SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

to the Governor
and the
General Assembly

COMMONWEALTH of VIRGINIA

December 2005

COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

Patty L. Gilbertson
Chair

P. O. Box 1797
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December 2, 2005

The Honorable Mark R. Warner
Governor of Virginia
Patrick Henry Building, Third Floor
1111 East Broad Street
Richmond, Virginia 23219

Dear Governor Warner:

In accordance with Article 31, § 2.2-2696 of the *Code* of Virginia, I am pleased to present the "2005 Annual Report and Comprehensive Interagency State Plan for Substance Abuse Services".

The 2005 Annual Report focuses on two major areas that were discussed by the Council. The first is the lack of state funding dedicated to providing alcohol and other drug prevention services in the Commonwealth. The second is the need to focus on substance use disorders as chronic, reoccurring disorders, similar to asthma, hypertension or diabetes. This approach would require prevention as a public health strategy, and ongoing treatment and management to assure successful outcomes.

The 2005 Annual Report also contains recommendations in response to a new Virginia Code requirement (§ 2.2-2697. Review of state agency substance abuse treatment programs) enacted in 2003. This legislation required the reporting of outcome information by agencies that provide treatment for substance use disorders.

As the newly appointed Chair of the Substance Abuse Services Council, it is my honor and privilege to serve. I am most honored to have the opportunity to work with some of the most highly respected and credible addiction and recovery experts in Virginia, particularly the previous Chair, Dr. James May. Members of the Council have devoted many hours and resources to the work of the Council and for that I am indebted.

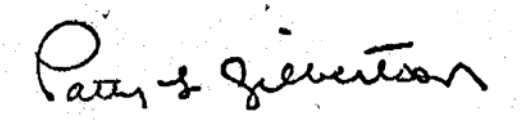
Substance use disorders affect more than one life: families, friends, and communities also experience the effects of a person's disorder. A great deal of work remains to be done to strengthen Virginia's treatment infrastructure, to expand the types of prevention and treatment services available, and to improve the

quality of and access to comprehensive prevention and treatment services. We must commit to a broader prevention effort to stop the use of illicit substances before it starts and to spare our families and communities the devastation and economic costs of addiction. Prevention is our first line of defense against the use of illicit substances in the Commonwealth.

We must also commit to shifting our focus on substance use disorders. We must not view them exclusively as social and criminal justice problem, but must also recognize these disorders as a public health issue. No one can deny that substance use disorders affect public safety and social issues. We cannot, however, ignore the compelling evidence that addiction is best considered a chronic, relapsing condition and, as such, requires ongoing, well integrated treatment and management.

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

Sincerely,



Patty L. Gilbertson, R.N.,C.

Cc:The Honorable Jane H. Woods, Secretary, Health and Human Resources

Preface

The Substance Abuse Services Council is established by the *Code* of Virginia §2.2-2696 *et seq*. to advise and make recommendations to the Governor, the General Assembly, and the Board of the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Council provides advice both on broad policies and goals, as well as on the coordination of the Commonwealth's public and private efforts to control alcohol and other drug abuse. In 2005, the General Assembly expanded the Council by adding representatives from six agencies and organizations to the Council.[1] The representatives of these agencies and organizations bring a wealth of knowledge and perspective that is already enriching the focus of the Council's work. Their time, energy and dedication are essential to the Council's accomplishments.

The work reflected in this report was initiated under the leadership of James C. May, Ph.D., Council chair from 2002-2005, and completed under a newly appointed chair, Patty L. Gilbertson, who was already a member of the Council. Building on the 2005 report, this report reflects the work of three Council committees. The Budget Committee, led by Brent McCraw, provided the basis for Part One of this document. Scott Reiner chaired the Planning Committee, which directed the work reflected in Part Two to comply with *Code* of Virginia § 2.2-2697 (Review of state agency substance abuse treatment abuse). Finally, the Program Committee, chaired by Rudi Schuster, addressed the assignment of tasks to the Council by the Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol. These activities have been supported by a grant administered by the Department of Motor Vehicles on behalf of the National Highway Transportation Safety Administration. A report on the Council's work on this initiative is available on the Council's website (http://www.dmhmrsas.virginia.gov/SASC/documents/DUIPlan2005.pdf.).

The Office of Substance Abuse Services of the Department of Mental Health, Mental Retardation and Substance Abuse Services provides staff support to the Council. Under the leadership of Office Director Ken Batten, Mellie Randall, Mary Shawver, Laurie Rokutani, Marc Goldberg, Lynette Bowser and Lisa Street assisted the Council in accomplishing its work. In addition, Ernestine Joyner of the Richmond Behavioral Health Authority and Renee Davenport of the Hampton-Newport News Community Services Board provided invaluable assistance with meeting logistics.

Finally, the Council wishes to recognize Governor Mark Warner for his continued support of the work of this Council. The Commonwealth has been fortunate to have leadership that recognizes the impact of substance use disorders on its citizens.

[1] The legislature added representatives from the Department of Alcoholic Beverage Control, Department of Medical Assistance Services, the Department of Motor Vehicles, the Governor's Office for Substance Abuse Prevention, Virginia Tobacco Settlement Foundation, and the Drug Court Association. In addition, Governor Warner appointed a representative from Lawyers Helping Lawyers as a consumer advocate representative to the Council. A complete Council roster is included as Appendix B.

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Executive Summary

This year's report is presented in two sections, with related appendices. Part One emphasizes the public health aspects of substance use disorders. In that vein, the Council recommends improved funding for prevention and treatment services. Prevention and treatment both fall on the same continuum of activities. The Institute of Medicine has adopted a paradigm of prevention that recognizes three ranges of prevention strategies. The Institute starts with universal strategies focused on the broad needs of the total population. Then, it narrows its sights to address selective strategies focused on populations with specific risk factors. Finally, the Institute identifies indicated strategies for populations with specific identified needs but not yet requiring treatment. This paradigm is increasingly used in designing prevention strategies for a broad range of diseases, and is being applied to substance use disorders as well.

Substance use disorders present the same challenges as other chronic disorders, comparable to asthma, diabetes and hypertension. Effective treatment, therefore, must address disease management over a period of time. Advances in treatment, supported by research and evaluation, have significantly expanded knowledge about effective treatment approaches, including specific counseling strategies and the use of medication. Meanwhile, nearly the entire criminal justice population needs treatment for substance abuse. Innovative community strategies, such as drug courts, can help divert and redirect many nonviolent offenders needing treatment from long-term involvement with the criminal justice system.

While Virginia's agencies clearly recognize the validity of these modalities, their ability to apply this knowledge is hampered by lack of funding. Currently, no General Funds are appropriated for the specific purpose of supporting prevention programs. Publicly funded support for treatment is stagnant at both the federal and state level. Medicaid reimbursement for substance abuse treatment is very limited in Virginia, and private insurance policies are very restrictive, as well. The result is that community capacity is shrinking, and services for some populations, including adolescents, are extremely limited.

Part Two provides the Council's response to Virginia *Code* § 2.2-2697 (Review of state agency substance abuse treatment programs), enacted in 2003. This legislation requires the Council to report on the capacity of state agencies that provide treatment for substance use disorders to provide outcome information. To address this requirement, the Council surveyed its membership and identified the three agencies actually providing treatment services: the Department of Corrections, the Department of Juvenile Justice Services, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. It is difficult to compare these agencies, for each provides treatment for substance use disorders under very different circumstances and varies considerably in their capacity to collect outcome information.

Furthermore, the Council cautions that strict analysis of outcome measures do not tell the whole story about the success of treatment. Given the chronic nature of substance use

disorders, evaluation of services should encompass an array of conditions that are not limited to measuring outcome post-treatment.

The report concludes by identifying five recommendations for consideration:

1. ***Expand Medicaid funding.***
   The Council recommends that the General Assembly appropriate $6.1 million to provide General Fund match for Medicaid to fund the full range of treatment for substance use disorders for all eligible populations. This funding would produce a total of $12.2 million in new funds available for community-based substance abuse treatment. In addition, the Council recommends that the Department of Medical Assistance Services collaborate with the Department of Mental Health, Mental Retardation and Substance Abuse Services as well as public and private providers of treatment for substance use disorders to draft regulations for the State Medical Assistance Plan.

2. ***Appropriate funds designated for prevention services.***
   The Council recommends that the General Assembly increase the user fees on tobacco products by $.01 and appropriate the resulting revenue to the Department of Mental Health, Mental Retardation and Substance Abuse Services for allocation to the community services boards, specifying that these funds shall support only evidence-based prevention practices.

3. ***Expand capacity to treat adolescents.***
   The Council supports the initiatives of the Department of Mental Health, Mental Retardation and Substance Abuse Services requesting a total of $1.7 million to provide 16 bed residential unit and services for youth at the Commonwealth Center for Adolescents, Virginia's public mental health facility for youth.

