provide funding for services at 19 additional CSBs that have not yet utilized buprenorphine. In addition to assisting with funding the purchase of the drug, the funds would be used to pay for physician time necessary to examine patients and manage the care of patients using this medication. This funding would also support six two-day physician training events throughout the state about addiction and the use of buprenorphine and other medications.

Funding Schedule:

Year 1: \$4,100,000 (ongoing)

Proposal 5: Develop Residential Treatment Capacity for Pregnant Women and Women with Dependent Children in Southwest Virginia. Currently there are only three publicly-funded residential treatment programs designed to meet the needs of women with dependent children in Virginia. These are located in Hampton, Richmond and Roanoke. Experience and research clearly indicate that women are more successful in treatment that is gender-specific segregated, and that allows them to bring dependent children with them into treatment. Such programs provide services and supports that help the woman recover and bond with her children, thereby strengthening the family unit and reducing the need for foster care.

The abuse of prescription narcotic pain medication in Southwest Virginia has reached epidemic proportions with devastating effects on the health and social fabric of many communities that are already suffering from very high rates of unemployment, poor rates of school completion and poor access to routine medical care. The rate of death for the state related to drugs is 8.7 per 100,000, but some communities in this region have had recent death rates as high as 50 per 100,000.³⁴ Because this area is so remote, women needing this level of treatment are resistant to seeking services in another part of the state. This project would prevent deaths of women, keep families united and reduce the need for costly foster care for children removed from the custody of their families due to abuse or neglect. DSS reports that the rate of foster care entries for the Western region is significantly higher (1.6 per 1,000 children) than any other part of the state (0.9 per thousand was the next highest rate), and that 32% of these entries had parental drug abuse, a rate nearly twice as high as the next highest region.³⁵

Ongoing funding in the amount of \$2 million would support development and operation of this therapeutic program to house up to 16 individuals (mothers and children up to age 12) and would provide intensive therapy for women who are dependent on drugs. It would include access to medical services for the women and their children, psychiatric and

³⁴ Virginia Department of Health Office of the Chief Medical Examiner's Annual Report, 2006, p. 98.

³⁵ VDSS Research Brief: Parent Substance Abuse and Foster Care Entry by Region in Virginia. October 15, 2010.

psychological services, daily counseling, classes in parenting skills, coaching in independent living, and intensive case management for the children to address the problems caused by the mother's addiction. Services would be delivered by CSB staff. The average length of stay is estimated to be between six months to one year. Women would be transitioned into the community with extensive case management and a plan of ongoing treatment and other supports.

Funding schedule

Year 1: \$2,000,000 (first year would involve start up and capital outlay, ongoing operations at \$2,000,000 per year)

Proposal 6: Re-establish Transitional Therapeutic Communities for DOC. DOC currently operates three therapeutic communities (TCs) for offenders with severe substance use disorders, one for men at Indian Creek, and one for women at the Women's Correctional Center, and at Lawrenceville, a privately operated facility. Together, these institutions have a capacity of 1,432 beds. These programs are quite intensive, involving the incarcerated offender in treatment programming virtually every waking hour. Prior to 2009, approximately 300 of these offenders each year re-entered society by entering a transitional therapeutic community (TTC), a service which was purchased from existing community providers. Funds for this service were eliminated, however, in 2008. DOC outcome data indicate that men who completed both the institutional program and the TTC had a recommitment rate of only 13.6%, whereas offenders who completed only the institutional TC had a recommitment rate of 20%.³⁶ The results were similar for women, with those who completed both the TC and the TTC having a recommitment rate of 8.8% compared to 19.3% among those who completed only the TC.³⁷

The TTCs would provide room and board and intensive treatment for approximately 300 offenders with substance use disorders per year in a closely supervised residential treatment setting licensed by DBHDS. The TC program would include individual, group and family therapy using evidence-based treatment models and services approved by DOC. Residents would also be responsible for many tasks involving the operation of the residence, such as cooking, cleaning and basic clerical work, thereby learning basic life skills under the supervision of staff. The TTC program would also include assistance with moving back into the community independently, such as finding employment and housing. TTCs would be staffed by persons who are licensed or certified by the DHP in behavioral health and substance abuse specialties. By providing this additional post-release support, these individuals would be much less likely to re-offend. Residents would stay for approximately 6 months.

Funding schedule: \$3,000,000 (assumes that each offender will reside in a TTC approximately 6 months)

³⁶ Department of Corrections (DOC) (2005) Evaluation Update: Therapeutic Community Program (2001 Males).

³⁷ Department of Corrections (DOC) (2005) Evaluation Update: Therapeutic Community (2002 Females).

C. Proposals to Provide Additional Services and Supports Needed to Sustain a Recovery Oriented System

In addition to treatment services, systemic problems must also be addressed to make the treatment system whole. These issues include non-treatment supports necessary for successful recovery, a coordinated system-wide approach to work force development, and examination of Virginia's system of drug treatment courts.

