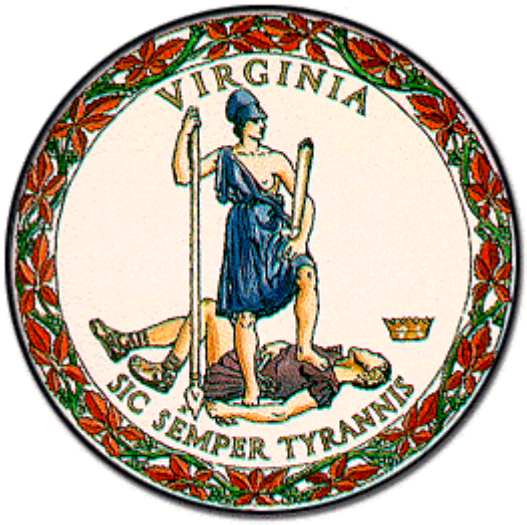
SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

TO THE GOVERNOR
AND THE GENERAL ASSEMBLY OF VIRGINIA



COMMONWEALTH OF VIRGINIA
December 31, 2004

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Substance Abuse Services Council

James C. May, Ph.D.
Chairman

P. O. Box 1797
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December 2004

TO: The Honorable Mark R. Warner
Members of the General Assembly

FROM: James C. May, Ph.D.

IN RE: **2004 Annual Report and Comprehensive Interagency State Plan for Substance Abuse Services**

As chair of the Council, it has been my personal pleasure and professional privilege to work with some wonderful addiction and recovery experts on the completion of this report. Most of the appointed members to this Council found ways to manage their already busy schedules to participate and contribute to this Council's discussion and deliberations. For that, I would like to personally thank all of the members for their hard work and helpful recommendations.

Most of us know or are aware of someone – a friend, a relative or a co-worker – who suffers or has suffered from an addictive disorder. Some of us know people who are addicted but have not been treated; others know people who were treated, voluntarily or otherwise. We probably feel comfortable talking about those who remain actively addicted to nicotine, and perhaps comfortable talking about people who are addicted to alcohol, but would deny knowing anyone, or feel uncomfortable talking about someone we know who is addicted to other drugs. Because of the *stigma* associated with addiction, most people who are addicted try to hide their use and deny their addictions, and even people in recovery tend to remain anonymous. Media images tend to focus on people whose addiction has resulted in serious trouble within one or more of our social or criminal justice systems. Rarely do the media portray an addict as someone in stable recovery who works and pays taxes. Most Virginians cannot, therefore, fully appreciate the message of hope that recovery from alcohol and other drug addiction is possible, and that treatment was the first step in the process for most people in recovery. Unfortunately, it has become more difficult to access treatment for addiction in Virginia, and recovery is becoming a more distant hope for those who still need treatment.

Virginia needs to strengthen its existing treatment infrastructure, expand the types of addiction treatment services available, and increase the prevention and treatment capacity in our communities. We need a broader prevention effort to reduce future demands upon our health care, social services and criminal justice systems, and an enhanced treatment effort to interrupt existing, multi-generational cycles of addiction. We must better evaluate the services we currently provide, recognizing that this process will require significant resources that are not currently available. Meanwhile, it is critical that we recognize that the cost effectiveness of both the prevention and treatment of addictive disorders has already been demonstrated. The burden created by failing to prevent or treat these disorders is far greater than the cost of funding prevention, treatment and evaluation. Let us all commit to using our limited resources most wisely. Let us start a new effort to treat those in need instead of continuing to dedicate resources to bearing the burden of not preventing and treating addiction. Our challenge today is to make treatment, prevention and recovery opportunities more accessible to more Virginians. I believe this report opens the door for that process to begin. I invite you to join us in making it happen.

Preface

The Substance Abuse Services Council is established by the *Code* of Virginia § 37.1-207 to advise and make recommendations to the Governor, the General Assembly, and the Board of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services on broad policies and goals and on the coordination of the Commonwealth's public and private efforts to control alcohol and other drug abuse. The membership of the Council is established by the *Code*, and the current and recent past members of the Council are listed in Appendix B of this report. In carrying out these duties, the *Code* specifies that the Council is "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." The *Code* also directs the Council to make an annual report with recommendations. This document addresses both of these requirements.

The *Code* directs that the Office of Substance Abuse Services in the Department of Mental Health, Mental Retardation and Substance Abuse Services should provide staff to the Council. Under the direction of Ken Batten, Director of the Office of Substance Abuse Services, Mary Shawver, Mellie Randall, Lisa Street and Lynette Bowser contributed to fulfilling this staff function, with assistance from other colleagues in the Office. In addition, under the direction of Dr. Jim May, the Council Chair, Ernestine Joyner and Verna Barlow of the Richmond Behavioral Health Authority also provided logistical support for the Council's meetings.

Many people contributed to the development of this report, which was based on a survey conducted by the Council, the *Survey of State Agencies and Organizations Concerning Services for Prevention or Treatment of Substance Use Disorders*, and information collected in five regional focus groups during the Summer of 2003. Survey respondents include: Walter A. McFarlane, Correctional Education (DCE); Donna P. Whitney, Health Professions (DHP); W. Stephen Pullen, Juvenile Justice (DJJ); H. Scott Richeson, Corrections (DOC); Catherine Hancock, Medical Assistance Services (DMAS); Cynthia A. Vernacchia, State Police (DSP); Marilyn Harris, Governor's Office for Substance Abuse Prevention (GOSAP); Joan Corder-Mabe, Health (VDH); and Barbara Cotter, Social Services (DSS). Participants in the five focus groups conducted by the Council include: Anthony Bailey, Nathan Barge, Ken Barter, Mindy Beam, Chris Boyd, Roberta Boyd, Wendy Brooks, Joe Bullock, Gail Burruss, Linda Carr, Earl Clarke, Anthony Crisp, Anna Csaky-Chase, Phil Erickson, Judge Anne Holton, Linda P. Hopkins, Cara Jackson, Wes Jordan, Diana Keegan, Teresa Layne, Charles D. Logan, Patty McGrath, John Meyer, Jr., Chuck Moore, Kris Payne, Anna Powers, Joan Rodgers, Robert Schon, Joe Scislowicz, Mark Seymour, Jeffrey Shelton, Keith Papp Shuster, J. Thomas Treece, Richard Woodard, and Laura Yager.

The Council also received critical information during its meetings from the following individuals, who took the time to prepare interesting and informative presentations and discuss them with the Council: Gaynelle Whitlock, Ed.D., Chair, Prevention and Promotion Advisory Council; Myra Shook, Safe and Drug Free Schools and Communities Program; Marilyn Harris, Executive Director, GOSAP; Morris Henderson, D.Min., Assistant Pastor, 31st Street Baptist Church, Prevention and the Faith Community; Greg Brittingham, Governor Warner's DUI Task Force; Kevin Doyle, Ed.D., LPC, LSATP, and Maeve O'Neill, Vanguard Services Unlimited,

Substance Abuse Treatment for Adolescents; Brian L. Meyer, Ph.D., Executive Director, Virginia Treatment Center for Children; Susan Rook, Addiction and Recovery in the Media; Steven J. Ashby, Ph.D., Executive Director of Richmond Behavioral Health Authority; and Robert L. Johnson, (now former) Director, Office of Substance Abuse Services, DMHMRSAS.

Finally, the Council wishes to recognize Governor Mark R. Warner for demonstrating his intent to enhance substance use disorder education, prevention, intervention and treatment throughout the Commonwealth by revitalizing this Council. The Commonwealth of Virginia is fortunate to have leadership that recognizes the importance of these issues. The reconstituted Substance Abuse Services Council is working to meet its charge of advising and making recommendations to the Governor and the General Assembly on the coordination of the Commonwealth's public and private efforts to reduce alcohol and other drug abuse and addiction in our communities. This report is the first product of those efforts.

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Executive Summary

Virginians, like other Americans, are seriously affected by abuse of and dependence on alcohol and other drugs. Based on national estimates, 544,608 Virginians aged 12 or older meet criteria for a substance abuse disorder or substance dependence, but only 5.5% received treatment. [1] Substance use and misuse is a serious problem among Virginia's youth. According to the Virginia Community Youth Survey conducted in 2000, more than half of Virginia high school seniors reported recent use of alcohol, more than one-third report smoking cigarettes, and nearly as many reported using marijuana. These facts have an impact on the economy, health, welfare and personal safety of all Virginians.

Providing treatment, however, is highly cost-effective. Studies done in other states demonstrate significant cost savings in health, welfare and criminal justice systems, ranging from $5 to $7 for every $1 spent on treatment. Similarly, the cost of not treating substance use disorders also costs the Commonwealth money. A national study that utilized state budget information determined that the cost of untreated substance abuse in Virginia exceeded $1.7 billion, or approximately $260 per person per year. In contrast, only $4.20 is spent on treatment, prevention and research. In 2004, Virginia spent slightly more than $150,000,000 to treat substance abuse, including federal resources.

Modern medical technology has facilitated considerable advances in knowledge about the nature of addiction, specifically, the mechanisms of addiction in the brain. The scientific evidence overwhelmingly supports the conclusion that addiction is a brain disease with considerable psychological, biological and social consequences. Like many other chronic and disabling diseases, substance use disorders have strong genetic components that put whole families at risk.

These advances have also provided scientific knowledge about what treatment works. Researchers consistently agree that the complex nature of substance use disorders requires that treatment be individually tailored to meet the specific and unique needs of each individual. Medical, psychological, social, vocational and legal issues must be assessed, and treatment must be designed to help the individual address these issues. For some, pharmacological interventions are critical, in addition to specific types of psychological counseling and social supports. Others may need an intensive psychological approach with concrete supports, such as childcare and assistance with housing or transportation. Most will need multiple episodes of treatment, and support services to sustain recovery. In addition, people in recovery need advocacy and support to help them overcome the shame and fear associated with these disorders.

In addition to national data, the findings of this report relied on survey data collected from key state agencies and focus groups conducted throughout the Commonwealth. The overarching issue raised is the lack of capacity for treatment, both in the public and private sectors. Unstable funding and lack of insurance coverage for treatment have exacerbated the capacity issue. Recent reductions in General Fund spending on substance abuse treatment have been estimated

[1] Substance Abuse and Mental Health Services Administration, 2002

to exceed $28,000,000, resulting in a lack of access to treatment for the general public as well as special populations, such as offenders and youth.

One option that has been the subject of considerable study is the use of Medicaid to support treatment services. The advantage of using Medicaid is that the federal government will match dollar for dollar the nonfederal funds that are expended for approved health services, including substance abuse treatment. Although a relatively small proportion of those receiving treatment qualifies for Medicaid, use of these funds would permit existing resources to be used to expand the treatment system. A recent study estimated that the entire array of services could be available to every Medicaid eligible person who needed them for less than $6,000,000 per year in General Funds.