4. ***Support the development and funding of drug courts.***
   The Council supports the initiatives of the Supreme Court of Virginia and recommends that the General Assembly fully fund the budget request of the Court to
   a. Provide formula funding to ten drug courts that currently do not receive state funding at a cost of $1,726,795 in each year of the biennium for a total cost of $3,353,590;
   b. Increase the statewide funding formula for drug courts by 3% at an annual cost of $88,560 in each year of the biennium, and a total cost of $177,120; and
   c. Fully fund existing drug courts according to the statewide formula at an annual cost of $449,175 in each year of the biennium, and a total cost of $898,350.

   In addition, the Council supports request of the Department of Mental Health, Mental Retardation and Substance Abuse Services for $2,625,000 to support expanded treatment capacity for drug court participants.

   Finally, the Council recommends support in the amount of $600,000 for the second year of the biennium to fully fund two family drug courts that are losing federal grant funds in 2007.

5. ***Develop and implement a statewide strategy for evaluation of treatment programs funded with public dollars.***
   a. Require state agencies providing treatment for substance use disorders to report on the short *and long term* results of treatment.
   b. Require state agencies providing treatment for substance use disorders to adopt the National Outcome Measures (NOMS) when appropriate. To the degree possible, data definitions and coding conventions should be consistent with those set forth in the NOMS.
   c. Require *all* state agencies to share data for the purposes of evaluation while also assuring careful, secure maintenance of the data to protect confidentiality and privacy in accordance with agency requirements and state and federal law.
   d. Provide funding to invest in research and evaluation of cost-effective treatment policies and programs for substance use disorders, including funding to support the required sharing, maintenance and analysis of interagency data.
   e. Given the limitations on the agencies' current capacities to report outcomes, modify the language of § 2.2-2697-B as summarized below:

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

Part One--Current Issues

I. Current Concerns of the Council

This year, much of the Council's discussion focused on increasing public understanding of substance use disorders as chronic illnesses, similar to asthma, high blood pressure or diabetes. As such, substance use disorders requiring the same public health strategies as other diseases: prevention, ongoing treatment, and continuous management. Moreover, just as with other chronic diseases, prevention and treatment for substance use disorders must be understood as ranges of a single continuum. This understanding is especially important in light of static public funding on both the state and federal level for prevention and treatment.

A. A Prevention Paradigm

The focus on prevention of substance use disorders has implications beyond the traditional concerns, addiction and public safety. Prevention, in this context, must be understood as a public health issue with significant implications for general health status, educational achievement and economic success.

Advances in epidemiology have identified t characteristics typically shared by people who develop certain diseases. These characteristics, or *risk factors*, may include genetic factors, lifestyle issues, the presence or absence of other diseases, and environmental exposure, to name just few. Risk factors are a key component of many prevention strategies.

In a public health context, prevention strategies focus on three groups: the general population, subgroups that may be statistically likely to develop the illness, and people showing early signs of the public health problem. These strategies are respectively referred to as *universal, selective* and *indicated*.

1. *Universal strategies* address the entire population, regardless of risk factors, but may be targeted to specific subgroups, such as pregnant women or adolescents. The current focus on sound nutrition and exercise is an example of this type of campaign. In the substance abuse arena, one common strategy is public awareness campaigns. For instance, one campaign reminds expectant mothers that "A Pregnant Woman Never Drinks Alone," and in doing so addresses not only substance abuse issues but also concerns for healthy pregnancy. Another campaign generally warns adolescents and their parents that delaying initial use of alcohol or drugs can significantly reduce the likelihood of developing a later problem.

2. *Selective strategies* target a portion of the population *at-risk* of developing a substance use disorder. These individuals do not exhibit any symptoms, but they all share a *risk factor* that indicates a statistical likelihood that they are more likely than the general population to develop a specific health problem. Campaigns using selected strategies educate at-risk populations about the disease and early symptoms. These approaches are based on the premise that the knowledgeable persons may make choices that will reduce risk factors (or increase protective factors). These campaigns may also provide information about treatment options, in the hope of reducing the fear and anxiety that contribute to delayed treatment.

An example of this kind of prevention strategy is a pubic health campaigns focusing on children of alcoholics. By learning about the strong genetic predisposition for developing substance use disorders, the child of an alcoholic can make an informed choice about use of alcohol or other drugs. This type of approach can also provide information about the effects of growing up in a home in which a parent is alcoholic, and can help to ameliorate the impact of the neglect or abuse often associated with the parent's alcoholism.

3. *Indicated strategies* focus on those who show early signs of the health problem. In a different context, one familiar indicated strategy is physician screening of chronically overweight people for Type II diabetes. In substance abuse, *indicated* strategies focus on people showing early danger signs, such as adolescents who are failing in school and "experimenting" with drugs and alcohol, or adults with certain types of health problems that may indicate a previously undetected alcohol or drug problem. Just as with the example of diabetes, indicated strategies can inform people with substance abuse problems about early warning signs and symptoms, can educate them about treatment options, reducing the fear and anxiety often associated with seeking treatment, and can start them on the road to treatment before all is lost.

B. Evidence-based Practices

Research has identified clearly defined prevention practices that have proven to be effective. These practices are supported by empirical research and are referred to as "evidence-based practices" (EBPs), are designed to be implemented using a defined approach or protocol for specific populations. In Virginia, substance abuse prevention professionals in the public sector have received extensive training in implementing these practices and must utilize these EBPs as a condition of funding.

II. Treating Substance Use Disorders as Chronic, Relapsing Health Problems

Substance use disorders are chronic, relapsing illnesses. The medical community universally recognizes substance abuse as a disease. Yet, throughout the United States, treatment and prevention policies have almost always perceived substance abuse as a social or criminal justice problem, rather than a health problem. Although substance use disorders certainly affect public safety and social problems, these illnesses are first and foremost health problems. The resulting stigma of this misperception compounds the personal hopelessness and denial experienced by the hundreds of thousands of Virginians who are currently or who will, at some point, be confronted with this problem in their own lives. As a collection of chronic diseases, substance use disorders continue over the life span of the person, progress over time, but can be managed with the appropriate treatment of the correct type, intensity and duration.

A. Treatment

As in most chronic diseases, treatment requires that the person with the disease change his behavior. The change may include counseling, use of medications, and changing or controlling environmental cues or triggers. Research has identified treatments and protocols that consistently produce successful outcomes, and has documented this success through empirical evidence. These proven approaches, evidence based strategies, achieve remarkable

success when utilized by a trained professional. These successes include increased periods of abstinence, reduced criminal activity, and improved employment or educational status. The 2003 Session of the General Assembly amended the *Code* (§2.2-2697) to require the Council to assess and report on the capacity of state agencies to collect and report outcome data on treatment programs for substance use disorders. The r current assessment is included as Part Two of this report.

The Council cautions, however, that over reliance on these outcome measures can belie the success of treatment. A relapse does not necessarily indicate failure of the treatment approach. All chronic diseases have periods in which symptoms reappear. In the treatment of hypertension, for instance, it is common for patients to have episodes of high blood pressure. When this occurs, the health care provider typically adjusts the patient's medication, diet, or both. In this case, however, the patient is not viewed as having failed in treatment. By the same token, when a person with a substance use disorder has a recurrence of symptoms, it is also an indicator of a need to adjust treatment, and not necessarily a sign that the patient has failed in his treatment regimen.

B. Medication and Counseling

Counseling practices include methods to increase and sustain motivation for behavior change, a problem encountered in addressing any chronic health disorder. These approaches literally train the person to think and solve problems in a different way, and measurably change the person's emotional state. Under certain conditions, medication can also be a critical part of the treatment regimen. In addition to methadone, widely and successfully used to treat narcotic addiction, and disulfiram (Antabuse), used to deter alcoholics from drinking by making them feel nauseous when they ingest alcohol, other medications have recently joined the treatment arsenal. These include buprenorphine, naltrexone, and acamprosate. When used in conjunction with counseling and other treatment, these medications consistently produce positive outcomes.

C. Compliance

One myth that haunts the credibility of treatment is that people in treatment for substance use disorders waste resources because they are less compliant with treatment instructions than victims of other illnesses. This myth likely arises from the false belief that people suffering from alcoholism or other drug abuse are somehow morally culpable for their disease.

Substance abuse patients are no less compliant than patients with other diseases. For instance, according to the American Medical Association, fewer than 40 percent of patients with asthma or high blood pressure take their medications as prescribed, and fewer than 30 percent make the necessary behavioral changes necessary to sustain health improvements and prevent recurrence of symptoms. During the course of a year, the AMA reports that between 30 and 50 percent of adults with diabetes and 50 to 70 percent of adults with high blood pressure or asthma will suffer a recurrence of symptoms severe enough to require medical attention, including hospitalization. These rates of noncompliance and recurrence of symptoms are similar to those experienced by those engaged in treatment for substance use disorders.