Proposal 1: Expand Department of Rehabilitative Services Substance Abuse Vocational Counselors Project. Stable employment is a key component of successful recovery from substance use disorders. Often people in substance abuse treatment have lost their jobs due to their disorder, and may have never developed essential job-seeking and job-keeping skills. In 1988, DBHDS entered into a memorandum of agreement (MOA) with DRS to provide specialty vocational rehabilitation (VR) counseling services to persons receiving substance abuse treatment at CSBs. Currently there are 21 VR counselors working with 18 CSBs. DRS's annual evaluation of this project indicates the following:

- Case service costs for clients with substance use disorders receiving specialized VR services from dedicated VR counselors is 39% lower than the case service costs for clients with substance use disorders served by generalist VR counselors (\$1,042 versus \$1,700, on average, over the "life" of the case).
- The typical "life" of a VR case for clients with substance use disorders served by the dedicated counselors is somewhat shorter which reduces the per-client cost of in-house services.
- VR clients with substance use disorders served by the dedicated counselors are more likely to achieve successful employment outcomes (56% with SA specialty counselors) as opposed to these individuals being served by general caseload counselors (45%).
- VR clients with substance use disorders served by dedicated VR counselors have significantly higher hourly earnings when their VR cases are closed (\$9.98 versus \$9.19, on average) than other clients with substance use disorders served by general caseload counselors.

This initiative would provide funds to DBHDS to expand the MOA with DRS to support 22 FTEs at a total cost of \$2,200,000 for the sole purpose of providing VR counseling services to people receiving substance abuse treatment through CSBs. The specialty counselors would provide vocational assessments, counseling, job coaching and other vocational rehabilitation supports. Some of the counselors will be physically located at CSB treatment sites at which treatment is provided, and some will be housed at local DRS offices. Of the CSBs currently without dedicated VR counselors, four (Prince William, Manassas, Loudon, and Hanover) are in identified High Intensity Drug Trafficking areas; two are in high population-density localities (Virginia Beach and Williamsburg); and the remainder are in primarily rural parts of Virginia (Farmville, Harrisonburg, Abingdon, Lexington, Martinsville, Saluda, Culpeper, Dickinson County, Goochland, Suffolk, and South Boston).

Funding schedule:

22 FTEs @ \$100,000 = \$2,200,000

\$30,000 for training event to provide DRS counselors with information about substance use disorders, clinical treatment approaches and likely vocational issues.

Year 1 and ongoing: \$2,230,000

Need assignment of an additional 22 FTEs to DRS.

Proposal 2: Expand Access to Housing Options Available to Adult Offenders in the Community. The first 30 to 60 days of an offender's return to the community are critical to successful re-entry. Unfortunately this period of time also represents a time frame in which return to substance use and criminal behavior are likely unless basic needs are met. Returning offenders often lack the financial resources to pay for their own housing, such as security deposits for apartments and utilities, and initial rent. Lack of safe, sober housing can present a major barrier to recovery, employment and establishing relationships with others who support a sober, law-abiding life. Family relationships may be too strained to move home, and former friends are likely to have criminal ties or to be using illegal drugs or abusing alcohol. Yet, without housing and social supports, the returning offender may recidivate, a costly proposition financially and in terms of human life.

One option that could be explored would be to utilize a model such as the Oxford House model already in use in Virginia. Oxford Houses are self-run households of 4-6 same gender adults who provide mutual support for living without alcohol or other drugs. They live in rented houses under self-developed rules and additional structure, along with the Oxford House requirement that all must stay sober. Through a contract with DBHDS, the houses receive technical assistance from Oxford House, Incorporated (OHI), and OHI has an agreement with each landlord, as well. In order to participate in the Oxford House, the individual must make a minimum deposit and contribute financially to the operation of the Oxford House. Most recently returning offenders are unable to make this monetary contribution.

DOC is already engaged in a pilot with OHI of paying the initial entry costs of approximately \$560 per individual. This provides the returning offender with six weeks' grace to locate employment and then assume responsibility for the cost of remaining at the Oxford House. The current pilot is focused on the 22 Oxford Houses in Fredericksburg, Lynchburg and Hampton. An additional \$160,000 would permit DOC to provide assistance to an additional 279 returning offenders in other areas of the state.

Funding Schedule:

Year 1: \$160,000 (ongoing)

Proposal 3: Establish Capacity for Supported Living Services. Lack of a safe place to live that supports sobriety is a frequent barrier to successful recovery. People seeking recovery have often alienated family and friends and lack income to rent safe secure housing. This might include persons leaving correctional institutions, people being discharged from

detoxification or residential treatment, or people who are simply without a safe, supportive environment while they actively seek recovery through some level of outpatient service. Supported living services can provide an option to placing a person in an expensive residential treatment program whose clinical needs do not really warrant that level of treatment services. In the DBHDS Creating Opportunities survey, CSBs indicated that the lack of safe, sober housing is a significant barrier to recovery, but one-third indicate that they have no access to this type of resource.

This proposal for ongoing funding would provide support to CSBs to operate supported housing services that provide a limited amount of structure and support for people who are actively engaged in treatment. The projects would be geographically distributed throughout the state. Many of the activities and supports, such as transportation, recreation, basic case management, and support groups, could be provided by peer-counselors supervised by a professional at the CSB or through a peer-run support service. As they are able, residents would be employed, would purchase and prepare their own food, and would pay a monthly fee to supplement the costs of living in the facility.