Another potential resource is improved use of private health insurance. Currently many private insurers place unrealistic restrictions on duration of treatment, or reimbursement rates are too low to cover actual costs. The impact is that these individuals turn to public sector services, resulting in an additional burden to the taxpayer and further crowding an already overloaded public system.

Substance abuse and dependence are obviously harmful to families. Parental substance abuse accounts for at least one-third of all children in Virginia's foster care system. In addition to the obvious personal damage to the child, the cost to Virginia taxpayers is significant.

In addition, these children are at serious risk of developing addiction themselves. Among Virginia's youth in general, a recent survey indicated that children begin using tobacco at age 12, followed soon after by marijuana. Yet, nearly 50,000 Virginians between the ages of 12 and 25 need treatment every year but don't receive it, due to lack of treatment capacity.

Just as in the treatment realm, knowledge about effective prevention services is increasingly sophisticated. Youth who do not use tobacco, alcohol or other drugs before the age of 21 are virtually inoculated against addiction as adults. Yet all current prevention programs are funded by either federal funds or local dollars; no General Funds are designated for prevention efforts.

In the criminal justice system, over half of adult felons screened warranted additional assessment and of those, over 85% needed treatment. The Department of Corrections reports that more than three-fourths of its inmates report the use of alcohol and other drugs, and the Department of Juvenile Justice reports that 64% of youth in its custody require treatment. Meanwhile, Virginia's prison population may reach nearly 45,000 by 2009, with the majority of inmates needing treatment. An obvious approach, substantiated by research, is to provide treatment to those under supervision, including community diversion programs (such as drug courts), service while in custody, and supervised aftercare programs. Yet the previously discussed budget constraints have seriously impacted the availability of services for this population.
In addition, there is a growing awareness among treatment professionals that many people who abuse or who are dependent upon alcohol and other drugs are also suffering from some form of mental illness. Similarly, between 40 to 60 % of those suffering from severe mental illness are abusing alcohol or other drugs, compromising their ability to live stable lives. In order for the person to recover from either disorder, he or she must be treated for both. Unfortunately, few

mental health professionals are trained to recognize or treat substance use disorders, and few addiction treatment professionals are knowledgeable about mental illness. In addition, funding streams for mental illness and addiction are quite distinct from one another, even though both are brain diseases. The net result is that there are few programs providing integrated treatment for mental illness and substance use disorders. The impact is that people with co-occurring mental illness and substance use disorders have considerable difficulty accessing the specialized types of care needed to achieve sober, stable lives.

Underscoring all of these issues is the growing awareness that suffering from an addiction is terribly stigmatizing. Although many people successfully recover, fear of job loss, social humiliation and loss of friends keeps them from sharing their recovery stories to educate and inspire others, as they would if they were recovering from another disease, such as cancer or heart disease. And they are almost never celebrated in a manner similar to those who recover from other relapsing diseases.

These findings resulted in the development of six major recommendations, which are detailed in the Recommendations section of this report. These six recommendations are summarized as follows:

RECOMMENDATION 1:

Expand capacity for the treatment of substance use disorders for all citizens in need of those services throughout the Commonwealth.

Action steps for this recommendation focus on obtaining $5.8 million in General Funds beginning in 2006 to match Medicaid funding to support reimbursement of the full range of treatment services for the entire eligible population; addition of a representative from the Department of Medical Assistance Services to the Council; reinvestment of funds to support community-based substance abuse services; and a study of insurance coverage for substance abuse treatment, to be conducted by the Council.

RECOMMENDATION 2:

Expand the scope of substance use disorder prevention activities for youth and families of Virginia.

Action steps for this recommendation include raising user fees on tobacco products as a source of revenue for prevention programs; sponsorship of a summit on underage drinking; adding representatives from four (4) agencies and organizations (Department of Alcoholic Beverage Control, Department of Motor Vehicles, Governor's Office for Substance Abuse Prevention, and the Virginia Tobacco Settlement Foundation) to Council membership; and integration of the Governor's Office for Substance Abuse Prevention *"Substance Abuse Prevention Plan for Virginia's Youth: Gaining Traction"* into the Council's plan; integration of assigned tasks of the *Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol* into the Council's plan.

RECOMMENDATION 3:

Expand the availability of substance use disorder treatment for youth and families throughout the Commonwealth.

Action steps for this recommendation include seeking funding for Family Drug Courts from the General Assembly; evaluating and identifying model programs; identifying funding to support treatment for youth; and collaboration with the Department of Social Services to identify screening tools and training for child welfare services staff.

RECOMMENDATION 4:

Expand treatment opportunities for adults in the criminal justice system, both within institutions and in community-based settings.

Action steps include seeking funding from the General Assembly to support services, community-based and institutional, for offenders with substance-use related problems, including drug courts; and the addition of a representative of the Virginia Drug Court Association to the membership of the Council.

RECOMMENDATION 5:

Advocate and market recovery from substance use disorders and reduce stigma throughout the Commonwealth.

Action steps include collaboration with the Substance Abuse and Addiction Recovery Alliance (SAARA) to educate the public about addiction, treatment efficacy, recovery, and recovery-related economic benefits for the community; development of a campaign to emphasize that "Recovery Works"; and involvement of public officials throughout the Commonwealth in training about addiction, treatment and recovery.

RECOMMENDATION 6:

Improve the quality and effectiveness of existing services.

Action steps address the development of standards; implementation of requirements set-forth in § 37.1-207.1, which requires the Council to assess the capacity of state agencies to evaluate publicly-funded treatment services; close collaboration with the Commission on Virginia Alcohol Safety Action Programs to standardize and improve the quality of local services; and expansion of professional staff training opportunities and treatment services for people with both mental illness and substance use disorders.

Introduction

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2002, nearly 22 million (9.4%) persons 12 years of age and older in the United States were classified as experiencing substance dependence or substance abuse disorders (SAMHSA, 2003). In 2002, an estimated 19.5 million Americans (8.3 % of the population aged 12 or older) had used an illicit drug in the past month, and more than a fifth (22.9 %) participated in binge drinking in the past 30 days (defined as drinking 5 or more drinks on the same occasion on at least one day in the 30 days prior to the survey). These national figures come from the *National Survey on Drug Use and Health* (NSDUH), the primary source of statistical information on the use of illicit drugs by the U.S. civilian population (Wright, 2004). The NSDUH also provides the same information for each state, estimating the prevalence of illegal substance use and substance use disorders, as well as the need for treatment for substance use disorders at the state level. As this report is being written, state-specific information is not yet available from the 2003 survey. However, according to the 2002 report, over half a million – an estimated 544,608 – Virginians aged 12 or older were classified with substance dependence or substance abuse disorders, when both alcohol and illicit drug use disorders were included (SAMHSA, 2004). Nationally, only 18.2 % of people needing treatment for an illicit drug use disorder, and only 8.3% of people needing treatment for an alcohol use disorder actually received treatment for their substance use disorders (SAMHSA, 2003). Closer to home, only 5.5% of Virginians who needed treatment for illicit drug dependence or abuse disorders actually received treatment for their disorders (SAMHSA, 2002).

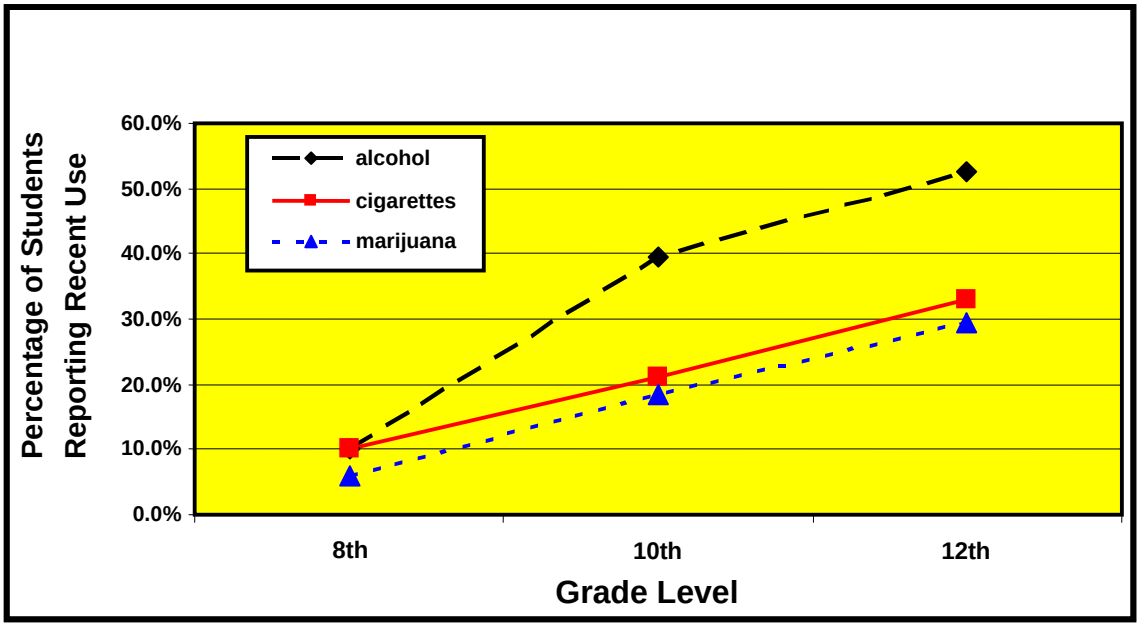
In 2001, more than 92,000 Virginians were addicted to or abusing illicit drugs (i.e., not including alcohol), but fewer than 5,000 of those Virginians who needed treatment for their illicit substance use disorders received the treatment they needed.

-- SAMHSA, 2002

As this report will illustrate, these surveys, statistics, and prevalence estimates are more than numbers. They are indicators of a pervasive societal problem – the use of illicit substances, the misuse of legal substances and addiction – that negatively affects the lives of virtually every citizen of the Commonwealth. For example, SAMHSA has determined that 8% of full-time workers are current users of illicit drugs, and that 10.6 % of full-time employed adults are classified with substance dependence or substance use disorders. Employees who use drugs or abuse alcohol take more sick leave, have more workplace accidents, file more worker's compensation claims, and are more likely to suffer from injuries, hypertension, and mental disorders. The majority of illicit drug users in Virginia are adults who are employed full time.

Substance use and misuse remains a serious problem among Virginia's youth. CSR, Incorporated, under a federally funded contract with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), recently conducted a survey to determine the prevalence of substance use and the need for treatment among young people (CSR, Incorporated, 2001).