D. Driving Under the Influence

Unfortunately, people with untreated substance use disorder do often become involved with the courts, either because of criminal involvement or because of child abuse or neglect. One of the most common criminal offenses of substance abusers is driving under the influence. Twenty-four communities in Virginia operate alcohol safety action programs (ASAPs) designed to provide intervention for those arrested for this offense. The Commission on the Virginia Alcohol Safety Action Programs, a legislative agency, oversees for these programs. As a result of the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol, convened in 2002, the Commonwealth has placed a special emphasis on Repeat Offenders and Hardcore Drunk Drivers[2]. In this area, the Task Force has assigned five specific objectives to the Substance Abuse Services Council: establishing goals and objectives for intervention and treatment; recommending standardized approaches to clinical assessment; developing standardized treatment definitions; identifying successful programs; and recommending methods of collecting information populations at risk of becoming Repeat Offenders or Hardcore Drunk Drivers that will be useful in improving program design. With support from a National Highway Transportation and Safety Administration grant administered by the Department of Motor Vehicles, the Council made significant progress on the first three of these objectives, and will complete its work by 2008. A report on the Council's work on this project may be found at http://www.dmhmrsas.virginia.gov/SASC/documents/DUIPlan2005.pdf). The Council has received continued funding from the DMV to continue its work.

E. Drug Courts

Research indicates that drug courts are extremely effective in reducing substance use and criminal activity. Drug courts are specialized dockets that operate within the existing structure of Virginia's court system. They handle nonviolent adult and juvenile offenders charged with felony drug possession. Family drug courts work to resolve parental substance abuse issues in order to keep families together and insure a safe, secure environment for the children in them.

Drug courts offer an alternative to traditional adjudication and sentencing options. According to the Virginia Drug Court Association website (http://www.vdca.net/pages/1/index.htm), these courts provide intensive supervision, drug testing, treatment, and frequent court appearances. Drug courts rely on a team of judges, prosecutors, defense attorneys, public defenders, sheriffs, deputies, police officers, probation staff, treatment professionals and clerks of the court to assist offenders with substance use disorders. They accomplish this goal by integrating criminal case processing with comprehensive treatment services and an intensive system of offender accountability under the leadership of the court. Currently 28 drug courts are operating in Virginia. The 2004-2006 Strategic Plan of the Supreme Court of Virginia includes action items that focus on evaluating drug treatment programs in Virginia to assess their impact on recidivism rates, evaluating the effectiveness of family treatment drug courts, and assessing the results of court-connected DUI programs with a goal of

[2] The Century Council. From the Grassroots to a National Agenda. Community Forums Report: Issues and Insights on Hardcore Drunk Driving. p. 2. No date given.

establishing more of these programs in Virginia. Several of the specific items to be explored include services to parents with substance use disorders involved in child dependency cases, specialized DUI dockets, additional drug courts, or other problem-solving courts.

III. Implications for Funding

In fiscal year 2005, the Commonwealth received $43,461,008 in federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, and the community services boards (CSBs) expended $40,460,119 in State General funds for substance abuse treatment. (CSBs are entities of local government.) The federal legislation that authorizes the SAPT Block Grant requires that 20 percent of these funds be dedicated to prevention programs. State and federal funding supporting both prevention and treatment have remained stagnant for several years. As the cost of providing services has risen, the impact of level funding has been to reduce capacity for those who seek treatment, and to discourage others from doing so. At the same time, the criminal justice systems, both juvenile and adult, have lost funding dedicated to supporting treatment for substance use disorders among their populations.

A. Insurance

Approaching substance use disorders as a health problem opens many issues to policy makers. One issue is that federal laws governing health insurance still do not assure parity for substance abuse treatment. One study recently indicated that providing health insurance coverage for treating alcoholism, the most common type of substance use disorder, would cost employers only $5.11 per employee and family member per year. When compared to the cost of addressing the myriad of health problems connected to untreated alcoholism, the cost of treatment is truly a bargain.

B. Medicaid

Virginia Medicaid does not cover most treatment for substance use disorders. Medicaid only reimburses providers for adolescents and for limited substance use disorder treatment services to pregnant and post-partum women. Yet coverage for other types of behavioral health care (not to mention "physical" health care) is extended to all eligible populations. An annual allocation of $6.1 million in General Funds could potentially produce an equal amount of federal funds, enough to support a full range of services to all eligible Medicaid recipients in the Commonwealth. This change would primarily affect women with dependent children and people eligible for Medicaid due to disability. It would ultimately save the Commonwealth from paying far greater Medicaid costs for illnesses that result from the progression of untreated substance use disorders. Since many of the beneficiaries of Medicaid are women with dependent children, this benefit would prevent the dissolution of families resulting in savings to foster care services. In summary, expanded funding for treatment is sound fiscal policy, as well as sound health and public safety policy.[3]

[3] For a more detailed discussion concerning Medicaid as a potential funding resource for treating substance use disorders, please refer to the Council's 2005 report.

C. Adolescents

The lack of insurance coverage and stagnant public funding has had an especially significant impact on treatment services for adolescents. The capacity to provide services to this vulnerable population is extremely limited. Only one residential substance abuse treatment program is currently operating in Virginia. Yet the Department of Juvenile Justice finds that upwards of 70% of the children in its care need treatment for substance use disorders, and reports great difficulty in locating community-based treatment for this population.

D. Prevention

Three Virginia entities fund substance abuse prevention services. [4] The Department of Mental Health, Mental Retardation and Substance Abuse Services is required to utilize 20% ($8,692,208 in FY 2005) of the federal SAPT Block Grant for community-based prevention services. These funds are allocated to the 40 CSBs. Due to level funding of the grant at the federal level, the amount has remained static for several years.

The Department of Education and the Governor's Office for Substance Abuse Prevention (GOSAP) receive Drug Free Schools and Communities Act funds from the federal Department of Education. The Virginia Department of Education uses these funds to support school-based prevention services delivered by local school districts. GOSAP houses a number of prevention resources, including the GOSAP Collaborative and its Clearinghouse. GOSAP also maintains social indicator database for each jurisdiction in the state. GOSAP hosts a statewide prevention conference, and awards grants to community organizations to support substance abuse and violence prevention, community coalitions, and youth and professional development opportunities. In addition, GOSAP developed and directs implementation of Virginia's statewide prevention plan and created a prevention "pocket guide, "Our Common Language: A Quick Guide to Prevention Terminology in Virginia" to unify the prevention community.

DMHMRSAS. DOE and DMHMRSAS all require that these funds be spent on evidence-based substance abuse prevention services, utilizing proven models designed for specific environments and populations, virtually guaranteeing their effectiveness, and yet they are all totally dependent on federal funds to support these services.

[4] The Virginia Tobacco Settlement Foundation funds prevention services specifically limited to tobacco use.

Part Two--State Agency Assessment

I. Overview and Introduction

The 2004 Session of the General Assembly passed Senate Bill 304 (Patron: Senator O'Brien), directing the Substance Abuse Services Council to collect information about the impact and cost of substance abuse treatment provided by public agencies in the Commonwealth. This legislation amended the *Code* of Virginia (§ 2.2-2697) by adding the following:

(§ 2.2-2697) Review of state agency substance abuse treatment programs.

> A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also include an assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.
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> B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse treatment program: (i) the amount of funding expended under the program for the prior fiscal year; (ii) the number of individuals served by the program using that funding; (iii) the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person costs and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs; and (vii) recommendations on the funding of programs based on these analyses.

As required, this 2005 report responds to Section A by summarizing the results of a survey conducted by the Substance Abuse Services Council and providing background about substance abuse treatment and the evaluation of treatment effectiveness. Treatment here is defined narrowly as those services directed toward individuals with identified substance abuse and dependence disorders and does not include prevention services for which other evaluation methodologies exist.

II. Treatment Services

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior. To meet these goals, these agencies have implemented several evidence-based practices (EBPs), practices for which strong research support exists, and consensus-based practices (CBPs), techniques that experts agree to be effective, but for which insufficient research exists to meet the stringent criteria of evidence-based practices. EBPs and CBPs used by these agencies include Motivational Enhancement Therapy (MET), Cognitive-Behavioral Therapy (CBT), and Therapeutic Communities (TCs). Each agency provided descriptions of its treatment programs, which are included in Appendix C.

A. Department of Mental Health, Mental Retardation and Substance Abuse Services

1. CSB Services

DMHMRSAS supports substance abuse treatment services through the community services board system. Title 37.2 of the *Code* of Virginia establishes DMHMRSAS to ensure delivery of publicly funded services and supports to individuals with substance use disorders (as well as mental illnesses, mental retardation) and authorizes the Department to fund these community substance abuse services. Sections 37.2-500 through 37.2-614 of the *Code* of Virginia require cities and counties to establish community services boards (CSBs) to provide these services. There are 40 community services boards.