Funding schedule:

Year 1: \$500,000 to lease/acquire, renovate and furnish facilities
(5 facilities @ \$100,000)

Proposal 4: Create a Multi-Agency Work Force Development Capacity Focusing on the Treatment of Substance Use Disorders. In the last 20 years, a substantial body of knowledge has evolved concerning effective treatment for substance use disorders. It has also become clear that certain practices and programs are more effective for some populations or specific clinical issues than others. For instance, there are particular models that are effective for addressing clinical issues that are common among women. The developmental needs of adolescents call for specific evidence-based practices and programs, and with the help of a grant procured by DBHDS, DJJ has been able to convert its institutional service system into one that is evidence-based. Research indicates that people with criminal histories benefit from specific approaches, and DOC is implementing these practices system-wide. However, when the individuals served by DJJ or DOC re-enter the community, they need to be able to continue to receive treatment using the same practices that worked for them in the institution. In its 2008 report, JLARC noted that although three-quarters of the CSBs had incorporated some EBPs in their array of services, their inclusion needed to be more widespread. In addition, fewer than half of CSBs have the appropriate supervisory framework to assure that they are properly implemented, which can undermine effectiveness.³⁸ Generally, this knowledge is not conveyed in college or graduate level courses where health or behavioral health professionals are trained. In addition, improved collaboration concerning work force development could promote system-efficiencies in developing training events and ongoing coaching and supervision opportunities.

Ongoing funds in the amount of \$200,000 would support 1 FTE at DBHDS to identify and promote evidence-based practices concerning the treatment of substance use disorders and

³⁸ Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, pp.81-85.

co-occurring mental illness that are appropriate to the populations served in the community, and to collaborate with DJJ and DOC, as well as other agencies when appropriate, in the dissemination of knowledge, skills and abilities throughout the work force, and to purchase, promote and coordinate training events throughout the state. This activity needs to be ongoing because of staff turnover, because evidence-based practices are constantly evolving, because existing staff need to periodically refresh their skills and knowledge, and because implementing evidence-based practices often involves making changes to the organizational culture that must occur overtime.³⁹

Funding schedule:

DBHDS: 1 FTE @ \$100,000 for salary and fringe	
	\$100,000 to support training events (hire consultants, develop curricula, manage training sites, occasional support for travel and per diem for participants)
Total:	\$200,000

Proposal 5: Develop an Ongoing Evaluation Process for Established Drug Treatment Courts. Many adults, youths and families end up in court facing felony convictions for nonviolent crimes related to drug or alcohol abuse or dependence which are costly to the person, his family and the Commonwealth. Drug treatment courts, which provide intensive supervision, treatment and case management under the supervision of a judge, have proven to be an effective alternative to conviction and incarceration. Currently there are 27 drug treatment courts in Virginia. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that “Drug courts should be established in all localities throughout the Commonwealth, and should be funded by the General Assembly.”⁴⁰

The process for establishing a drug treatment court in Virginia is rigorous, and requires that a court present a consensus of significant community stakeholders and make application to the Supreme Court of Virginia. The application is reviewed by the State Drug Treatment Court Advisory Committee, whose membership consists of judges, sheriffs, representatives of state agencies and advocacy organizations. Once an application is reviewed and approved, it is forwarded to the General Assembly where it is reviewed by the appropriate legislative committees. However, failure to gain an affirmative vote prevents the establishment of the drug treatment court in the locality requesting it, and denies its residents of the benefits of such a court, even if no funds are being requested to support the operation of the court. In the 2011 Session of the General Assembly, six applications were presented for approval; however, the General Assembly did not approve any of the applications. It appears that many legislators are not convinced drug treatment courts are cost-effective.

³⁹ See Fixsen, Dean L., et.al. Implementation Research: A Synthesis of the Literature (2005). University of South Florida.

⁴⁰ Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

Appendix A

Virginia Localities by National Survey of Drug Use and Health (NSDUH) Region

Region 1

Albemarle, Augusta, Bath, Buckingham, Buena Vista City, Caroline, Charlottesville City, Clarke, Culpeper, Fauquier, Fluvanna, Frederick, Fredericksburg City, Greene, Harrisonburg City, Highland, King George, Lexington City, Louisa, Madison, Nelson, Orange, Page, Rappahannock, Rockbridge, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton City, Warren, Waynesboro City, Winchester City

Region 2

Alexandria City, Arlington, Fairfax, Fairfax City, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William

Region 3

Alleghany, Amherst, Appomattox, Bedford, Bedford City, Bland, Botetourt, Bristol City, Buchanan, Campbell, Carroll, Clifton Forge City, Covington City, Craig, Danville City, Dickenson, Floyd, Franklin, Galax City, Giles, Grayson, Henry, Lee, Lynchburg City, Martinsville City, Montgomery, Norton City, Patrick, Pittsylvania, Pulaski, Radford City, Roanoke, Roanoke City, Russell, Salem City, Scott, Smyth, Tazewell, Washington, Wise, Wythe