Figure 1: Selected Drug Use by Drug Type in Virginia's High Schools



The Virginia Community Youth Survey 2000 found that:

- More than one out of ten 8th graders, almost four out of ten 10th graders and more than half of 12th graders reported recent use of alcohol.
- More than one out of ten 8th graders, more than one out of five 10th graders, and more than one out of three 12th graders reported recent use of cigarettes.
- One out of seventeen 8th graders, almost two out of ten 10th graders, and almost three out of ten 12th graders reported recent use of marijuana (See Figure 1).

The previously described NSDUH report also indicated how many people who are in need of treatment for their substance use disorders are ***not*** receiving treatment services. This provides one indicator of Virginia's capacity, or lack thereof, for providing substance use disorders treatment services. While there are many Virginians who need but will not receive treatment for substance use disorders, the problems in accessing needed treatment appear to be much worse for Virginia's youth than for adults. For Virginia, the NSDUH (2002) reported that:

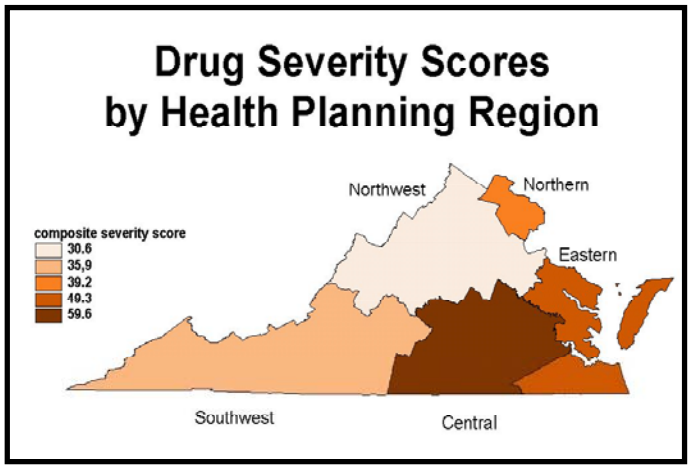
The percentage of adolescents needing but not receiving treatment is more than four times that of adults over age 25.

-- SAMHSA, 2002

- There were 87,768 persons, aged 12 or older, who needed treatment in the past year but did not receive it.
- There were 19,913 youth aged 12-17 years, 30,225 young adults aged 18-25 years, and 37,630 persons aged 26 or older who needed treatment last year but did not receive it.

DMHMRSAS has also commissioned studies to document the need for treatment for substance use disorders at the regional level. A social indicator study, conducted in 2002, compiled and compared drug and alcohol abuse-related crime and mortality data for each city and county (Dembling and Kurtz, 2003). As can be seen in Figure 2, the need for drug treatment is greater in the central part of the state, while the need for alcohol treatment is most evident in the southwestern portion of the state (Figure 3).

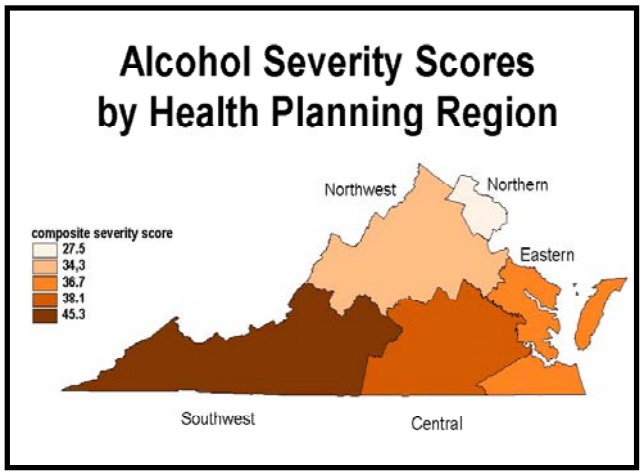
Figure 2: Drug Severity Scores by Health Planning Region (HPR)



Contrary to the images sometimes conjured up in response to political rhetoric, or common portrayals of substance abuse and addiction in the media, alcohol clearly stands out as the drug which is causing the most people the greatest number of problems, across all age groups. Information derived from the Dembling & Kurtz study, the NHSDUH survey, as well as Virginia's arrest and mortality statistics shows that alcohol-related problems far exceed those for other drugs in Virginia. Alcohol arrests outnumber drug arrests four to one; alcohol deaths outnumber drug deaths by two to one; and alcohol abuse exceeds other drug abuse by more than two to one.

The Substance Abuse Services Council is committed to involving the widest possible range of stakeholders in the development of its reports, recommendations, and plans. For this report, the Council used two primary methods of gathering information from key stakeholders throughout the Commonwealth. First, the Council surveyed state agencies and organizations regarding their relevant needs, programs, services, and recommendations for the future. The Council then conducted five regional focus groups to elicit even broader and richer stakeholder input.

Figure 3: Alcohol Severity Scores by HPR



In June 2003, the *Survey of State Agencies and Organizations Concerning Services for Prevention or Treatment of Substance Use Disorders* was distributed to 23 potentially relevant state agencies and five other statewide organizations. Sixteen (16) agencies under the Secretariats of Commerce and Trade, Education, Health and Human Resources, and Public Safety responded to the survey, reflecting both the widespread impact of this problem, as well as how broadly funds for substance abuse services are allocated across state government. The

survey instrument and a detailed summary of survey responses are included in this report as Appendix D.

Regional focus groups were conducted in July 2003 in Fairfax, Richmond, Wytheville, Harrisonburg, and Newport News. Each focus group was facilitated by Council staff as well as the Council Chair or a Council member living in that region. A broad range of individuals attended and participated in each group, including representatives from the private sector, education, advocacy groups, prevention services, treatment programs, law enforcement, the judiciary, and other federal, state and local agencies and organizations. The agenda for the focus groups, a list of participants, and a detailed summary of the issues raised by the participants appear in this report as Appendix E.

The Economics of Addiction

Recent studies have consistently demonstrated that treating substance use disorders is highly cost-effective. A number of states have conducted cost-benefit analyses of treatment for substance use disorders. These analyses typically focus on the impact of substance use disorder treatment on other health care costs or costs incurred within other systems, such as the criminal justice system. Specifically, these studies seek to determine if there is a cost reduction or "offset" associated with treatment and, if so, how much of these other costs is saved as a result of treatment. Untreated substance abuse increases not only the costs within a state's criminal justice system, but also elementary and secondary schools, Medicaid, child welfare, juvenile justice, mental health, highways, and state payrolls. Figure 4 displays some of the critical findings of these studies.

The National Opinion Research Center conducted a study for the State of California that examined a wide array of effectiveness measures, including reduced use of alcohol and other drugs and criminal activity (Gerstein et al, 1994). This was a point-in-time study that used outcome measures of post-treatment effects (data collected at an average of 15 months post-discharge) for 1,900 persons in treatment. This study revealed that seven dollars were saved for every dollar spent on treatment.

Figure 4: Providing Treatment for Substance Use Disorders Saves Money

Washington State	**→**	**$2,200 saved in Medicaid costs per person treated**
Washington State	**→**	**$252.00 saved *per month* for each person treated**
Oregon	**→**	**$5.00 saved for every $1.00 spent**
California	**→**	**$7.00 saved for every $1.00 spent**
CSAT (National)	**→**	**$4.00 saved for every $1.00 spent**

The State of Oregon also conducted a point-in-time cost benefit analysis of 1,100 adults using existing state databases to measure treatment outcomes (Finigan, 1996). These existing data systems included information on treatment monitoring, law enforcement, offender profiles, social services, and Medicaid utilization. Investigators reviewed data on each participant two years prior to treatment and three years post-treatment. This study's authors concluded that five dollars were saved for every one dollar spent on treatment.

Washington State has commissioned a number of studies related to the cost effectiveness of substance abuse treatment. One study compared Medicaid medical costs of 344 persons who received publicly-funded treatment to a similar group who were eligible to receive treatment but did not. The study tracked Medicaid costs for five years after treatment and found that treated persons, on average, cost $4,500 less than untreated persons, compared to an average cost of substance abuse treatment of $2,300. This positive effect was largest for persons who had Medicaid medical expenses prior to treatment ($7,900 less) (Albert, 2002).

Washington State is also currently conducting a Supplemental Security Income (SSI) Cost Offset Pilot Project (Estee and Nordlund, 2003) According to its recent interim report, 16% of adults receiving SSI between 1997 and 2001 were identified as having a need for substance abuse disorder treatment. Numerous health care cost offsets were identified. Among those savings accrued for those who had ***entered*** treatment compared to those who ***remained untreated*** were:

- ***Lower medical costs.*** One of the largest benefits found to accrue for those who had received treatment for an addictive disorder, reduced medical costs accumulated at a rate of $311 in savings per treated client per month.
- ***Lower state hospital expenses.*** Persons treated for substance use disorders incurred lower state hospital expenses, with savings accumulating at a rate of $48 per client per month.
- ***Lower community psychiatric hospital costs.*** The reduced psychiatric costs accumulated at a rate of $16 in savings per client per month. These savings were essentially "traded" for somewhat higher costs in community outpatient mental health services, where the treated group incurred additional costs of $17 per client per month.
- ***Lower nursing home care costs.*** Persons treated for substance use disorders incurred lower nursing home expenses, an expense increasingly paid for with tax dollars, with savings accumulating at a rate of $56 per client per month.

Additional savings or cost offsets were identified within the criminal justice arena. Among the societal savings accrued within the criminal justice system as a result of people ***entering*** treatment for their substance use disorders, compared to those who ***remained untreated*****,** are the following:

- ***Decreased numbers of arrests.*** People who had entered treatment demonstrated a reduced probability of subsequent arrest of 16% compared to those who had not entered treatment.
- ***Reduced numbers of convictions for any offense.*** People who had entered treatment for their substance use disorders were 15% less likely to be convicted for any subsequent offense.
- ***Reduced likelihood of felony convictions.*** For people who entered treatment, the likelihood of incurring any subsequent felony convictions was reduced by 34%.

For those who remained in treatment at least 90 days, or who completed their prescribed treatment episode, the cost savings and reductions were even higher. The 2003 Interim Report from the Washington state study indicates a total cost offset of medical care, state and community psychiatric hospitalizations, and long-term care relative to the cost for providing at least 90 days of treatment for substance use disorders of $252 per treated person *per month*. The report estimates that if an additional 30% of the 10,572 untreated SSI clients in Washington who are in need of treatment got it, the annual cost savings could amount to nearly $10 million.