2. Treatment Gaps

§37.2-505 states that the CSBs shall function as the single point of entry into the publicly funded services system. In FY 2004, CSBs expended $107,117,000 (including federal, state, and local funds, as well as fees) to provide substance abuse treatment services to 51,300 individuals. Each CSB fulfills this role for individuals who reside or are located in its service area. The Department functions as the state authority for the public services system, and the CSBs function as the local authorities for that system. Each CSB is required by the *Code* to provide Emergency Services and, to the extent possible, Case Management Services. All CSBs provide some form of outpatient services. A number of CSBs offer additional services, such as crisis stabilization, intensive outpatient, and residential services. However, the availability of treatment beyond the bare minimum varies greatly across the 40 CSBs.

According to the federal National Survey on Drug Use and Health [5], approximately 159,000 Virginians age 12 or over who were identified as needing treatment for illicit drug abuse in the past year did not receive this treatment. Similarly, 418,000 individuals in this age group needed but did not receive treatment for alcohol abuse. Given that CSBs were able to serve 51,300 (and considering that there is substantial overlap between the people who need alcohol treatment and those who need drug treatment), these data suggest that the CSB system is only able to meet the needs of 8.2%-10.9% of Virginians in need of treatment.

[5] Substance Abuse and Mental Health Services Administration, 2003.

National studies clearly document limited insurance coverage for treating substance use disorders, placing a large burden on the public sector.

3. Measurement and Performance

To monitor performance of the service system (pursuant to § 37.1-198 of the *Code* of Virginia), CSBs report data on consumer outcomes, provider performance, and consumer satisfaction. Client outcome data is collected through monthly, semi-annual, and annual Community Consumer Submission (CCS) extracts that report individual consumer characteristic and service data.

Over the last four years, staff from DMHMRSAS have collaborated with the National Association of State Alcohol and Drug Abuse Directors and the federal Center for Substance Abuse Treatment to identify a set of outcome measures for alcohol and drug treatment services supported by the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, the primary source of federal funding for community based services in the Commonwealth. This effort culminated in the development of the National Outcome Measures (NOMS), released in 2005. The collection of these data is mandated by federal funding sources and is a prerequisite of continued federal funding. The NOMS and their domains are listed in Table 1. (Note: the NOMS were developed and defined to measure the effectiveness of community-based services and may not be appropriate for institutionally based services such as those provided by DOC and DJJ.)

States are expected to begin reporting the NOMS as soon as possible, with all states reporting by FY 2008. Because of its involvement in the development of NOMS, DMHMRSAS developed its client-level data system, the Community Consumer Submission (CCS) to allow collection, analysis and reporting of these outcome measures. Initial analyses of CCS data, however, have indicated that there are significant issues related to data quality. Further refinements to the system must be addressed before CCS will provide useful information on service outcomes.

Table 1. Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs) for Substance Abuse Services

DOMAIN	OUTCOME	MEASURES
Abstinence	Abstinence from Drug/Alcohol Use	Reduction in/no change in frequency of use at date of last service compared to date of first service
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Increase in/no change in number of employed or in school at date of last service compared to first service
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service
Stability in Housing	Increased Stability in Housing	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service
Access/Capacity	Increased Access to Services (Service Capacity)	Unduplicated count of persons served; penetration rate – numbers served compared to those in need
Retention	Increased Retention in Treatment – Substance Abuse	Length of stay from date of first service
		Unduplicated count of persons served
Social Connectedness	Increased Social Supports/Social Connectedness	*Under Development*
Perception of Care	Client Perception of Care	*Under Development*
Cost Effectiveness	Cost Effectiveness (Average Cost)	Providing substance abuse treatment services within approved cost per person bands by the type of treatment
Use of Evidence-Based Practices	Use of Evidence-Based Practices	*Under Development*

B. Department of Juvenile Justice Services

1. Community Treatment

Many youth served by DJJ are in need of treatment for substance abuse problems. For those in community settings, primarily on probation supervision, approximately 40% are likely to require treatment. DJJ is unable to meet this need. The General Assembly terminated Substance Abuse Rehabilitation and Education (SABRE) funding in the amount of $2,300,000 beginning in FY 2004. These funds, plus a now-expired federal grant in the amount of $300,000, supported substance abuse treatment for youths in the community under DJJ supervision. As a result, DJJ does not currently directly provide or fund substance abuse treatment in community settings. Presently, juveniles supervised by DJJ and needing substance abuse treatment must obtain such treatment through their local community services board or providers funded by private health insurance, when available.

2. Treatment in Secure Juvenile Correction Centers (JCCs)

Approximately, 70 percent of youth committed to DJJ custody in a juvenile correctional center (JCC) need substance abuse treatment. Although, DJJ recently closed a facility dedicated to substance abuse treatment, and terminated a contract with a private treatment services provider that operated the program in that facility, services in the DJJ operated Juvenile Correctional Centers are sufficient to meet the needs of all committed juveniles while they remain in custody. Treatment is provided by the Department's Behavioral Services Unit at each of the seven JCCs. The services are described in greater detail in Appendix C.

3. Costs

In FY 2004, the cost of the DJJ institutional programs was approximately $1,551,211 and 678 boys were served (100% of eligible and appropriate referrals). Additionally, a program funded by a $160,000 grant served 50 girls in FY 2005 (100% of eligible and appropriate referrals).

4. Follow-Up

DJJ collects data on rearrests, reconvictions, and reincarceration for all of their program participants. In addition, the grant funded program for females followed all participants at 3, 6, and 12 months and assessed abstinence, rearrests, and mental health functioning.

C. Department of Corrections

1. Treatment Model

DOC uses a phased treatment model for which the final phase is a transitional therapeutic community (TC). For an overview of the range of treatment services provided, see Appendix C.

2. Follow-Up

DOC collects outcome data on persons who complete the prison and transitional TC programs as those are funded services. DOC also offers educational and counseling services in prisons that are provided by case-managers in addition to numerous other job duties. DOC requires that graduates be employed at discharge; DOC monitors employment as an outcome

indicator. DOC also monitors re-arrests, reconvictions, and recommitments and plans to follow participants for 3-5 years. In addition, DOC proposes to survey 10% of the graduates at 3, 6, and 12 months post-discharge. In FY 2004, the cost of the DOC in prison and transitional therapeutic community programs was approximately $6,000,000 and approximately 1,800 individuals were served.

3. Staffing

DOC's therapeutic community programs are staffed with persons that hold or are working to attain state substance abuse counselor certification. Recent statewide agency budget cuts and reductions in overall funding to support substance abuse services, has hampered the DOC's ability to purchase treatment services for offenders in community corrections and has limited training available to grow its own cadre of certified substance abuse staff. Most state prisons are limited to providing substance abuse education programs that are facilitated by case management counselors, not certified staff. To treat inmates with severe substance abuse and addiction problems and to provide more than basic education groups, seasoned, highly skilled clinicians are mandatory. Clinical supervision is critical to develop counselors' skills and train counselors for certification. Currently, the DOC employs only one clinical supervisor for the entire state; while each institution would benefit from a clinical supervisor, at least four regional supervisors are needed to meet minimal supervision and service delivery requirements.

III. Evaluation of Treatment Effectiveness

Numerous studies of the impact of substance use disorder treatment have demonstrated significant reductions in crime, improvements in employability, reductions in health care costs and additional "cost-offsets". Research has repeatedly demonstrated a strong return on the substance abuse treatment dollar. Society saves $7 for every $1 invested in treatment. While important, savings in state dollars are not the only goal of treatment. Any evaluation of service quality must consider the impact of treatment on public welfare, health and safety.

A. Data-Sharing

Several states have used available data to address accountability, quality improvement, and fiscally responsible resource allocation. They use data available from numerous sources as pragmatic indicators of ate their substance abuse services. These states have linked information systems from various agencies to provide concrete data to measure the effectiveness of services (e.g., medical costs, criminal activity, and social and economic functioning as indicated by utilization of various forms of public assistance and measures of employability and earnings). These states have legislated requirements for interagency cooperation in sharing the necessary data, specified standards for maintaining the personal privacy of their service recipients, earmarked funding for evaluation, and used the results to inform policy initiatives and affect subsequent resource allocation.

Virginia agencies have taken some steps in this direction. The Departments of Corrections and Juvenile Justice have collaborated with the State Police to share data to determine

recidivism rates for those individuals who have completed treatment while in state custody. DMHMRSAS has recently obtained cooperation from the State Police and the Virginia Employment Commission (VEC) to share data for the purposes of evaluation beginning in December 2005.