Region 4

Amelia, Brunswick, Charles City, Charlotte, Chesterfield, Colonial Heights City, Cumberland, Dinwiddie, Emporia City, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell City, Lunenburg, Mecklenburg, New Kent, Nottoway, Petersburg City, Powhatan, Prince Edward, Prince George, Richmond City, Surry, Sussex

Region 5

Accomack, Chesapeake City, Essex, Franklin City, Gloucester, Hampton City, Isle of Wight, James City, King and Queen, King William, Lancaster, Mathews, Middlesex, Newport News City, Norfolk City, Northampton, Northumberland, Poquoson City, Portsmouth City, Richmond, Southampton, Suffolk City, Virginia Beach City, Westmoreland, Williamsburg City, York

Appendix B

List of Virginia Cities and Counties by Region Office of the Chief Medical Examiner – Virginia Department of Health

CENTRAL *Counties of* Albemarle, Amelia, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Essex, Fluvanna, Gloucester, Goochland, Greene, Greensville, Halifax, Hanover, Henrico, James City, King and Queen, King George, King William, Lancaster, Louisa, Lunenburg, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northumberland, Nottoway, Powhatan, Prince Edward, Prince George, Spotsylvania, Stafford, Surry, Sussex, Richmond, and Westmoreland. *Cities of* Charlottesville, Colonial Heights, Emporia, Fredericksburg, Hopewell, Petersburg, Richmond, and Williamsburg.

NORTHERN *Counties of* Arlington, Clarke, Culpeper, Fairfax, Fauquier, Frederick, Loudoun, Madison, Orange, Page, Prince William, Rappahannock, Shenandoah, and Warren. *Cities of* Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and Winchester.

TIDEWATER *Counties of* Accomack, Isle of Wight, Northampton, Southampton, and York. *Cities of* Chesapeake, Franklin, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, and Virginia Beach.

WESTERN *Counties of* Alleghany, Amherst, Appomattox, Augusta, Bath, Bedford, Bland, Botetourt, Buchanan, Campbell, Carroll, Craig, Dickenson, Floyd, Franklin, Giles, Grayson, Henry, Highland, Lee, Montgomery, Patrick, Pittsylvania, Pulaski, Roanoke, Rockbridge, Rockingham, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe. *Cities of* Bedford, Bristol, Buena Vista, Covington, Danville, Galax, Harrisonburg, Lexington, Lynchburg, Martinsville, Norton, Radford, Roanoke, Salem, Staunton, and Waynesboro.

Appendix C

Participating Agency Information Submissions

The following are more detailed descriptions of the substance abuse or related services provided by the state agencies who partnered in the development of this report. This information is summarized in the report (Section III), but provided in full detail here for a more complete understanding of the roles, activities, and recommendations of the state agencies.

Department of Corrections

System Description

As of June 20, 2011, there were 31,439 offenders incarcerated in DOC correctional centers. In addition there were also 6,789 state responsible offenders incarcerated in local/regional jails equating to 38,228 total incarcerated offenders. Approximately 13,000 state responsible offenders, on average, complete their sentence each year and return to the community. Of offenders released in 2009, almost 80% had some degree of supervised probation, parole, or post release supervision. Moreover, in May 2011 DOC probation and parole districts totaled 58,306 offenders. Of that number, 53,700 were being actively supervised. In May 2011 the number of offenders in the VADOC totaled 89,749.

Approximately 85% of all offenders have need of some type of treatment service or intervention, and upwards of 75% of offenders have substance use specific treatment needs which equates to approximately 40,275 offenders out of 53,700 under active supervision. The DOC is cognizant of the enormity of substance abuse occurring within the offender population, and is rigorously addressing substance abuse by the integration of evidence-based practices (EBP) into treatment interventions. Treatment services are implemented so that they align with EBP principles and standards, which research has proven to reduce recidivism.

The Department of Corrections provides a multi-level substance abuse services approach to address varying offender treatment needs based on the severity of the problem. The EBP term of responsivity, or matching the offender to the appropriate treatment services based upon criminogenic factors and risk to recidivate is utilized in the delivery of treatment.

DOC Substance Abuse Treatment Services

- DOC Virginia Adult Re-entry Initiative, a four year strategic plan, presented to Governor Robert F. McDonnell on July 10, 2010 emphasized a comprehensive and detailed re-entry initiative that seeks to reduce recidivism by preparing offenders for successful re-entry and transition into the community. Addressing substance abuse within our offender population is an integral component of effective re-entry. DOC utilizes a variety of substance abuse interventions.
- Cognitive Therapeutic Community (CTC) – There is currently one CTC for males and one CTC for females, totaling 1,400 beds. The women’s program is currently being reorganized from one to two prisons to better address the population’s needs. The CTC

program is an evidence-based treatment model designed to address substance addiction, criminal thinking and anti-social behaviors.