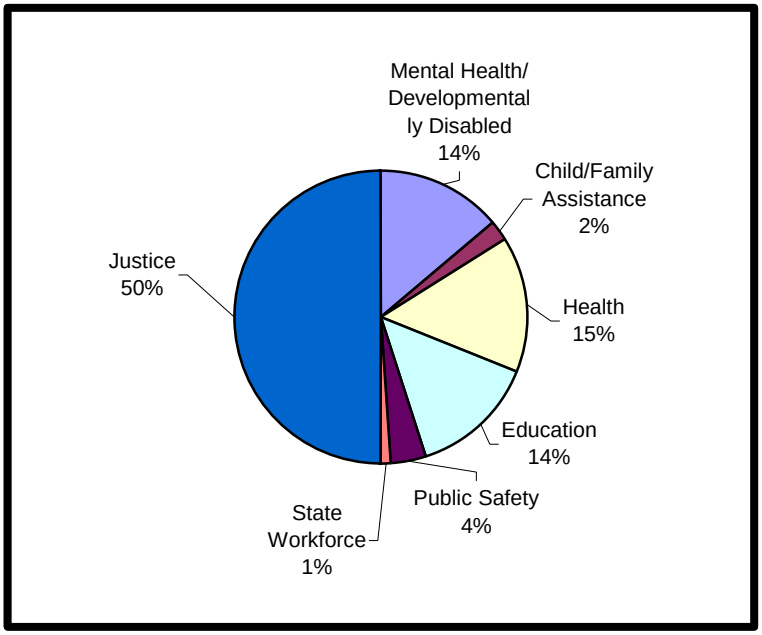
The federal Center for Substance Abuse Treatment (CSAT) recently sponsored a cost benefit study using national data (Koenig et al, 1999). The investigators in this study reviewed

information from over 5,000 clients participating in treatment at 72 programs across the country that were part of the National Treatment Improvement Evaluation Study. Costs associated with health, welfare benefits, criminal activity, and employment income were tracked for the year prior to treatment and for the year following treatment. On average, the authors of this study found that for every dollar spent on treatment, more than four dollars were saved.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University analyzed the 1998 budgets for 45 states, the District of Columbia and Puerto Rico in an unprecedented attempt to understand the impact of substance use disorders on program costs for 16 budget categories. These included programs in health, social service, criminal justice, education, mental health, and those for people who are developmentally disabled, as illustrated in Figure 5. In its report, *Shoveling Up: The Impact of Substance Abuse on State Budgets* (CASA, 2001), for which the CASA reportedly used the most conservative assumptions about the burden substance use disorders place on state budgets, the authors reached some very consistent and striking conclusions:

- Of the $620 billion grand total states' expenditures for that year, $81.3 billion, or 13.1%, were spent to deal with substance use disorders.
- For every one of these $81.3 billion dollars the states spent related to substance abuse, 96 cents went to "shoveling up the wreckage" of substance abuse and addiction, while only four (4) cents were used to prevent and treat it.
- On average, the states spend 113 times as much to clean up the devastation substance abuse and addiction visit upon children as they do to prevent and treat it in children.

Figure 5: "Shoveling Up" the Burden of Substance Abuse in Virginia

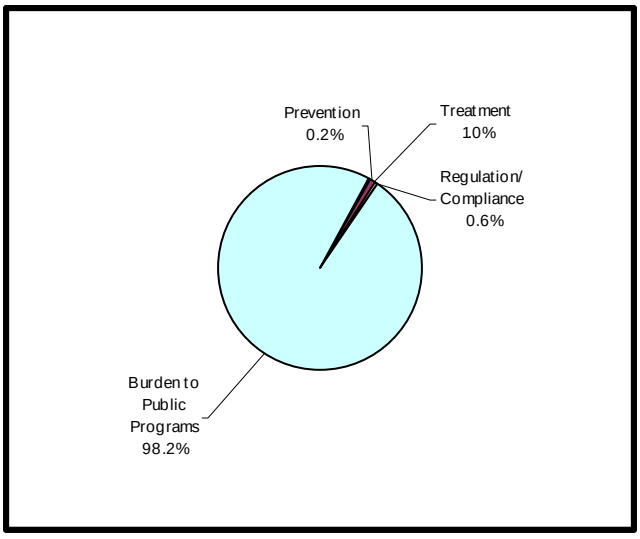


- Each American paid $277 per year in state taxes to deal with the burden of substance use disorders in their social programs (i.e., "shoveling up the wreckage") and only $10 per year for prevention and treatment.

The CASA authors also noted that they were unable to assess the impact of substance use disorders in several areas, including public housing, higher education, and state employee healthcare, because of lack of data. As a result, CASA cautions that this report significantly underestimates the impact of substance abuse on state budgets (2001).

Of every dollar spent associated with substance use disorders, Virginia spends approximately 98 cents on the cost burden of substance use disorders, compared to approximately 1 cent for treatment, and less than 1 cent for prevention. An additional cent is spent on regulation and compliance activities. A total amount of approximately $1.7 billion is expended to address the cost of untreated substance abuse on affected systems and programs in Virginia, translating to a per capita amount of $261.18. This compares to $4.20 on prevention, treatment and research, compared to a national average of $11.20 (see Figure 6) (CASA, 2001).

Figure 6: The Substance Abuse Dollar in Virginia



- The CASA study's use of a consistent methodology across each of the 47 entities allows for some comparisons to be made. Most relevant for the present purposes are the following (see Figure 6): Virginia spends significantly less than most other states (33 of 47) to prevent and treat substance use disorders.
- Virginia spends slightly less than most other states (33 of 47) in order to clean up the wreckage or to address the consequences of substance abuse and addiction.
- Fifty percent (50%) of Virginia's public monies spent "shoveling up" are in the criminal justice system.

National economists have noted that financing for the treatment of addictive disorders in the U.S. varies from state to state and, taken as a whole, reflects a heterogeneous set of funding sources which include but are not limited to private insurance, patient out-of-pocket, federal, state and local government revenues, and charity (Cartwright & Solano, 2003). These authors note that, in spite of the diversity of funding sources, only a small fraction of those persons in need of treatment actually receive the treatment they require. They also note that in spite of the fact that treatment has repeatedly been demonstrated empirically to yield substantial and positive net benefit to society overall, treatment financing is poorly organized, inefficient, and always insufficient to meet the demand. They characterize the present market for the treatment of substance use disorders as being characterized by excess demand combined with an implicit social policy of rationing. The net result, according to these authors, is a "system" which is less than optimally organized, often poorly coordinated across different agencies and funding networks, and one guaranteed to produce unintended negative social consequences. Virginia is no different than other states in terms of having multiple streams of funding for the treatment, as well as the prevention, of substance use disorders that are not always coordinated at the state or local level.

Agencies and organizations participating in the *Survey of State Agencies and Organizations for Prevention or Treatment of Substance Use Disorders* were asked to provide information about

actual expenditures for 2002, and budgeted expenditures for 2003 and 2004. Figure 7 below displays a summary of responses for 2004 (budgeted) by agency and revenue source, except for DMAS and GOSAP. Because DMAS funding is based on reimbursement by the federal government for actual funds expended, the DMAS figure is for 2001. Additional detail for each responding agency can be found in Appendix D.

Figure 7: 2004 Budgeted Spending for Substance Abuse Services Among Survey Respondents

Agency/Org	Federal	State	Other	Total
DOE	6,658,953	0	0	6,658,953
DHP	0	0	2,000,000	2,000,000
DMAS (2001)	55,000	55,000	0	55,000
DMHMRSAS	40,191,898	38,357,800	54,240,621	132,790,319
DSS	1,321,500	0	0	1,321,500
DJJ	344,510	858,015	0	1,202,525
DOC	2,221,589	4,967,413	1,066,000	8,255,002
GOSAP (2003)	0	0	0	0
TOTAL	$50,793,450	$44,238,228	$57,306,621	$152,338,299

Most of the funding for treatment and prevention is appropriated to DMHMRSAS, which allocates it to the community services board system. It is worth noting that this table is only a "snap shot" of funding, and does not reveal any trending data. For instance, General Funds for DJJ and DOC declined significantly from 2002 to 2004, due to the discontinuation of the SABRE (Substance Abuse Rehabilitation and Education) program. The three-year federal grant that initially supported most of GOSAP's programs ended in 2002. The federal funds it reported for 2003 is the discretionary portion of an ongoing federal grant that also funds programs at the Department of Education.

A report from the Council to the General Assembly due in 2005 will focus more discretely on funding, programs, services and the availability of data and infrastructure to track outcomes.

Joe Battle, President of the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia, J. Thomas Treece, member of the Board of Directors and immediate past President, and Mary Emory-Bentley, Executive Director of SAARA of VA, at the SAARA Annual Meeting, September 2003. Treece stated, "There are many paths to recovery; we also know that treatment works. A person in recovery is a contributor to society."

The Science of Addiction

"Recognizing addiction as a chronic, relapsing brain disorder characterized by compulsive drug seeking and use can impact society's overall health and social policy strategies to help diminish the health and social costs associated with drug abuse and addiction."

-- Alan I. Leshner, Ph.D., former Director, National Institute on Drug Abuse (NIDA)

Modern medical technology (e.g., Magnetic Resonance Imaging, or MRIs, and Positron Emission Tomography, or PET Scans) has created the opportunity to learn more and more about the very nature of addiction. Scientific advances have rapidly and dramatically created a clearer understanding of the nature of addiction and drug dependence and opened exciting new avenues for the health care professions about how to best treat and prevent addiction to alcohol, nicotine and other drugs. The results of many studies utilizing these technologies capable of studying the living brain and how it is transformed during the process of addiction have shed new light on why addiction is such a persistent, chronic, relapse-prone, but treatable illness. Many researchers are now comfortable referring to addiction as a *brain disease*.

The discoveries from the study of the brain and human genetics have shown how certain people, from the moment of birth, are more vulnerable to becoming addicted than others. Additional findings from social and behavioral science (e.g., psychology) research have helped us to better understand how addiction and the entire range of substance use disorders develop, how they are maintained and how they must be treated in order for stable recovery to be attained. These same studies have better informed us as to how to prevent the development of addictive disorders in our youth. Future studies will shed similar light on how to best prevent the development of late life addiction in the growing number of seniors in Virginia. The results of all of these studies have confirmed the personal experiences of many recovering addicts and the observations of many prevention and treatment professionals, who have long noted that addiction cannot be prevented through fear, nor cured through punishment, and that recovery is an ongoing journey rather than a singular destination. This information has contributed to better understanding about major classes of substance-related disorders, which fall into two major groups.