B. Limitations

Generally speaking, each of the three agencies has the capability to report data on the costs of service and the number of individuals served. Beyond reporting these "process" indicators, however, the current resources do not allow these three agencies to fully evaluate the effectiveness of treatment. Faced with severely limited resources, agencies have prioritized service delivery over the evaluation of effectiveness. A number of factors limit the ability to collect, analyze and report on outcome measures as well as to use these data to improve services. These factors include lack of information technology infrastructure, data quality in existing information systems, and the need to implement methodologies to assess the effect of long-term treatment on a chronic, relapsing disorder. Ideally, evaluation budgets should be approximately 20% of overall program costs when attempting to track and report on outcomes for large numbers of individuals receiving services. While certainly not cost-free, evaluation approaches relying on sharing of already available data through interagency data sharing are considerably less expensive and can provide concrete indicators of effectiveness.

C. Long-Term Evaluation

Substance use disorders are recurrent, chronically relapsing diseases with courses similar to diabetes and chronic hypertension. Recurrent, episodic treatment is necessary for such illnesses. Appreciation of the chronic nature of the disease leads to a long-term approach to illness management. Current approaches to treatment tend to be relatively brief and episodic. Treatment should be accessible on a periodic basis, just as it is for other chronic relapsing diseases. Numerous studies demonstrate a strong correlation between treatment length and the effectiveness of treatment as indicated by long periods of abstinence. Treatment should not be evaluated by snapshot at the conclusion of a course of treatment or even at a single point in time 3 months, or even 3 years later. Evaluation needs to take a long-term view of the process of treating a recurring illness over time.

Recommendations for 2006

In offering these recommendations, the Substance Abuse Services Council reviewed, updated and refined the recommendations offered in the 2005 report. The following five recommendations are those the Council believes to be most critical for the treatment and prevention of substance use disorders in the Commonwealth at this time:

1. ***Expand Medicaid funding.***
   The Council recommends that the General Assembly appropriate $6.1 million to provide General Fund match for Medicaid to fund the full range of treatment for substance use disorders for all eligible populations. This funding would produce a total of $12.2 million in new funds available for community-based substance abuse treatment. In addition, the Council recommends that the Department of Medical Assistance Services collaborate with the Department of Mental Health, Mental Retardation and Substance Abuse Services as well as public and private providers of treatment for substance use disorders to draft regulations for the State Medical Assistance Plan.

2. ***Appropriate funds designated for prevention services.***
   The Council recommends that the General Assembly increase the user fees on tobacco products by $.01 and appropriate the resulting revenue to the Department of Mental Health, Mental Retardation and Substance Abuse Services for allocation to the community services boards, specifying that these funds shall support only evidence-based prevention practices.

3. ***Expand capacity to treat adolescents.***
   The Council supports the initiatives of the Department of Mental Health, Mental Retardation and Substance Abuse Services requesting a total of $1.7 million to provide 16 bed residential unit and services for youth at the Commonwealth Center for Adolescents, Virginia's public mental health facility for youth.

4. ***Support the development and funding of drug courts.***
   The Council supports the initiatives of the Supreme Court of Virginia and recommends that the General Assembly fully fund the budget request of the Court to
   a. Provide formula funding to ten drug courts that currently do not receive state funding at a cost of $1,726,795 in each year of the biennium for a total cost of $3,353,590;
   b. Increase the statewide funding formula for drug courts by 3% at an annual cost of $88,560 in each year of the biennium, and a total cost of $177,120; and
   c. Fully fund existing drug courts according to the statewide formula at an annual cost of $449,175 in each year of the biennium, and a total cost of $898,350.

   In addition, the Council supports request of the Department of Mental Health, Mental Retardation and Substance Abuse Services for $2,625,000 to support expanded treatment capacity for drug court participants.

Finally, the Council recommends support in the amount of $600,000 for the second year of the biennium to fully fund two family drug courts that are losing federal grant funds in 2007.

5. ***Develop and implement a statewide strategy for evaluation of treatment programs funded with public dollars.***
   a. Require state agencies providing treatment for substance use disorders to report on the short *and long term* results of treatment.
   b. Require state agencies providing treatment for substance use disorders to adopt the National Outcome Measures (NOMS) when appropriate. To the degree possible, data definitions and coding conventions should be consistent with those set forth in the NOMS.
   c. Require *all* state agencies to share data for the purposes of evaluation while also assuring careful, secure maintenance of the data to protect confidentiality and privacy in accordance with agency requirements and state and federal law.
   d. Provide funding to invest in research and evaluation of cost-effective treatment policies and programs for substance use disorders, including funding to support the required sharing, maintenance and analysis of interagency data.
   e. Given the limitations on the agencies' current capacities to report outcomes, modify the language of § 2.2-2697-B as summarized below:

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

Appendix A
***Code* of Virginia**

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

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

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

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

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

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

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

F. The duties of the Council shall be:

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

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

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

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

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

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

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

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

A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the

program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also include an assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.

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

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

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

Appendix B

SUBSTANCE ABUSE SERVICES COUNCIL
2005 MEMBERSHIP ROSTER

Patty L. Gilbertson, Council Chair
Virginia Drug Court Association

General Assembly	
Delegate Clifford L. Athey	Delegate Robert B. Bell
Delegate James M. Scott	Delegate Beverly J. Sherwood
Senator Stephen D. Newman	Senator W. Roscoe Reynolds
Agencies	
Agency Head	Delegated Representative
Vernon M. Danielsen *Department of Alcoholic Beverage Control*	W. Curtis Coleburn, III
Gene E. Johnson *Department of Corrections*	Inge Tracy, CSAC, CAC, CCS, CCJP
Leonard Cooke *Department of Criminal Justice Services*	Rudi Schuster
Jo Lynne DeMary *Department of Education*	Arlene Cundiff James Ashton
Robert B. Stroube, M.D., M.P.H. *Department of Health*	Janice M. Hicks
Barry Green *Department of Juvenile Justice*	Scott M. Reiner
Patrick W. Finnerty *Department of Medical Assistance Services*	Catherine K. Hancock, APRN, BC
James S. Reinhard, M.D. *Department of Mental Health, Mental Retardation and Substance Abuse Services*	Ken Batten
D. B. Smit *Department of Motor Vehicles*	David L. Mosley
Anthony Conyers *Department of Social Services*	Vickie Johnson-Scott
Marilyn Harris *Governor's Office for Substance Abuse Prevention*	Ivan Tolbert
Debra D. Gardner *Commission on the Virginia Safety Action Programs*	
Other Organizations	
John A. Gibney, Jr. *Lawyers Helping Lawyers*	Joseph S. Battle *Substance Abuse and Addiction Recovery Alliance*
Jennie Springs Amison *Substance Abuse Certification Alliance of Virginia*	Jennifer Johnson *Virginia Association of Alcoholism and Drug Abuse Counselors*

Michael Fragala, M.S., NCACH, CSAC *Virginia Association of Drug and Alcohol Abuse Programs*	Gail Burrus *Virginia Association of Community Services Boards – Substance Abuse Council*
Freddie Simons *Virginia Association of Community Services Boards – Prevention Task Force*	James C. May, Ph.D. *Virginia Association of Community Services Boards*
Charles Walsh, L.C.S.W. *Virginia Association of Community Services Boards*	Sheriff Ryant L. Washington *Virginia Sheriffs' Association*
Sandra W. Ryals *Virginia Tobacco Settlement Foundation*	

Appendix C

Overviews of Treatment Services Provided by State Agencies

Department of Mental Health, Mental Retardation and Substance Abuse Services

Descriptions of substance abuse treatment services provided by CSBs follow.

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

2. ***Inpatient Services*** – These services provide short-term, intensive psychiatric treatment or substance abuse treatment, except for detoxification, in local hospitals or d*etoxification Services* using medication under the supervision of medical personnel in local hospitals or other 24-hour-per-day-care facilities to systemically eliminate or reduce effects of alcohol or other drugs in the body.
3. ***Outpatient and Case Management Services -*** These services are generally provided to an individual, group or family on an hourly basis in a clinic or similar facility. They may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and medication services. Intensive substance abuse outpatient services are included in this category, are generally provided over a four to 12 week period, and include multiple group therapy sessions plus individual and family therapy, consumer monitoring and case management.
4. ***Methadone Detoxification Services and Opioid Replacement Therapy Services –*** These services combine outpatient treatment with the administering or dispensing of synthetic narcotics approved by the federal Food and Drug Administration for the purpose of replacing use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.
5. ***Day Support Services –*** These services provide structured programs of treatment in clusters of two or more continuous hours per day to groups or individuals in a non-residential setting.
6. ***Highly Intensive Residential Services –*** These services provide up to seven days of detoxification in nonmedical settings that systematically reduces or eliminates the effects of alcohol or other drugs in the body, returning the person to a drug-free state. Physician services are available.
7. ***Intensive Residential Services*** - These services provide substance abuse rehabilitation services up to 90 days and include stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.
8. ***Jail-Based Habilitation Services*** –This substance abuse psychosocial therapeutic community provides intensive daily group counseling, individual therapy, psycho-

education services, self-help meetings, discharge planning, pre-employment and community preparation services in a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Normally the inmates served by this program are housed separately within the jail. The expected length of stay is 90 days.