- DOC has reviewed the Matrix Model (a registered evidence-based program) and is recommending the model as a primary outpatient substance abuse treatment intervention. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. The initial phase of treatment would take place in the correctional center followed by the relapse prevention and family component taking place in the community through probation & parole districts.
- DOC has a multitude of substance abuse programs in both the correctional centers and districts facilitated by trained and/or certified DOC staff. They include Substance Abuse (SA) Orientation, SA Education, Relapse Prevention, Motivational Enhancement, and in several districts the Matrix Model. The prison system is reviewing programs to ensure they are evidence based and if not (such as the current psycho-educational program, they will be eliminated). DOC's goal is that current and future DOC substance abuse programs will be reviewed for fidelity and adherence to EBP.
- To further augment substance abuse services, the DOC offers a Behavioral Correction Program (BCP) as a sentencing option. This program was enacted by the General Assembly in 2009. The program is designed for offenders with substance abuse needs. Under this sentencing option, judges have the ability to place offenders directly into the DOC substance abuse Therapeutic Communities at Indian Creek Correctional Center and Virginia Correctional Center for Women.
- DOC has begun statewide implementation of "Thinking for a Change", a cognitive-behavioral curriculum in correctional centers and several probation & parole districts. Although not designed exclusively as a substance abuse treatment intervention, this curriculum will assist offenders with substance abuse issues to more realistically view the consequences of their drug/alcohol use, examine thinking that underlies their substance use, and consequently be more amenable to treatment interventions.
- In response to the accomplishments of the CTC and reduced recidivism rates noted in its participants, the DOC has implemented a Cognitive Community program in two additional correctional centers. Currently there is one Cognitive Community Program for males and one cognitive community for females.
- Twelve-Step programs such as Alcohol Anonymous and Narcotics Anonymous; 12-step study guide, and peer support groups, such as those found at the SAARA Center in Richmond, VA, are readily utilized by DOC. These programs alone are not evidence based for offenders with higher substance abuse treatment needs, but are a useful support for lower need offenders or for offenders reached a pro-social level of adjustment in cognitive-behavioral treatment.
- High Intensity Drug Trafficking Area (HIDTA) initiative is a DOC program funded by a federal grant that provides intensive substance abuse treatment and case management to participants that have significant substance use histories. Changing Offender Behavior is the core cognitive-behavioral intervention used by participants of the High Intensity Drug Trafficking Area (HIDTA) initiative to address cognitive distortions and distorted thinking. The intervention is similar to that of "Thinking for a Change".
- DOC has begun a pilot collaboration with the Oxford House to provide temporary transitional housing for those individuals not having a stable or supportive home

environment to return to. The DOC will pay for 4-6 weeks of rent at a designated Oxford House to assist in re-entry and recovery process of offenders. The pilot covers the Lynchburg, Fredericksburg and Hampton localities.

- DOC contracts for many of its community substance abuse treatment services with Community Service Boards (CSBs) and private vendors. Most Probation and Parole Districts (43), Detention Centers (3) and Diversion Centers (4) have a memorandum of agreement with their respective CSBs for substance abuse treatment services or a contract with a private treatment vendor. There are four (4) private contractual vendors providing inpatient substance abuse services, and 21 private non-residential service providers, as well as 41 Memoranda of Agreement with CSBs for outpatient substance abuse treatment services.

DOC Screening and Assessment

- DOC has deployed the COMPAS Risk and Needs Assessment Instrument, a web-based software system for offender screening, global assessment, classification, and case management. COMPAS is a state-of-the-art assessment system designed to identify the risk and needs of offenders. Through the identification of certain criminogenic factors, one being substance abuse, DOC staff are able to develop a more accurate case supervision that better meets the treatment needs of the offender. Thus far the DOC has completed 40,360 COMPAS core assessments and 13,247 COMPAS re-entry assessments
- In terms of the criminogenic factor of substance use, COMPAS core results of assessments completed thus far indicate 18,451 offenders are at a high probability to abuse substances and 9,231 are deemed as probable for substance abuse. This means over 70% of the offenders administered the COMPAS have a substance abuse problem.
- The DOC makes treatment program determinations based on COMPAS screening scores.
- In addition, the COMPAS suite contains a more comprehensive assessment instrument, the Texas Christian University (TCU) Drug Screen. The DOC has just begun to utilize the TCU screen. This particular screen will further enhance the ability of DOC staff to make appropriate SA treatment referrals based upon need.

Estimated Cost per Offender for prison Cognitive Therapeutic Community Treatment

- \$2,500 per offender per year overlay to prison operational costs

Estimated Cost per Offender for community corrections Outpatient Substance Abuse Treatment

- \$494.00 per person for Motivational Enhancement Group
- \$640.00 per person for Outpatient Group
- \$532.00 per person for Relapse Prevention Group
- \$3,240.00 per person for Intensive Outpatient Group

The above-captioned amounts do not reflect indirect costs or drug/alcohol testing. In using the active supervision number of 53,700 offenders and the COMPAS percentage of 70% of

offenders needing substance abuse intervention; the total number of offenders in need of substance abuse programming is 37, 590 in a given year. Using an outpatient cost of \$640.00 (group meeting once per week for 16 weeks at 40.00 per session); we have a total cost of \$24,057,600. Although this is an estimated amount, it clearly demonstrates the large amount of money required to provide SA treatment services to the offender population.