There are two distinct substance use disorders: **substance dependence** (often referred to as "addiction"), and

Addictive substances alter the structure and function of the brain – the very way the cells work. Virtually all substances of abuse have common effects on a single pathway deep within the brain commonly known as the reward or pleasure pathway, resulting in pleasurable or euphoric feelings. This is a common element in the drive to compulsively use substances, as well as relapse. *"Relapse"* is the term used to indicate that an individual has experienced an episode of using substance(s) of abuse after a period of abstinence. ***-- NIDA, 1999***

substance abuse (Diagnostic and Statistical Manual [DSM IV], see Appendix F). Substance abuse is defined as a pattern of substance use leading to *significant impairment* or distress in important life domains. Examples of impairment include failure to fulfill obligations at work, school or home; recurrent use in hazardous situations (e.g., driving); or recurrent substance-related legal or interpersonal problems. In addition to these types of problems, an individual with substance dependence has typically developed *tolerance* to the substance, requiring greatly increased amounts, and, with many drugs such as alcohol and heroin, experiences uncomfortable symptoms of *withdrawal* when the person stops taking the substance.

The unique effects of individual substances on brain chemistry are becoming more clearly understood; this knowledge is leading to the rapid development of new medications for the treatment of substance use disorders. The changes caused by the ingestion of alcohol and other drugs range from fundamental and long-lasting changes in the biochemical makeup of the brain, to transient arousal and mood changes, to long and short-term changes in memory processes and motor skills. Recent studies indicate that 50 % to 75 % of chronic alcoholics show cognitive impairment, even after they have abstained from alcohol for a substantial period of time. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), alcoholic dementia is the second-leading cause of adult dementia in the United States, exceeded only by Alzheimer's disease (NIAAA, 2001).

Substance dependence is a disease with four primary symptoms:

- **Craving – a strong need, or urge to use**
- **Loss of control – not being able to stop using**
- **Physical dependence – withdrawal symptoms, such as upset stomach, sweating, shakiness, and anxiety after stopping using**
- **Tolerance – the need to use greater amounts of the substance in order to get "high".**

-- NIAAA

Although any use of an addictive substance, such as cocaine, alcohol, or nicotine, will alter brain function, not all people who use these substances will experience lasting changes in their brain structure and function. Some people can use some substances periodically and remain occasional users. Some drugs (e.g., heroin) are so highly addictive that few people will be able to use without becoming addicted. Some people, however, start using substances casually and seem to progress inevitably to addiction, including some who appear to become addicted upon the very first use of a substance (Erickson, 2003). Researchers do not yet fully understand why this is so, but they know that heredity plays an important role. Current evidence suggests that the genetic contribution to the risk of addiction is in approximately the same range as for other chronic illnesses such as asthma and hypertension (Toft, 2001). Being the child of a substance dependent parent plays a significant role in the chance of developing a substance use disorder, for genetic as well as environmental factors. Being the biological child of two substance dependent parents doubles that risk (NIAAA, 2003).

Children of alcoholics are about four times more likely than the general population to develop alcohol problems. -- *NIAAA, 2003*

These recent findings have clear implications for the treatment and prevention of addiction. The recognition that addiction is a bio-psycho-social illness, with critical biological, behavioral, and social-context components dictates that effective treatment strategies must include biological, behavioral and social-contextual elements. Addiction involves an impaired brain that may require medication to manage the early stages of withdrawal or to block cravings. Behavioral and social patterns must be interrupted and reprogrammed, and certain environments must be avoided or modified. New behaviors and new ways of thinking about old behaviors, previous social patterns and environmental cues must be learned as is the case any time a complex, long-standing behavior pattern needs to be changed or when the brain has been challenged, such as occurs with a stroke or Alzheimer's disease. Combinations of behavioral therapies and medications are likely to be necessary to directly address some of the brain and behavioral dysfunctions that characterize addiction (Leshner, 1997).

Treatment Works[2]

Treatment of substance use disorders is as successful as treatment of other chronic diseases such as diabetes, hypertension, and asthma.
-- National Institute on Drug Abuse (NIDA), 1999

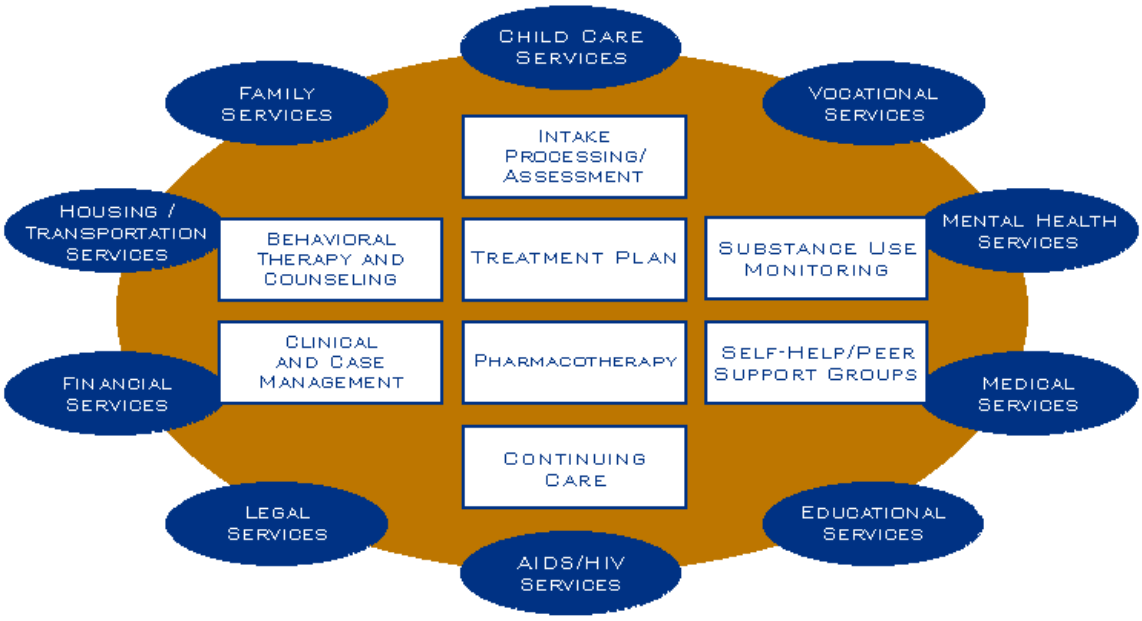
For many, addiction is a chronic relapsing disorder that must be approached like other chronic illnesses such as diabetes or hypertension (Leshner, 1997). Many recovering people have learned to constantly monitor themselves and to seek critical, positive social support, and to accept that periodic relapses may occur, requiring additional interventions. Thus, recovery from addiction is best viewed as a series of incremental changes that will unfold at different rates for different people, and not always in a straightforward, linear fashion. The goal of treatment is not to impose the "cure" for addiction, but rather to start or continue the recovery process. In addition to stopping the use of the substances upon which the person has become dependent, treatment also strives to return the individual to productive functioning in the family, workplace, and the community. Measures of effectiveness typically include levels of employment, health status, criminal activity, and family functioning. For example, prospects for employment are improved by up to 40% upon the completion of treatment for substance use disorders.

Recovery from addiction may start with the simple mental act of considering that there may be a problem. The recovery process may progress through stages initially characterized by significant decreases in substance use, increased efforts to stop using, longer periods of abstinence between use episodes, and gradual improvements in a broad range of areas such as family life, employment, and decreased involvement with law enforcement and the justice system, with possible occasional relapses before stable recovery is achieved. Gradually, the face of someone in recovery becomes indistinguishable from other faces in the crowd.

Decades of scientific research and clinical practice have yielded a variety of effective approaches to the treatment of addiction. Numerous studies have demonstrated that the treatment of addiction is as effective as are treatments for other similarly chronic medical conditions. Not all treatment is equally effective, however. The findings of controlled studies of treatment outcomes have revealed overarching principles that characterize the most effective substance abuse disorder treatments and their implementation. These principles and many ongoing program evaluation efforts are beginning to form the foundation for evidence-based practices. Because addiction involves virtually every aspect of an individual's life (e.g., health, family, social, occupational and spiritual), the treatment of substance use disorders typically requires many components (see Figure 9).

[2] Much of the material for this section was excerpted from *Principles of Drug Addiction Treatment: A Research-Based Guide*, National Institute on Drug Abuse (NIDA) National Institutes of Health (NIH), 1999. See Appendix G for NIDA's ***Principles of Effective Treatment***, as well as information on evidence-based practices.

Figure 8: Components of Comprehensive Substance Use Disorder Treatment



Some aspects of treatment focus directly on the individual's substance use. Some focus on restructuring the way the addicted person thinks about people, situations and stress. Others, like employment training, focus on preparing the addicted individual for productive membership in the family and society. Still others, such as childcare and transportation, are designed to facilitate the individual's ongoing participation in the treatment service. The best treatment programs provide a combination of therapies and other services to meet the needs of the individual. To be effective, treatment must address the individual's substance use and any associated medical, psychological, social, vocational, and legal problems. Matching treatment settings, interventions, and services to each individual's particular set of problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Good outcomes are contingent on adequate lengths of treatment.

-- NIDA, 1999

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. For residential or outpatient treatment, participation for less than 90 days is generally of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years. Successful outcomes may require more than one treatment experience. Addicted individuals may have multiple episodes of treatment, often with a cumulative impact.

During periods in which the addict is using less or is abstinent, there are dramatic reductions in other behaviors that are important to all Virginians. As substance use is reduced, so too is the likelihood of the spread of communicable diseases (as happens when injection needles are shared or when prostitution is resorted to in an effort to obtain drugs) including some, such as hepatitis C or HIV, for which there are no known cures. As substance use is reduced, so too are the

crimes committed in our communities. And as substance use is reduced or eliminated, the risk of domestic violence within the homes in our communities is also lessened.

During periods in which the addict is using less or is abstinent, there are also dramatic increases in certain desirable behaviors that are also important to all Virginians. Long-term reductions in general health care costs occur as a result of treatment, as have been demonstrated consistently in the studies commissioned by the states of Oregon, California, and Washington. As drug use is reduced or eliminated, the employability of the addict is increased, and income from legal means increases, and the taxes paid by the recovering addict are also increased, so that the individual is once again contributing positively to the larger community. In addition, many persons in recovery make it a point to "give back" the benefits that they have reaped from recovery, volunteering many anonymous hours of their time and energy serving as sponsors for others in the early stages of recovery, or helping to establish support groups in their communities so that others will have a chance to achieve recovery as well.

Although rigorous and scientific approaches to program and outcome evaluation have allowed for the measurement of some, but not all, of the personal and social benefits of long-term recovery from addictive disorders, these benefits can also be seen in families and communities across Virginia where recovering individuals have returned to health, employment and productive citizenship. Indeed, they constitute the most critical evidence that treatment indeed works and that recovery from addiction is possible. The combination of scientific advances toward a better understanding of the nature of addiction, and the human evidence of the benefits of recovery demonstrate the importance of informed public policy access to treatment, recovery, realistic expectations about the course of recovery. Equally important is the recognition that shame and fear, fueled by stigma, prevent many in recovery from sharing their success with others, robbing hope from those still afflicted.