Department of Juvenile Justice

DJJ currently operates seven institutional facilities, including one for females, one for developmentally delayed males, and one for males age 18 or older. The general treatment design is two-tiered. The first tier could best be described as educational in nature and focuses on increasing knowledge about the effects of substance use, the addiction process, the consequences of substance use, impact of substance abuse on the family system, the connection between feelings and behavior, and relapse prevention strategies. This information is delivered in 16 sessions over an eight week period.

The second tier is more therapeutic in approach, is individually tailored, and of about four months duration. The objectives for the second tier typically include achieving insight about one's personal substance abuse history, improving insight about the connection between feelings and behavior, concentrated and personal examination of family issues, and individualized relapse prevention strategies. In addition, depending on individual need, a youth may focus on consequences of dealing drugs, increased understanding of the impact of offenses on victims, and developing positive social skills. For motivated youth with extended lengths of stay, additional services focused on relapse prevention are available. Most of the therapeutic work is accomplished in groups; however individual sessions are available as needed.

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

Beaumont Juvenile Corrections Center

Currently Beaumont has three staff positions and one clinical supervisor designated for substance abuse treatment services. In addition to a general population of males who can access both tiers of service, Beaumont also houses sex offender treatment units, an intensive services unit, and housing units that can access the both tiers of services.

DJJ proposed to create an enhanced therapeutic setting designated for substance abuse treatment services at Beaumont. This program would be focused on specific housing units and would serve to increase the intensity of services available. The development of such a service would require two additional staff.

Bon Air Juvenile Corrections Center

Bon Air houses both males and females and has three positions designated to provide substance abuse treatment services. The services to the male population are the same as those provided at Beaumont. DJJ is proposing a similar plan as proposed at Beaumont to

enhance substance abuse treatment services for boys at Bon Air, to include the addition of two staff designated for substance abuse treatment services.

Services to females at Bon Air are also two-tiered, but include some materials specific for adolescent girls to address gender differences. The second tier is a self-contained program funded with federal grant funds from the Department of Justice. This program, which serves 50 girls per year, is in its sixth year and has been funded for an additional year (FY 2006). Funding for FY 2005 in the amount of $159, 347 was comprised of $39,837 in state General Funds, and $119,510 in federal funds from the Department of Justice. In 2006, state funding will increase to $135,000 and federal funding will decrease to $45,000, for a total of $180,000. This program focuses on the special treatment issues of adolescent girls, and also provides services to address co-occurring mental illness. The mandatory minimum length of stay is six months, with a maximum stay of twelve months. The program includes six groups per week that include an emphasis on education about substance abuse, development of social skills, group therapy and issues specific to adolescent females. Individual counseling is also available. The grant funds two designated positions and state General Funds are used to support one additional position.

Both programs utilize evidence-based practices.

Culpeper Juvenile Corrections Center
This facility has transitioned from all female to all male youth. Currently there are two designated staff for substance abuse treatment services at Culpeper. DJJ plans to develop a 24-bed self-contained program that would provide intensive substance abuse treatment services similar to the female program at Bon Air. In addition, services comparable with those offered to the general population at Beaumont and Bon Air would also be available. Services are also provided to the general population and the sex offender unit. Two additional staff designated for substance abuse treatment services are needed to implement this plan. Individual services would also be provided, when needed.

Hanover Juvenile Corrections Center
Both tier one and tier two services are provided at Hanover, and two staff are designated to provide substance abuse treatment services. Individual services are available when needed. Services are also available to the sex offender unit at Hanover. DJJ plans to create an enhanced therapeutic program that would provide intensive services for specific housing units. At least one designated position is needed at Hanover, with additional positions to be added as the population dictates.

Natural Bridge Juvenile Corrections Center
Both tiers of services are provided at Natural Bridge, and individual services are also available. In addition, an extended relapse prevention program is offered to accommodate the number of youths transferring from other facilities who will enter the community from this facility. There is only one designated staff for substance abuse treatment services at Natural Bridge.

Oak Ridge Juvenile Corrections Center
This center serves males who have developmental disabilities. A general counselor utilizes a curriculum to provide substance abuse treatment services developed for the special needs of these youth.

Department of Corrections

The primary SA treatment modality employed in the DOC is the Therapeutic Community (TC). The TCs utilize the following program actions as appropriate to the individual:

1. Cognitive Behavioral and social learning models
2. Individual and Group Counseling (including MET and CBT)
3. Urine Screen Monitoring
4. GED Program
5. Employment counseling and job placement
6. Health Services
7. Daily Living Skills (banking, parenting, etc.)
8. Mentorship Program
9. Entrepreneurial skills
10. Community Living

Institutional Therapeutic Communities include:
Botetourt Correctional Center – Capacity 176 beds
Indian Creek Correctional Center – Capacity 781 beds
Lawrenceville Correctional Center – Capacity 160 beds *
Virginia Correctional Center for Women – capacity 274 beds
*(Note: this is a voluntary program at this institution)

Transitional Therapeutic Communities:
Bethany Hall – 8 Women
Gemeinschaft Home - 52 men
Hegira House – 15 men and women
Serenity House – 35 men and women
Rubicon – males only
Vanguard – males only

Substance Abuse Services other than Therapeutic Communities are available in many places within the DOC. There are twenty-six (26) Correctional Centers, ten (10) Work Units and four (4) State Prisons within Department of Corrections. Institutional substance abuse programs are offered at all reception centers and most of these institutions.

The substance abuse orientation program is to prepare inmates for participation in substance abuse groups. The program covers group dynamics and the group process. It introduces participants to the concept of the addictive disease process and acquaints participants to the types of programs available within the Department of Corrections and community-based programs to consider when close to release. The program is set into four (4) modules of two (2) hours in length. These can be offered in any time frame that suits the facility. Except for TC, the DOC does not receive funding for substance abuse programs.

Community Corrections:

Substance Abuse Services:

Virginia has implemented a substance abuse screening, assessment, testing and treatment (DSAT) program, for all offenders who committed felony offenses on or after January 1, 2000.

All Probation and Parole districts have memoranda of agreement with respective Community Services Boards (CSB) for treatment services. There are 36 private vendors under contract to provide outpatient or residential services.

The Department of Corrections has developed a network of services to ensure that institutional therapeutic community participants enter residential therapeutic communities followed by Peer Support groups and relapse prevention services upon their return to the community.

Urinalysis is done on a random basis, both on site and with laboratory testing. Hair testing is performed in a many districts as well. More than 3000,000 tests are conducted annually in the district and field offices.

Diversion Center: A 20-week residential program. Offenders reside in the facility. Program staff monitors offenders working in the community at paid jobs and performs random urinalysis testing. Programs provided are employment counseling, substance abuse education, NA/AA meeting groups, basic education/GED, parenting skills, transitional services, domestic violence, and living skills. Court cost and reception will be collected and community service work performed. Offenders have a mandatory one- (1) year Probation Supervision upon release following intensive supervision.

Diversion Centers listings:

Chatham Diversion Center
Chesterfield Diversion Center
Harrisonburg Diversion Center
Stafford Diversion Center
White Post Diversion Center

Detention Centers – A 20-week residential program emphasizing military drill, military discipline strict hygiene and limited privileges. Detainees perform physical labor in organized public works projects/community service projects and at some prison complexes. Detainees participate in random urinalysis, medical, and psychological counseling, breaking barriers, transitional services, substance abuse treatment, Life Skills, GED/ABE classes and are evaluated for therapeutic treatment groups. Mandatory 1 year of probation supervision upon release following initial intensive supervision.

Detention Center Listings:

Appalachian Detention Center
Richmond Women's Detention Center
Southampton Detention Center
White Post Detention Center

Day reporting programs and Drug Courts (DRC)-- Nonresidential program staffed by probation and parole staff. Daily offender contract and monitoring, including random checking on daily itineraries, job interviews, counseling attendance and community service. Offenders are provided intensive substance abuse treatment; aftercare/relapse prevention counseling AA/NA groups, GED/ABE and life skills, job referrals, and vocational services based on offender's needs.