Recommendations to Improve Substance Abuse Services

- Improve the collaboration between the DOC and community agencies such as the CSBs and private treatment providers in order to deliver effective, timely, and cost efficient substance abuse programming.
- Augment the continuum of care for offenders by providing a seamless transition of substance abuse interventions and services.
- Increase the utilization of EBP substance abuse programs statewide, like the Matrix Model, in the CSB's.
- Increase the number of recovery/transition houses statewide similar to scope and purpose of the Oxford House.
- Treatment providers integrate a valid screening and assessment instrument when determining the substance abuse treatment needs of the offender. The Adult Substance Abuse Subtle Screening Inventory – 3 (SASSI-3) is an example. The COMPAS and TCU Drug Screen results from the district can further be utilized in conjunction with the treatment provider substance abuse assessment.
- Simplify the process of making referrals and decrease waiting time to access services.
- Increase the number of inpatient and detox facilities statewide.
- Increase the number substance abuse treatment providers that can address co-occurring disorders.
- Develop and establish additional peer support programs that provide recovery coaching and mentoring to offenders.
- Integrate a system of graduated incentives and sanctions to recognize positive progress and address negative behaviors.

Department of Juvenile Justice

System Description

- All youth all youth placed on probation or committed to DJJ are screened for substance use disorders with the Youth Assessment and Screening Instrument (YASI), DJJ's risk-needs assessment tool. In 2010, approximately 5,800 juveniles were screened.
- Youth committed to DJJ are additionally screened utilizing the Substance Abuse Subtle Screening Inventory (SASSI). In 2010, approximately 600 youth in FY 2010 participated in this screening.
- DJJ has funds (limited) appropriated to purchase community-based substance abuse treatment (approximately \$200,000 per year).
- DJJ provides evidence-based treatment programs in all juvenile correctional centers, employing the Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) models in both 5- and 12-session programs. These programs serve approximately 85% of the youth admitted in FY2010.

- DJJ provides evidence-based, gender specific substance abuse treatment for committed females, with an emphasis on co-occurring mental health disorders.
- The development of transition plans for committed youth with substance use disorders and need for continuing care is addressed through the Mental Health Transition Plan process.
- DJJ utilizes transitional services funds to purchase community-based substance abuse treatment for youth released from a juvenile correctional center.
- DJJ provides on-site, urine and saliva drug testing kits to court service units to monitor substance use for youth on probation and parole.

Department of Criminal Justice Services

As the Commonwealth's criminal justice planning agency, DCJS does not provide direct services; however, state and federal funds are utilized to support substance abuse efforts at both the state and local level. These efforts cross a multitude of criminal justice agencies such as juvenile services, adult corrections, local jails, law enforcement, pre-trial, community corrections, local probation and victim services. Programs funded by DCJS utilize evidence based practices in their implementation. The list below gives some examples of how DCJS supports substance abuse efforts.

- DCJS provides grant funding to create or enhance residential substance abuse treatment programs in jails, detention centers and adult corrections.
- DCJS supports substance abuse prevention and intervention projects for juveniles. These programs occur in schools, local community service boards, detention centers, universities, nonprofit organizations and local youth serving commissions.
- DCJS provides training support on substance abuse issues to professionals working in the criminal justice field.
- DCJS participates in interagency committees dealing with many issues, including substance abuse.
- DCJS convenes stakeholders to engage in policy discussions on issues of importance to the criminal justice field.

DCJS provides direct funding and technical assistance to support local community-based adult probation and pretrial services agencies. This includes assistance for the local agencies' substance abuse assessment of defendants awaiting trial and offenders placed on local probation, and for referral and placement of defendants and offenders in appropriate substance abuse programs. For FY2010, these DCJS funded agencies reported:

- 11,364 offenders were drug tested.
- 4,317 offenders were placed in substance abuse education.

- 3,371 offenders were screened for substance abuse problems.
- 2,880 offenders were assessed or evaluated for substance abuse problems.
- 2,858 offenders were placed in substance abuse counseling.
- 675 offenders were tested for alcohol use.
- 502 offenders were screened, assessed or evaluated for alcohol.

The gaps in service occur whenever there are waiting lists beyond a few days to see a clinician or the local CSB does not provide appropriate individual or group intervention for an individual's substance issues. Some CSBs are not able to provide any directed service to the criminal justice population, despite the close link between substance use and crime.

Department of Health

Description of Programs Related to Substance Abuse

- The Family Planning Clinics provide Sexual Transmitted Infection (STI) testing and treatment.
- The VDH Aids Drug Assistance Program (ADAP) provides medications for low-income, uninsured individuals with HIV/AIDS. Due to unprecedented enrollment and increased treatment costs, ADAP is closed to new enrollment except for pregnant women, children 18 years old or younger, and people receiving treatment for an active opportunistic infection.
- Clinics provide referral to CSBs (relationship between local health departments and the CSBs varies from one locality to another).
- Virginia's Home Visiting Consortium is a collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy through age 5. The Consortium reports to the Early Childhood Advisory Council and is a partner in Virginia's Plan for Smart Beginnings. DBHDS represented on the Consortium and has provided funding to support training about screening for substance use disorders.
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Recommendations

- A standard substance use screening tool needs to be identified and health department staff trained to use the screening.
- More treatment facilities for pregnant women and women with children are needed.