Emerging Issues

"No matter where we went, the concern named most often and articulated most clearly, was that of capacity."

-- James C. May, Ph.D., Chair of the Substance Abuse Services Council

Several key areas of statewide concern emerged from responses to the *Survey of State Agencies and Organizations Concerning Services for Prevention or Treatment of Substance Use Disorders*, as well as the regional focus groups. Stakeholders throughout the Commonwealth are concerned with the overarching issue of **capacity**. Many focus group participants expressed frustration over the lack of funded treatment slots or treatment beds relative to the number of people who need treatment, creating waiting lists in many communities. This issue is a concern for all types of treatment settings and populations, including adolescent, adult, and offender populations, as well as those with co-occurring mental illness and substance use disorders.

Beyond the inadequate capacity for treatment in general, respondents also indicated concerns over limited availability of new *evidence-based treatment practices* within many existing programs, again for a wide range of populations. The need for adequate, cohesive funding to support *evidence-based prevention services*, to be funded and implemented on a consistent basis, was also a concern heard from multiple respondents. Others expressed concern regarding the Commonwealth's ability to maintain an adequate workforce in the substance use disorder field, noting that the number of new people entering the field is decreasing. Similar concerns were expressed about whether adequate training opportunities are available for current treatment and prevention specialists to learn evidence based practices.

An additional concern repeatedly identified by the Council and stakeholders pertains to funding. Federal, state, and local funding streams are undergoing rapid reductions, affecting all of the aspects of capacity mentioned above. Recent General Fund budget reductions which have had a significant impact on substance use disorder treatment in Virginia has been estimated to total $28,034,064 annually (Green, 2002)**.** Although there is a growing understanding that treatment for addictive disorders works, and as the knowledge about what types of treatment advances rapidly, services and programs for the treatment of substance use disorders in Virginia are downsizing or closing due to severe funding cuts. It is getting more difficult to access treatment for an addictive disorder in virtually any community of this Commonwealth. It has become much less likely that an offender will receive the treatment that he or she needs while under the supervision of the criminal justice system, and ongoing funding for the recently emerging drug courts providing supervision and treatment as an alternative to more expensive incarceration is uncertain.

Virginia is not alone in this regard. The recent, extended economic downturn crippled many state budgets, and treatment funding was reduced in many states. One recent report found that some women in Massachusetts were getting themselves arrested thinking they could receive the treatment for their addiction in jail or prison that they could not get in the community (Hillman, 2003). In Kentucky, state treatment officials said that about 348,000 people in the state are addicted to alcohol and other drugs, but that only 22,000 people were able to receive treatment

last year. Reportedly, Kentucky's governor is planning to order a comprehensive review of the state's drug problem and the resources available to address it (Yetter, 2004). A recent study in Pennsylvania documented the shifting of costs from the private sector insurance industry, as a result of providing inadequate coverage for addictive disorders, to the public sector treatment system and the criminal justice system (Pennsylvania, 2003)

In Virginia, there are particularly salient capacity problems concerning the lack of adequate services for substance-using and substance dependent youth and their families, for the growing number of offenders within the criminal justice system who are transitioning back to their communities following imprisonment, and for people who suffer from co-occurring mental illness and substance use disorders. There are even fewer evidence-based services and programs available for youth, offenders and people with co-occurring disorders. There have been national estimates suggesting that less than 20% of all addiction treatment services are based on science, and the Institute of Medicine has called for greater attention to the need to bridge this gap between research and practice (Lamb, Greenlick and McCarty, 1998).

Capacity is a concern in both the private and public sectors. The private substance abuse treatment industry in Virginia, as in most other parts of the country, has been severely constricted, due to changes in third party reimbursement for the treatment of substance use disorders during the last fifteen years. While there were once numerous private treatment facilities where many of our currently productive, tax-paying citizens were treated and placed on the road to their personal recoveries, Virginia now has only a few private treatment facilities remaining. This is primarily due to the inadequate insurance reimbursement for the services provided by these types of programs. However, it is also the result of Virginia's lack of Medicaid reimbursement for addiction treatment. Medicaid now funds more than half of the public sector mental health services in the United States and has helped create the necessary community-based services capacity to reduce the populations in state-operated mental institutions. States that have some Medicaid reimbursement for addiction treatment invariably have a higher number of private treatment providers, and greater community-based service capacity.

Since capacity issues are clearly related to funding issues, one approach to addressing the capacity issue would be to increase available funding by expanding the substance abuse treatment services for which Medicaid would pay. Medicaid is a federal program and requires that states provide some services but gives the states flexibility to add optional services, subject to approval by the federal Centers for Medicaid and Medicare Services (CMS). Each state is assigned a "match rate," based on the state's wealth relative to other states. Virginia's current match rate is 50:50 (Federal Funding Information for States, Issue Brief 02-50), so for every $1 of federal funds expended, another $1 from a nonfederal source must be expended as well. Medicaid is administered through the Department of Medical Assistance Services (DMAS). One of the required programs, Early Periodic Screening, Diagnosis and Treatment (EPSDT), for children under age 21, requires states to provide any treatment to children who, after screening by a physician, are determined to need the treatment. In Virginia, however, EPSDT supported substance abuse treatment services are not yet occurring. Currently, the state's Medical Assistance Plan only reimburses for some residential substance use disorder treatment services

for pregnant and post-partum women (post-partum is federally defined as two months post-delivery) and their young dependent children, and day treatment for this same population.

Although the federal government regulates minimum eligibility standards for Medicaid, states can modify them within the federal regulations. Eligibility for Medicaid is determined largely by income. Many disabled people are enrolled in Medicaid, however, addiction is not classified as a disability by the Social Security Administration. The impact of this policy is that very few men would receive substance abuse treatment supported by Medicaid. Those benefiting from Medicaid funded substance abuse treatment services would largely be low-income pregnant women, low-income single mothers and their dependent children, and children in foster care.

Expansion of services reimbursable by Medicaid has been studied several times. The most recent examination of this issue resulted in a report to the Governor and the chairs of the Senate Finance and House Appropriations Committees in 1999, "The Study of Expansion of Medicaid Coverage for Substance Abuse Treatment," jointly prepared by the staffs of DMHMRSAS and DMAS. For this study, William M. Mercer, Inc., under contract with DMHMRSAS, estimated the cost of expansion to cover the full range of the treatment continuum for adults and children at $7,848,324, based on DMAS enrollment data, CSB utilization data and unit costs, and encounter data from other sources.

These findings were reviewed by a work group comprised of representatives from the Virginia Association of Community Services Boards, the Virginia Association of Drug and Alcohol Programs, and the Virginia Association of Drug and Alcohol Counselors, staffed by DMHMRSAS and DMAS. Because federal regulations prohibit payment for adult (ages 18 - 64) residential treatment in facilities with sixteen or more beds, and few residential facilities in Virginia would be smaller than sixteen beds, the work group elected to remove these costs from the estimate. It also removed costs associated with methadone treatment, as most of these clients are working and would not be eligible for Medicaid. At the request of the work group, Mercer estimated the annual cost of providing residential services to those under 18 at $1,602,985. Finally, to provide assurance that services are medically necessary, thorough evaluations would be required, so those associated costs were added, for a total cost of $9,894,129. At that time, the match rate was 51.49 federal to 49.51 nonfederal funds (Federal Funds Information for States, Issue Brief 98-7). Assuming full utilization of the proposed service array, an annual General Fund appropriation of $4,898,583 could have resulting in an additional $4,995,546 in Federal Fund Participation to support expansion of substance abuse treatment.

Mercer estimated that approximately 5,920 adults and children would have annually received services reimbursed by Medicaid under this plan. These people may already be receiving services funded by state General Funds allocated to community services boards, or the federal Substance Abuse Prevention and Treatment Block Grant awarded annually to DMHMRSAS and distributed to the community services boards. However, the additional funds would have helped to expand capacity by freeing other funds to support additional capacity and services excluded by Medicaid regulation, such as jail services or residential services provided in facilities with sixteen or more beds.

In order to update the Medicaid estimates, the results calculated by Mercer were multiplied by the Medical Consumer Price Index for Urban Consumers in the Washington-Baltimore, DC, MD, VA and WV area (U.S. Bureau of Labor Statistics, 2004). The MCPI increased 10.4% from 1999, when the data for the original study were accurate, to 2003, with a mean average of 2.6%. This projection was added the mean for 2004-2006, the earliest year regulations would likely be enacted, resulting in a total increase of 18.2%. The projected amount of Medicaid funds needed for implementation in 2006 would be $11,694,860. The current match rate is exactly 50%, so the amount of state General Funds needed is $5,847,430. Any provider who met the regulatory criteria that would be established in the State Medical Assistance Plan would be eligible for reimbursement from this source.

General hospital emergency department staff are frustrated with trying to locate private or public placement for treatment services for those in need, as private beds are scarce, and there are tremendous waiting lists for publicly-funded services. Emergency departments are overwhelmed by the sheer volume of patients with substance use disorders seeking services. In many cases indigent patients falsely state thoughts or plans for suicide, knowing that this is an admission requirement, in order to gain admission to a psychiatric unit or on a medical-surgical unit in a hospital. Some studies have suggested that people with substance use disorders constitute the largest sub-group of uninsured or underinsured patients receiving care from all hospitals (Thacker et al, 1999 and 2001). People with substance use disorders are the largest group appearing in emergency room and trauma care settings (el-Guebaly, 1998).

General hospitals are reluctant to develop detoxification or stabilization services due to the low probability of obtaining insurance reimbursement and the high probability that these beds will be filled with homeless and indigent patients who cannot pay for uninsured services. Many inpatient treatment programs have closed permanently, unable to generate enough insurance or private pay revenue to cover operating costs, leaving only a few residential and intensive outpatient programs throughout the state.

Current models of managed health care and the typical “pre-authorization” requirements have had a major negative impact on the ability of privately insured individuals to obtain adequate treatment. Excessive or unrealistic restrictions to treatment such as annual service limitations or requiring failure at outpatient treatment prior to authorizing inpatient or residential care place a clinical burden on patients and a financial burden upon the private treatment providers, and generally fly in the face of effective treatment practices. Unreasonably low rates of reimbursement to treatment providers further limit access to the care many will require to achieve initial recovery and stable sobriety. Many facilities refuse to accept reimbursement rates that do not even cover costs. Most private treatment centers have reduced operating costs, become smaller and now pursue private patients who have the financial means to pay out of pocket. This is simply a financial survival strategy, on the part of the providers, but it leaves the majority of the “in-need-of-treatment” population without access to the private sector.