Appendix D

Summary of Agency Priorities (Survey Response)

The same survey instrument that was issued in 2003, with minor adjustments, was issued to ten entities, and all responded. These are: the Department of Education (DOE); the Department of Medical Assistance Services (DMAS); the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); the Department of Health (VDH); the Department of Social Services (DSS); the Department of Criminal Justice Services (DCJS): the Department of Juvenile Justice (DJJ); the Department of Corrections (DOC); the Governor's Office for Substance Abuse Prevention (GOSAP); and the Commission on Virginia Alcohol Safety Action Programs (VASAP). As agency budgets were in formation for submission to the General Assembly, budget information was not updated this year. Of the surveyed entities, only three actually provide treatment services: DMHMRSAS, DJJ and DOC. These agencies responded to additional questions regarding outcome evaluation as reported in Part Two of this report.

I. Needs Assessment

Only the three agencies actually involved in providing treatment for substance use disorders have actually conducted a needs assessment. However, both VDH and DSS routinely screen some of their clients. The three agencies providing treatment services also assess clients. DJJ and DOC operationally directly assess all clients. At DMHMRSAS, screening and assessment are the responsibility of 40 CSBs, and no standardized approach to screening or assessment is required. Adolescents are mentioned as an underserved population by several agencies. DJJ and DOC responded to the survey by updating the 2003 instrument that did not include this item.

1. Does your organization conduct formal or informal needs assessments related to services for substance use disorders? If yes, has your agency used this data in agency planning?		
Secretary of Education		
DOE	No	
Secretary of Health & Human Resources		
DMAS	No	
DMHMRSAS	Yes	Yes, used in agency planning
VDH	No	
DSS	No	
Secretary of Public Safety		
DCJS	No	
DJJ	Yes	Yes, used in agency planning
DOC	Yes	Yes, used in agency planning
GOSAP	No	
Legislative Agencies		
VASAP	No	

2. Does your organization routinely screen some or all clients to determine the need for substance use problem or disorder assessment or treatment? If yes, what screening instrument does your agency use?		
Secretary of Education		
DOE	No	
Secretary of Health & Human Resources		
DMAS	No	
DMHMRSAS	Yes	Clinical interview; each CSB is different. ASI is widely used for adults; DSM IV TR criteria are also widely used.
VDH	Some clients are screened	No instrument listed.
DSS	Some clients are screened	Uniform Assessment Instrument used with Adults Services Clients
Secretary of Public Safety		
DCJS	Not applicable	
DJJ	Yes	SASSI (adolescent version); alcohol and drug portions of the APSI, CAFAS, DSM-IV TR, and clinical interviews
DOC	Yes	SSI in Reception Unit; ASI in institutions.
GOSAP	Not applicable	
Legislative Agencies		
VASAP	Yes	Simple Screening Instrument and Michigan Alcohol Screening Test

3. Please list the three populations needing intervention for substance abuse most underserved by your agency:		
Secretary of Education		
DOE	Not applicable	
Secretary of Health & Human Resources		
DMAS	Not applicable	
DMHMRSAS	1. Adolescents 2. Co-occurring MI/SA 3. Prescription pain medication	1. Beginning Oct 05, agency received a 3-year grant to develop infrastructure support for services for adolescents. 2. Beginning Oct 04, agency received a 3-year grant to develop infrastructure support for services for people with co-occurring mental illness and SA.
VDH	1. Pregnant women, especially homeless 2. Hispanic pregnant women 3. Adolescents	
DSS	1. Adults age 60 and older 2. Adults age 18-59 with disabilities 3. Parents with children under age 18 involved with child welfare services (Child Protective Services & Foster Care); and children and adolescents in foster care.	
Secretary of Public Safety		
DCJS	1. Local probationers supervised by local probation programs 2. Regional jail inmates 3. Local jail inmates	
DJJ	1. Non-committed juvenile offenders needing residential treatment 2. Juvenile offenders needing community-based treatment	
DOC	1. Geriatric inmates 2. Inmates with co-occurring mental illness and substance use disorders 3. Inmates in gangs needing SA treatment	
GOSAP	Not applicable	
Legislative Agencies		
VASAP	1. Repeat DUI offenders (treatment services not available in all areas) 2. Young offenders	

II. Agency/Organization Planning

All three agencies that provide treatment services, as well as GOSAP, address substance use issues in their strategic planning. The three treatment agencies, as well as DSS, also provide staff training about substance use disorders for direct services staff and mid-level supervisory and management staff. At DOC and DJJ, upper level management also receives training. All of the agencies except DOE report significant levels of interagency collaboration focused on the issues of prevention and treatment, with DMHMRSAS or CSBs being the most commonly mentioned.

1. Does your organization's strategic plan address identification, prevention or intervention of substance use problems or disorders in its service populations?		
Secretary of Education		
DOE	No	
Secretary of Health & Human Resources		
DMAS	No	
DMHMRSAS	Yes	
VDH	No	
DSS	No	
Secretary of Public Safety		
DCJS	No	
DJJ	Yes	
DOC	Yes	
GOSAP	Yes	
Legislative Agencies		
VASAP	Yes	

2. Do staff in your organization routinely receive training about substance use disorders related to your service populations?		
Secretary of Education		
DOE	No	
Secretary of Health & Human Resources		
DMAS	No	
DMHMRSAS	Yes	Direct service and mid-level supervisory/management
VDH	No	
DSS	Yes	In adult services, direct service and mid-level supervisory/management staff receive training, which is optional for child welfare staff.
Secretary of Public Safety		
DCJS	No	
DJJ	Yes	Direct service, mid-level supervisory/management and upper level management
DOC	Yes	Direct service, mid-level supervisory/management and upper level management. Direct staff receive training to qualify for state and national certifications
GOSAP	No	
Legislative Agencies		
VASAP	Yes	Direct service, mid-level supervisory/management and upper level management

3. Please list the names of any organizations with which your agency collaborates in the provision of service related to substance use disorders, indicating the level of collaboration using the rating scale provided.

1 = Basic referrals to other agencies/organizations
2 = Collaboration and joint planning with other agencies or organizations on policies, procedures, regulations, interagency case staffing; may required joint or cross training.
3 = Joint program development to create needed, new programs and services.
4 = Organizational infrastructure – written agreements for information sharing, joint management information systems, staff liaison positions, outplacement of staff in another organization.
5 = Creating an interagency forum for collaborative program planning
6 = A state level collaboration.

Secretary of Education		
DOE	NA	
Secretary of Health & Human Resources		
DMAS	DMHMRSAS 2,3,4	
DMHMRSAS	Substance Abuse Services Council 5,6 VCU/Mid-Atlantic Addiction Technology Transfer Center 4 DRS 4 DMAS 2,3,4 DCJS 2,3	
VDH	CSBs 1 or 2 Hospitals 1 or 2 Private physicians 1 or 2	
DSS	DMHMRSAS 3,4,5,6 VDH 2 DMAS 4 GOSAP 6 Prevention Promotion Advisory Council (PPAC) 6	
Secretary of Public Safety		
DCJS	DOC 2,3,6 DJJ 2,3,6 DMHMRSAS 2,3,5,6 Substance Abuse Services Council 5,6 Consortium of Substance Addictions Organizations 5 Local Community Criminal Justice Services Boards 3,4	
DJJ	CSBs 1 DCJS 3 VCU/Mid-ATTC - training Community Programs: private service providers - 1	
DOC	DCJS – 5 DMHMRSAS 6 Blue Ridge Behavioral Health (Hegira) 3* Serenity House 3 Gemeinshchaft Home 3 CSBs 4	
GOSAP	GOSAP Collaborative (12 state agencies and the Virginia National Guard) 6 DOE 6 DMHMRSAS 5 GOSAP Council (locality and community-based SA prevention providers) 5 Substance Abuse Services Council 5 Community Builders Network (SA community-based prevention coalition) 3	
Legislative Agencies		
VASAP	CSBs 1 Licensed Private Treatment Agencies 1 "None for the Road" Agency Partnership 2 Interagency Drug Offender Screening and Assessment Committee 2 DMV Safety Management Systems 2,3	

II. Agency/Organization Trends

Except for DOE, all of the entities reported significant levels of attention to treatment for or prevention of substance use disorders. As strengths, many reported screening activities as well as training and an emphasis on evidence-based practices. All of the treatment agencies mentioned training and treatment practices using science-based models. Several agencies mentioned trends focused on meeting the treatment or prevention needs of adolescents and women with children, as well as persons with co-occurring disorders (MH/SA, MR/SA, physical disabilities/SA) or complex medical problems. Lack of access to treatment, suggesting capacity issues, was a common theme as well. Suggested improvements included better access (expanded capacity, increased resources) for the general communities and criminal justice populations. Collaboration at the state and local level to improve efficient use of resources and continuity of care) was also a common theme. Recommendations to the Governor and the General Assembly included funding to improve access with an emphasis on adolescents treatment services, family systems, and prevention services.