Department of Health Professions

Description of Programs Related to Substance Abuse

The Department of Health Professions has several ongoing programs that are related to substance abuse issues. The most obvious is the Prescription Monitoring Program (PMP), which maintains a database of information on all controlled substances prescribed and filled in

Virginia. The information is reported twice a month by all pharmacies and prescribing physicians. Prescribers or pharmacists may check the PMP database to see if patients are receiving multiple prescriptions for drugs that may be abused. Examples include OxyContin, methadone, morphine, Ritalin, Vicodin, Valium and Ambien. The PMP also sponsors an online pain management curriculum, developed at the Virginia Commonwealth University School of Medicine, for prescribers. The PMP has been an active partner with Department Behavioral Health and Developmental Services and community services boards in educating prescribers about addiction to pain medication, especially in the far southwestern region of the state where abuse of narcotic pain medication has become epidemic. The Department Behavioral Health and Developmental Services is also represented on the PMP Advisory Panel.

Through a contract with the Virginia Commonwealth University, the Department of Health Professions also operates the Health Practitioners Monitoring Program, which provides confidential treatment for physical, mental disability or chemical dependency for licensed health professionals.

Finally, the Department of Health Professions certifies substance abuse counselors and licenses health professionals who treat people with substance use disorders and other behavioral health problems. The Department of Behavioral Health and Developmental Services monitors these requirements and provides training opportunities to assist professionals associated with community services boards in meeting them.

Recommendations

- The Department of Behavioral Health and Developmental Services should continue to participate on the Advisory Panel of the Prescription Monitoring Program.
- The Department of Health Professions and the Department of Behavioral Health and Developmental Services should continue to collaborate regarding the education of health care professionals concerning substance use disorders.
- In addition, the two departments should explore how data from the Prescription Monitoring Program database might be useful in projecting need for services and targeting treatment resources.

Department of Rehabilitative Services

Description of Programs Related to Substance Abuse

Since 1988, the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Rehabilitative Services (DRS) have had an interagency agreement under which DRS provides specialized vocational rehabilitation (VR) services to individuals with substance use disorders who meet eligibility criteria for the VR program. The agreement is designed to address issues surrounding job entry and job retention by integrating DRS VR services with the community service boards' clinical treatment programs.

Currently, dedicated VR counselors serve only 18 of Virginia's CSBs. For the remaining 22 CSBs, individuals with substance use disorders are served by VR counselors who also serve

other individuals with a wide range of disabilities, referred for VR services from many different sources.

The DRS program manager who provides training and technical assistance to the dedicated counselors is also available for consultation with “general caseload” counselors on substance abuse issues. The generalist VR counselors typically do not have the opportunity to participate in specialized training, nor do they use the same type of integrated, collaborative services model as the dedicated counselors serving clients from the 18 targeted CSBs. This model has been demonstrated to be more effective with the target population at a lower VR services cost.

DRS experience with the integrated services model has demonstrated that the case service costs for clients with SA disorders served by the dedicated VR counselors is 39% lower than the case service costs for clients with SA disorders served by generalist VR counselors (\$1,042 versus \$1,700, on average, over the “life” of the case). Also, the typical “life” of a VR case for clients served by the dedicated counselors is somewhat shorter which reduces the per-client cost of in-house services.

VR clients with SA disabilities served by the dedicated counselors are more likely to achieve successful employment outcomes (56% with SA Specialty Counselors) as opposed to these individuals being served by a General Caseload Counselors (45%) and have significantly higher hourly earnings when their VR cases are closed (\$9.98 versus \$9.19, on average) than other clients with SA disabilities served by a General Caseload Counselors.

The two major types of VR services are core services and purchased services. Core services are services provided by the VR counselor and other DRS staff (e.g., job placement staff, vocational evaluators) to all clients and include: 1) guidance and counseling; 2) vocational evaluation; and 3) assistance with job placement to include 90-day follow up after placement. All VR clients receive counseling and guidance during all phases of the VR process. These core services help clients better understand their potential, set realistic job goals, revise goals when needed, and learn good work habits.

DRS also purchases services, as needed, from a network of providers to help clients reach their vocational goals. These services range from assessments, vocational training and supported employment to medical treatment and assistive technology services. Almost two-thirds of all case service costs for clients with SA disorders served by the dedicated VR counselors in SFY 2010 were for:

- Supported employment and job coach training (24% of total expenditures);
- Training, both vocational and post-secondary (17% of total expenditures);
- “Maintenance”, primarily for room, board, and other costs associated with attending college (14% of total expenditures); and
- Transportation, e.g., for bus tickets and mileage reimbursements to clients (10% of total expenditures).

All VR counselors employed by DRS have a master’s degree in rehabilitation counseling or a closely related field and/or a current certified rehabilitation counselor (CRC) credential.

DRS provides DBHDS with an annual report documenting the services provided and the employment outcomes for VR clients served by the dedicated VR counselors through the integrated model described earlier. DRS will significantly increase the number individuals with SA disabilities we are currently serving and the additional funding for case service expenditures will not put an undue strain on our existing case service budgets. We will expand this report to include similar information on the expanded program, to document the additional numbers of clients served and the outcomes of this much-needed service expansion.