The inability to access needed care from the private sector leads to an increased demand upon the public sector, which was never adequately funded and is now operating with fewer dollars than it has for many years. Due to the combination of the very low number of private treatment facilities, the various barriers to private providers obtaining insurance reimbursement for services provided, the inadequacy of the insurance industry's model for treating substance use disorders once identified, and the increasing number of uninsured individuals, most of the burden for treating patients falls back upon the public sector.

"***Access to Drug Recovery is Vital.…*** **Many of our family members and fellow citizens are not being treated for their addiction…. We hope to increase ways to get people into treatment and help them realize they have a problem, close the motivational gap to get those who know they need treatment through the clinic doors, tear down the stigma associated recovery and help families and friends come to terms with the problems associated with addiction."**

-- John Walters, Director of the Office of National Drug Control Policy (2003)

Youth and Family

Virginia spends $253,004,201 annually on foster care costs. Thirty percent of Virginia children are in foster care due to substance use problems in their families.

-- Virginia Department of Social Services2003

Substance use disorders harm children in many ways throughout their development. Although the financial and even societal costs of these negative effects can be measured, the personal costs to the individual children can never be completely or accurately measured. Virginia requires physicians to file a report with the local department of social services child protective services if they suspect that a newborn was exposed in utero to a non-prescribed controlled substance (Code *of Virginia* § 32.1-127). As a result, in 2002, Virginia physicians reported 483 newborns to child protective services for medical findings of prenatal substance exposure. Prenatal substance exposure can cause or contribute to premature birth, low birth weight, increased risk of infant mortality, and neurobehavioral and developmental complications including disabilities, hyperactivity, and other chronic health conditions. In addition, Virginia law requires that prenatal care providers (e.g., hospitals) routinely complete a substance use screening on all pregnant women they serve (*Code of Virginia* § 63.2-1509). Since this law went into effect, reports of prenatal substance exposure have more than doubled (VDSS, 2003). There is some indication that these figures may still underestimate the prevalence of this problem. In the Council's *Survey of State Agencies and Organizations Concerning Services for the Prevention or Treatment of Substance Use Disorders*, the identification of substance dependent pregnant women, the special needs presented by pregnant women who are addicted, and the need to improve their access to treatment for substance use disorders were all noted by the Department of Medical Assistance Services as representing three of the most significant trends or issues currently recognized within that agency's service population.

Parents under the influence of drugs or alcohol often have impaired judgment and a compromised ability to meet their child's physical, emotional, and developmental needs. A child's safety is at risk when a parent or family member is involved in illegal drugs. Accidental ingestion by the child, family violence, possible involvement of firearms, and exposure to strangers could all result in injury to the child or even death. Research indicates that children living in such home environments are at higher risk of academic failure; exposure to abuse and neglect; physical, behavioral, and mental health problems; involvement with the juvenile justice system; and future substance abuse (SAMHSA, 2003).

National data indicate that 8.3 million children are living with at least one parent dependent on alcohol and/or in need of treatment for illicit drugs. Nearly 1 child out of 200 in Virginia is reported to be abused or neglected. Currently, 4.2 children per 1,000 (7,879 children) are in foster care, at an annual cost of $253,004,201 (VDSS, CSA 2003). Virginia data indicate that 30% of children in foster care were placed in care due to substance use problems in their families that compromised their safety and well being (VDSS 1999-2000). Key stakeholder interviews suggest that the actual rate is much higher. Judges from the Juvenile and Domestic Relations Court in the City of Richmond, for example, estimate that approximately 80% of the child abuse

and neglect cases on their dockets involve parental substance abuse and addiction. In the Council's *Survey of State Agencies and Organizations*, the Department of Social Services viewed the adverse effects of parental substance abuse on child development, safety and well-being as being one of the most significant issues or trends seen in its current service population.

Once youth have begun using tobacco, alcohol and other drugs, they immediately become at higher risk for experiencing other negative health and social outcomes across the remainder of their lives, including increased use of these and other drugs, academic failure, underemployment, chronic health care problems and involvement with the juvenile and adult justice systems. Many of the drugs available to today's youth are highly addictive, and yet few adolescents actually understand the effects that drugs have on the brain, or how completely addiction can take over one's life. As is true nationally, Virginia's youth most typically start smoking cigarettes or chewing tobacco before using alcohol or other drugs. The *Virginia Community Youth Survey* (2000) found that many students in Virginia have started using alcohol or other drugs before completing middle school, and that virtually every type of drug has reportedly been used by someone in Virginia's high schools. For Virginia's youth, tobacco use typically starts at about 12 years of age, with the average first use of alcohol coming shortly thereafter at age 12 and a half. Age of first use of marijuana is about one year later, occurring on average at about age 13 and a half. As heroin has re-emerged as a significant drug of choice along the east coast of the U.S., it is also appearing in Virginia's high schools, without regard to race or socioeconomic status, according to informed stakeholders participating in the Council's regional focus groups.

Virginia's approach to youth drug use has historically included some community-based prevention efforts, significant state and local law enforcement responses, and some community-based treatment. In recent years, there has been extensive collaboration across the law enforcement, criminal justice, public health, treatment and prevention professionals. Law enforcement professionals are frequently involved in the provision of prevention services or referring troubled youth for treatment services. Criminal justice professionals frequently collaborate with treatment professionals to provide carefully monitored, structured treatment services to substance abusing youthful offenders. And as both treatment and prevention professionals have increasingly recognized the multi-generational nature of addiction, and that effective prevention for one member of a family may require treatment for another family member, prevention and treatment are regarded as complimentary components of a continuum of services necessary to address substance abuse and addiction in Virginia's communities.

Prevention strategies have changed with research findings; the days of scare tactics and drug paraphernalia displays are largely gone, giving way to programs and services with proven track records of success in preventing alcohol and other drug use in youth. More recently, prevention services have been designed around six primary intervention strategies (see Figure 10, below), each with the goals of reducing youth risk for future drug use or other problem behaviors (e.g., violence), and increasing youth resiliency or "protective factors", such as making informed, positive life choices and implementing socially adaptive skills to achieve success. These strategies should not be used in isolation; effective prevention programs will use multiple strategies to effect change.

Figure 9: Six Effective Community-Based Prevention Strategies

- **Information Dissemination** – Providing awareness and knowledge about issues related to alcohol, tobacco, and drug use and abuse and their effects on individuals, families, and communities; setting and reinforcing positive social norms (e.g., media campaigns, health fairs, brochures, and lectures).
- **Prevention Education** – Teaching important life and social skills, including decision-making, refusal skills, and cultural pride (e.g., parenting programs; substance abuse prevention education programs).
- **Alternatives** – Providing positive activities for youth that exclude alcohol, tobacco, and other drug use, to address their developmental needs in constructive and healthy ways (e.g., drug-free dances, mentoring, and recreational activities).
- **Problem Identification and Referral** – Identifying those youth who are experimenting or beginning to use alcohol, tobacco, and other drugs or beginning to engage in other negative behaviors and referring them to treatment resources (e.g., teacher training programs; student assistance programs).
- **Community-Based Process** – Enhancing overall community involvement in substance abuse prevention, such as through invitations to participate in the community prevention planning process (e.g., collaboration; coalition building).
- **Environmental** – Advocating and educating others about effective social policy regarding the incidence and prevalence of alcohol, tobacco, and other drug use (e.g., restricting alcohol and tobacco advertising; restricting the sale of alcohol and tobacco to youth; increasing taxes on alcohol and tobacco to reduce incidence and prevalence). (*45 CFR 96.125*)

In addition to the need for prevention strategies to be based on evidence, focus group participants and survey respondents alike indicated a need for more collaboration among state and local agencies regarding funding, evaluation, and monitoring of prevention services. Community-based prevention services are largely funded by a required 20 % set-aside from the federal Substance Abuse Prevention and Treatment Block Grant. Other funds come from discretionary sources or competitive grants, usually limited to three years, leaving localities to scramble to locate resources to continue effective programs, or switch precipitously to other newly funded programs. There are currently no state General Funds appropriated for prevention services.

Effective prevention programs represent the most significant opportunity to reduce the burden of substance use disorders on public programs. If youth do not smoke cigarettes, use illicit drugs, or abuse alcohol before the age of 21, they are virtually certain never to do so (CASA, 2001). Unfortunately, however, there were 19, 913 Virginia youth aged 12-17 years, and 30,255 young adults aged 18-25 who needed treatment last year but did not receive it, due to lack of capacity (SAMHSA, 2002).

Criminal Justice

Decades of research have unequivocally established the relationship between substance use, substance use disorders, and criminal behavior. The chain of causation is not clear, nor is it likely to always be in the same direction. However, this relationship includes criminal behavior that occurred while under the influence of alcohol and other drugs due to the disinhibiting effects and impaired judgment following substance use; person and property crimes committed to financially support an individual's addiction; and crimes related to the illegal trafficking in illicit substances. Crimes of violence, including domestic violence, are highly correlated with substance use, especially the use of alcohol. Illicit drug use is associated with significantly higher levels of criminal behavior and with increased recidivism to offending. During periods of active substance abuse and dependence, individuals commit crimes at high rates, while criminal activity virtually always diminishes and often ceases during periods of abstinence and recovery (Substance Use, Crime and Violence, 2000).

Similarly, research has shown that criminal offenders have higher levels of drug use than non-offenders. While exact figures vary, partially because different studies have measured offender drug use or substance use disorders at different points along the continuum of offender involvement with the justice system, rates of substance use disorders among adult and juvenile offenders are consistently high. Clearly, the majority of people incarcerated in jails and prisons have alcohol or drug problems. Three-fourths of state and federal prisoners report recent histories of alcohol or drug problems (Wilson, 2000). This includes people who were using drugs in the month prior to the crime, under the influence of alcohol or drugs when they committed the crime, or had committed a specific substance-related offense such as drug possession or drug sale. Although most people think of criminal offenders as being illicit drug addicts, alcohol use is more frequently detected in adult arrestees than are illicit drugs. In 2001, the Virginia Interagency Drug Offender Screening and Assessment Committee reported that 64.2% of adult felons screened for the presence of an addictive disorder were found to be in need of additional assessment, and that 51.8% of adult felons screened by probation officers needed a thorough assessment. Of those assessed, 85.5% needed treatment services (Virginia General Assembly Senate Document No. 22, 2001). Responses to the Council's *Survey of State Agencies and Organizations Concerning Services for Prevention or Treatment of Substance Use Disorders* indicate the following estimates: the Department of Corrections reports that 76.3% of inmates indicate drug/alcohol usage (Needs Assessment, 2001), and the Department of Juvenile Justice reports that 64% of youth in their programs require substance abuse services (2001).