1. Please list the organization's greatest strengths related to providing identification, prevention and or intervention services for individuals with or at risk for substance use problems or disorders.	
Secretary of Education	
DOE	Not applicable
Secretary of Health & Human Resources	
DMAS	Funds SA treatment for pregnant and post partum women; currently improving access to services
DMHMRSAS	1. Prevention services utilizing evidence-based practices are available across the state 2. Some level of treatment available across the state 3. Training in evidence-based treatment practices available across the state
VDH	1. Screening of pregnant women for involvement with substances is a standard of care
DSS	1. Pre-admission screening for nursing and assisted living facility placement; discharge planning teams 2. State and local collaboration with CSBs and DMHMRSAS to improve service delivery for prevention and intervention services 3. Training for SA is an optional class with the Virginia Institute of Social Services Training Activities (VISSTA)
Secretary of Public Safety	
DCJS	Not applicable
DJJ	1. Streamlined assessment process and ongoing staff training programs 2. Substance abuse treatment services are a function of mental health treatment services rather than correctional services 3. Community program staff are knowledgeable about substance abuse and have good relationships with local service providers
DOC	1. Mandated substance abuse treatment provided; treatment model based on research findings 2. Transitional substance abuse services provide continuum of services 3. Staff are trained and credentialed to provide substance abuse treatment
GOSAP	1. Requiring grantees to use evidence-based practices 2. Providing capacity building tools and opportunities (e.g., Community Profile Data Base, website information clearinghouse, KID*Safe* Virginia Conferences) to assist state and local prevention communities' improved prevention practice 3. Facilitating collaboration among state and local prevention-serving agencies
Legislative Agencies	
VASAP	1. Screening and classification of offenders 2. Alcohol and drug education/public information and prevention 3. Treatment referral services/probation monitoring

2. Please list the three most important trends or issues related to meeting the identification, prevention and/or intervention needs related to substance use problems or disorders in the populations served by your organization (examples: increased severity of drug abuse/dependence; changes in ages of clients; special cultural issues; special medical issues; drugs of abuse). Recommendations to the Governor and General Assembly focused on prevention, evidence-based practices		
Secretary of Education		
DOE	Not applicable	
Secretary of Health & Human Resources		
DMAS	1. Identifying pregnant women with substance abuse treatment needs 2. Improving access to services 3. Special medical needs of pregnant women	
DMHMRSAS	1. High proportion of population served has co-occurring mental illness and substance use disorder 2. Increasingly complex cultural issues, in both rural and urban areas 3. Capacity is increasingly constricted due to level funding over a period of several years.	
VDH	1. Lack of treatment resources, especially for women with children 2. Cultural issues relating to acceptable treatment for immigrant populations 3. Lack of treatment resources for teens and children	
DSS	1. Aging issues, including self-neglect, abuse and exploitation 2. Dual diagnosis; MH/MR/Elderly and substance abuse 3. Increase in meth[amphetamine] manufacturing, increase in use and abuse resulting in CPS and Foster Care intervention; and the lack of access to substance abuse services in local areas.	
Secretary of Public Safety		
DCJS	1. Decrease in General Funds and Federal Funds 2. Lack of rehabilitation and treatment services for SA offenders 3. Lack of strong Code structure to support ongoing funding of substance abuse treatment	
DJJ	1. Number of youth requiring substance abuse treatment services continues to rise in institutions; community also notes high correlation between substance use and juvenile offending 2. Developing treatment programs which will coordinate with length of commitment for committed youth 3. Developing treatment programs in institutions for a wide scope of juvenile population (i.e., gender, age, developmental level, range of substances used, cultural background, geographic influences, etc.)	
DOC	1. [Need] services for people with co-occurring mental health [problems] and substance abuse 2. Collaborative efforts between DOC medical department, CVU and DVH related to HIV and Hepatitis C [concerning] seamless discharge for medical services 3. [Need to] acknowledge and address special population issues, i.e., youthful offenders, co-occurring MH/SA, geriatric women, people with physical challenges, gang activities/groups, and multi-cultural issues.	
GOSAP	1. Reductions, real and threatened, in funding for substance abuse prevention programs and services 2. Scant understanding of prevention efforts among parents, policymakers and the general public regarding the efficacy of theory-based planning, model implementation, data assessment, use of evidence-based programs/practices, and evaluating outcomes – the fundamentals of effective prevention efforts 3. [In]Sufficient resources for widespread coverage throughout the Commonwealth.	
Legislative Agencies		
VASAP	1. Repeat DUI offenders 2. Increases in the numbers of clients classified as needing treatment 3. Incidences of young offenders (persons charged with underage possession of alcohol) classified as needing treatment.	

3. How can your agency strengthen services in order to have the greatest impact on the community?		
Secretary of Education		
DOE	No answer	
Secretary of Health & Human Resources		
DMAS	Improve access by changing service limits	
DMHMRSAS	1. Continue emphasis on training in evidence-based practices for prevention and clinical services 2. Establish clinical benchmarks for quality delivery of substance abuse treatment services to assure quality 3. Provide training in clinical supervision and/or treatment of substance use disorders for clinical supervisors in CSBs	
VDH	1. Collaborate at both state and local level to develop additional resources 2. Adopt standardized screening tool and provide training to health care providers	
DSS	1. More resources to provide more services & appropriate placements for the elderly and for adults with disabilities 2. Expand and enhance primary prevention programs 3. Encourage collaboration at the state and local levels to improve services	
Secretary of Public Safety		
DCJS	1. Additional funding 2. Increase planning, research and analysis of substance abuse service needs in the criminal justice system 3. Develop more specialty plans and evaluations on criminal justice trends to identify issues in offender rehabilitation	
DJJ	1. Community programs – reinstitute resources for screening/assessment/treatment activities in court services units 2. Improve continuity of services between JCCs and CSUs (parole) 3. Continue to develop state of the art treatment services, continue staff development, and continue to stay abreast of research in the field 4. Develop collaborative post-release aftercare substance abuse services.	
DOC	1. Develop additional transitional resources; collaborate closely with service providers 2. Need additional funding for SA treatment programs in institutions, in addition to transitional programs. 3. Need funding for additional specialized SA treatment staff for institutions.	
GOSAP	1. Continue to facilitate the coordination and collaboration of state and local agencies 2. Expand the use of outcome-based evaluation through capacity building among providers 3. Complete implementation and planned enhancements to the Community Profile Data Base.	
Legislative Agencies		
VASAP	1. Being consistently updated on available substance abuse treatment services 2. Increase resources and availability of substance abuse treatment services in rural communities.	

4. What top three recommendations would you make to the Governor and General Assembly to strengthen the quality of community life in regards to prevention or intervention in substance abuse problems or disorders?		
Secretary of Education		
DOE	No Answer	
Secretary of Health & Human Resources		
DMAS	Focus on prevention	
DMHMRSAS	1. Appropriate General Funds specifically for implementation of evidence-based practices in community prevention. 2. Appropriate General Funds specifically for implementation of evidence-based practices in community-based treatment services. 3. Appropriate General Funds specifically for implementation of evidence-based practices in jail-based treatment services.	
VDH	1. Provide more treatment resources for pregnant women and adolescents 2. Expand Project Link (a model for serving pregnant women based on a high degree of interagency collaboration, currently funded by DMHMRSAS) 3. Focus prevention efforts on youth.	
DSS	1. Fund primary prevention programs that promote healthy child development and promote resiliency factors in children 2. Fund substance abuse prevention programs for children and adults including geriatric adults and a coordinated response 3. The Governor should champion prevention programs for the citizens of Virginia	
Secretary of Public Safety		
DCJS	1. More planning and program development at regional and local jails 2. More General Funds to DCJS for "best practice" rehabilitation programs in corrections, generally 3. Increase General Funds available to replace federal funding decreases in "best practice" treatment programs	
DJJ	1. For community-base services, provide more treatment services for adolescents, and require CSBs to prioritize treatment for adolescents; 2. For institutions, return SABRE (Substance Abuse Rehabilitation and Education) funds to create enhanced treatment and transitional services; enhance community support programs for recovering persons 3. For institutions, enhance early intervention and prevention programming; require publicly funded CSBs to use more effective, evidence-based treatment services for adolescents.	
DOC	1. Create effective pathways for inmates transitioning into society by establishing a "single point of contact" concept, ensuring access to ancillary services 2. Strengthen family systems through promoting family involvement in the treatment process; increase parenting skills of inmates returning home to children who are at high-risk for drug and criminal activity 3. Emphasize prevention and early intervention services that are proven effective	
GOSAP	Not applicable – GOSAP is part of the Governor's Office.	
Legislative Agencies		
VASAP	1. Readily available access to substance abuse treatment services 2. Increase resources and availability of substance abuse treatment services in rural communities.	