Recommendation

Expand the existing integrated services model by establishing 22 additional dedicated VR counselors to serve individuals with SA disabilities in those areas of the state that do not currently have such positions, so that every CSB would have access to dedicated VR services. Of the CSBs/ currently without dedicated VR counselors, four (Prince William, Manassas, Loudon, and Hanover) are in identified High Intensity Drug Trafficking areas; two are in high population-density localities (Virginia Beach, Williamsburg), and the remainder are in primarily rural parts of the Commonwealth (Farmville, Harrisonburg, Abingdon, Lexington, Martinsville, Saluda, Culpeper, Dickinson County, Goochland, Suffolk, and South Boston.)

Department of Medical Assistance Services

Description of Programs Related to Substance Abuse

Medicaid began reimbursing providers for substance abuse treatment in 1998, with the initiation of services limited to pregnant and postpartum women (residential and day treatment). In 2007, the State Medical Assistance Plan was expanded to include an array of services for the general Medicaid eligible population. These services include crisis intervention, intensive outpatient, day treatment, opioid treatment (methadone), and case management. Federal regulations prohibit the use of Medicaid funding to support residential treatment in facilities that have 16 or more beds for persons between the ages of 18-64, therefore, no residential treatment is covered, except for pregnant women in facilities with fewer than 16 beds. Because state general funds dollars spent through the Medicaid program are matched by the federal government at an approximate 1:1 ratio, Medicaid is a cost-effective approach to funding services for the eligible population. In 2010, Medicaid paid approximately \$1.3 million to providers in reimbursements for substance abuse treatment services.

Due to federal Medicaid eligibility regulations, the pool of persons currently eligible to have their substance abuse treatment services reimbursed is relatively small and is largely limited to women with dependent children who are receiving public assistance, or people who are disabled due to co-occurring mental illness or physical disability.

Recommendation

As the federal Affordable Care Act is implemented, the pool of persons eligible to participate in Medicaid will increase substantially, and the number who will seek treatment for substance abuse treatment is unknown. Also unknown is the array of services that will be covered. Concurrently with the expansion of Medicaid, DBHDS anticipates that the federal Substance

Abuse Prevention and Treatment Block Grant will diminish in amount. DMAS and DBHDS should continue to work closely to ensure that funding to support a comprehensive treatment continuum that includes residential treatment is available.

Department of Social Services

Description of Programs Related to Substance Abuse

Statistics

- Approximately 19 percent of children entering foster care in Virginia have an indicator of parent drug abuse noted in the state child welfare information system. The highest entry-rate per 1,000 children is in the Western part of the state, which is reflective of other data from the Office of the Chief Medical Examiner data concerning drug-caused death rates and alcohol and drug-related arrest rate data.
- Nearly one-third (32 percent) of entries into foster care for the Western region had indicated parent drug abuse. (Table 5) This rate was the highest for all VDSS regions.
- All of the planning districts in the Western region exceeded the statewide rate of indication of parent drug abuse during this time period. Planning districts 1 and 4 had the highest rates of parent indicators of drug abuse during this three-year period. The rate in Planning District 1 (42 percent) was more than double the rate for the state. The rate in Planning District 4 (33 percent) was almost twice the statewide rate. (Table 6)

Initiatives

- VDSS, at the state and local levels has implemented Family Engagement Principles that encourage family participation in service planning.
- VDSS is also embracing a Family Strengthening framework evident in the new VDSS Practice Model. A few highlights include:
 - Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and community partners and across all programs and services.
 - Individuals and families face unique challenges that impact their ability to maintain self-sufficiency. VDSS values all programs and services that assist individuals and families to regain and maintain self-sufficiency and achieve personal accountability.
 - Cooperation, coordination and collaboration within and outside of the social services system are essential to providing the most comprehensive services to families. VDSS is committed to working across programs, divisions, agencies, stakeholder groups, and communities to improve outcomes for the children, individuals, families, and communities we serve.

Community supports

- Local departments of social services do not provide direct substance abuse services. Services may be part of a service plan.
- Local departments of social services collaborate with CSBs for the provision of community-based substance abuse services. (This may vary by locality.)

Gaps

- The line item that funds purchased services for local departments of social services has been eliminated in the FY 2012 budget. A portion of these funds were available and designated for the purchase of substance abuse treatment for adults and children.
- Domestic violence programs statewide report an increase in the number of victims with substance abuse problems seeking service. The only local resources for victims with no health insurance are community services boards that typically have very long waiting lists for services. (Office of Family Violence)
- Only two of the 49 VDSS funded domestic violence programs have initiatives that address the overlap of domestic violence and substance abuse. (Office of Family Violence)
- Southwest Virginia localities report a need for increased collaborations and coordinated services for the large number of individuals with substance abuse problems. (Family and Children's Trust Fund)
- Southwest Virginia participants in a family violence listening session indicated that dual screenings for domestic violence and substance abuse are needed. (Family and Children's Trust Fund)