Virginia's "Offender Forecast" reflects state prison population growth of 1,086 offenders between FY 2002 and FY 2003, and annual increases are expected to continue, with a projected prison population perhaps as high as 44,464 by FY 2009. Virginia's local and regional jails are expected to experience similar population increases (Virginia Secretary of Public Safety, 2004). With 60 to 80% of these offenders having substance use disorders requiring treatment, Virginia will be increasingly and unavoidably challenged by the consequences of the untreated addictions of thousands of offenders, most of whom will end up, unsupervised, back in our communities (Office of National Drug Control Policy, 1999).

A number of focus group participants commented on the rapidly recycling nature of the addiction and crime connection, expressing frustrations over the general lack of resources available for treating addicted offenders. Historically, offenders with substance use disorders have been imprisoned to punish them for the crimes that have been committed, to protect society from the crimes the offenders commit, and to suppress or eliminate future illegal activity and illicit drug use. Recent research has shown that neither criminal activity nor drug use is permanently eliminated as a result of imprisonment, but rather that the reductions in criminal activity and drug use associated with imprisonment are temporary and situation-specific. Within one month after imprisonment, many offenders begin to resume both their substance use and their criminal activity, and within three years of the date of release from prison, two-thirds of all offenders, including drug offenders, are rearrested for a new offense. Most of them will be re-incarcerated. Perhaps as many as 85 % of substance dependent offenders return to addictive alcohol and other drug use within one year of their release from prison (Belenko, 1990 and 1998a; Robins and Regier, 1991; Simpson et al, 1996; Peters, 1998). Focus group participants agreed that incarceration alone made little or no difference in the addiction-crime cycle for these offenders.

Over the past 20 years, most states and the federal government have invested substantial resources into establishing substance use disorder treatment programs within prisons in an effort to reduce criminal recidivism and addictive relapse. Virginia was an early participant in this effort, establishing programs for both juvenile and adult offenders within prisons. Unfortunately, most offenders still have not been able to access treatment for their substance use disorders while under the supervision of the criminal justice system. More importantly, the extent to which any gains are maintained in the community after release appears to be dependent upon the delivery of follow-up treatment in the community. Without immediate follow-up care, active substance use in offenders who receive prison-based substance abuse treatment re-emerges within a few months of release from prison, and the re-offending and relapse-to-drug-use rates soon become comparable to those who did not receive treatment in prison (Office of National Drug Control Policy, 1999). However, there are measurable reductions in offender alcohol and drug use and criminal activity shortly after their participation in prison-based treatment (.Office of National Drug Control Policy, 1999). In addition, treatment delivered in institutions leads to reductions in disciplinary infractions by inmates, reduced absenteeism by correctional staff, and a greater likelihood that the offender will enter treatment after release from prison (Gerstein and Harwood, 1990).

In Virginia and elsewhere, community-based drug treatment programs have also been combined with standard community supervision (i.e., probation) through the criminal justice system over the past 20 years. These programs continue to exist within many communities in Virginia, but access to limited treatment slots has reportedly become significantly delayed or almost unavailable for many offenders. Unfortunately, without special, intensive monitoring coordinated with immediately accessible, intensive treatment, more than 70% of probationers referred for treatment will drop out in less than 3 months, and almost none of them remain in treatment for a full year (Marlowe, 2003).

The recent movement to provide treatment opportunities for offenders with substance use disorders has brought together the public safety and public health systems. Most people now

recognize that substance use disorders represent a serious public health and public safety challenge. Due to the interrelationship of alcohol and other drug use and crime, a number of promising and innovative programs have been developed and implemented. In many communities in Virginia, treatment programs for addictive disorders are provided in local jails, probation offices and in certain types of special-focus courts. Integrated public health-public safety strategies combine the traditional responsibilities of the criminal justice system with the health-enhancing efforts of the treatment system in order to achieve maximum positive impact on future drug use and criminal behavior. Treatment professionals provide intensive rehabilitative services in community-based treatment programs that become central to these types of programs. This allows offenders the opportunity to re-establish positive family and social relationships and to seek employment while working on their recovery. Criminal justice system personnel provide supervisory monitoring of the participating offenders and can offer or implement plea agreements and suspended or modified sentence arrangements in order to maximize offender attendance in the program and enhance treatment retention, which has been shown to be critical to achieving successful outcomes. Figure 14 summarizes key characteristics of this approach.

Figure 10: Successful Treatment Programs for Offenders

Integrated public health-public safety programs for offenders with substance use disorders that have been demonstrated to be effective are characterized by the following:

- **Treatment is provided in community settings.**
- **Offenders are provided an opportunity to avoid incarceration, have their sentence reduced, or criminal record expunged.**
- **Criminal justice system personnel monitor offenders more intensively than is typical, to ensure compliance with the program.**
- **There are consistent and certain consequences for noncompliance with the program.**

-- Marlowe, 2003

Two types of combined public health-public safety approaches that have shown the most promise are drug courts and therapeutic communities coupled with aftercare programs for incarcerated offenders. Frequently, work-release types of aftercare programs are coupled with in-prison treatment immediately prior to the release to the aftercare program. Successful aftercare programs are highly structured, focusing on re-integration activities and are generally provided in residential settings. For incarcerated offenders with substance use disorders, the provision of institution-based treatment using a therapeutic community model, followed by community-based supervision and aftercare services, represents a model that has demonstrated significant positive outcomes. Both the Departments of Corrections and Juvenile Justice operate such programs in Virginia. Unfortunately, budget reductions of the past two years have stretched very thin those programs which continue to operate but have eliminated some of the community-based transitional and aftercare services required for the prison-based programs to be effective.

Promotion and Graduation Ceremony at the Richmond City Family Drug Treatment Court, October 2003

Drug courts represent the newest approach to treating offenders with addictive disorders. They have the additional advantage of having highly visible, non-treatment professionals such as commonwealth attorneys and judges advocating for the provision of treatment for offenders, reinforcing the integrated public health-public safety nature of these programs. Characterized by collaboration between executive branch agencies (e.g., prosecutors, defense bar, treatment providers, probation), combined with judicial leadership and strong accountability for the offender, drug court programs have begun to appear across Virginia and the rest of the country. Although well-controlled outcome studies of desired duration have not been published, initial results from national studies of drug courts, as well as anecdotal evidence from many of Virginia's drug courts have begun to demonstrate that they are effective in reducing both substance use and criminal recidivism. Drug courts definitely increase offenders' exposure to treatment, with the majority of drug court clients completing a year or more of treatment, and roughly 50 % graduating from the program (Belenko, 1998, 1999, 2001). This is clearly superior to standard treatment and supervision conditions that apply to most addicted offenders. In terms of whether drug courts actually reduce drug use and crime, some studies have found substantial reductions while others have not detected substantial reduction in crime and drug use rates (Marlowe, 2003). The variability among drug courts in types of services, relative size and characteristics of their client populations may account for these differences.

The potential for achieving better outcomes than other previously tried approaches has created substantial hope throughout the Commonwealth that drug courts will become the preferred approach for treating non-incarcerated offenders with substance use disorders, and for diverting selected offenders from more costly incarceration. The potential cost benefits of utilizing drug courts as a diversion from more expensive incarceration has generated increased attention from some state and local officials. Over the past five years, drug court programs for adult and

juvenile offenders have been implemented in over twenty-five Virginia localities, and another ten are in development or planning stages.

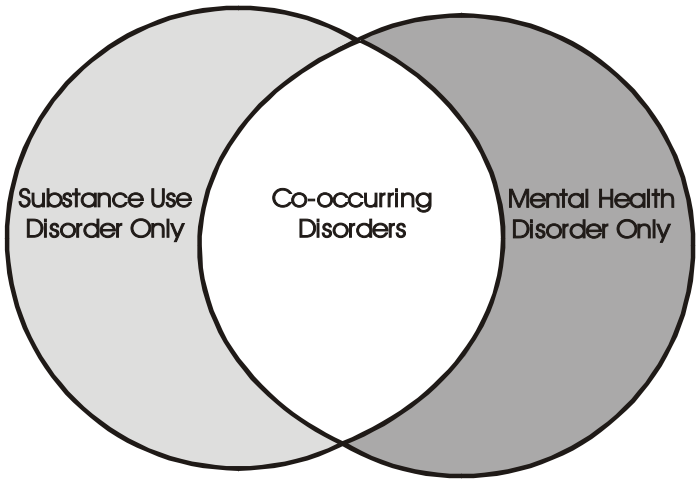
Most of Virginia's drug courts have been started with seed money from time-limited federal grants. Federal grant cycles generally run three years, and some of those require increasing levels of local or state match in order to continue. The most common concern expressed by focus group participants was that the staff from the drug courts in their localities spend tremendous amounts of time searching for continuation or expansion funding because the federal grants have expired or are about to expire, and Virginia has yet to identify a mechanism by which the different components of drug court programs – administrative, treatment and supervision – can be funded on an ongoing basis. Several focus group participants asserted that the current lack of capacity for treatment for offenders in Virginia's communities makes it essential that new funds be identified to support this resource-intensive, collaborative and potentially effective approach.

Co-Occurring Disorders

Many individuals with a substance use disorder also have another mental health disorder, such as depression, at the same time. "Co-occurring disorders" is the term used to describe this condition. As bronchitis may worsen the symptoms of asthma, co-occurring disorders are increasingly associated with negative outcomes.

Within the severely mentally ill population, current estimates of co-occurring disorders are at minimum from 40 to 60%, with similar estimates for the percentage of individuals with serious addiction and a psychiatric diagnosis (Minkoff, 2001). Figure 12 illustrates how these illnesses overlap in the population. Research suggests that these individuals are more susceptible to poor functioning and clinical outcomes including more severe illness symptoms, increased hospitalization, decreased social functioning, non-compliance with treatment regimens, an elevated risk for contracting HIV and hepatitis diseases, and increased risk for violent behavior, incarceration, and homelessness.

Figure 11: Overlap of Substance Use and Mental Health Disorders



Based on national estimates, there are approximately 191,210 adults with co-occurring disorders currently residing in the Commonwealth of Virginia (SAMHSA, 1998). According to the most recent data available, for adult consumers receiving CSB services between October 2000 and June 2002, 57 % were diagnosed with only a mental health disorder, 27 % with a single substance abuse disorder, and about 16 % of consumers statewide were diagnosed with co-occurring disorders (DMHMRSAS, 2003). The variance of these percentages from the expected prevalence of co-occurring disorders is likely due to current assessment and treatment practices, compounded by the different means of funding mental health and substance use disorders in Virginia. Clinicians have historically been trained to treat one disorder or the other, and funding is typically set up to pay for one type of treatment or the other. Medicaid, for example, is a major source of funding for treating mental illness, but not substance use disorders. Repeatedly, participants in the regional focus groups pointed out the need for integrated treatment, funding mechanisms that allow for such programs to be available, and training for staff to deliver evidence-based treatment for those with co-occurring disorders.

Recommendations

RECOMMENDATION 1:

Expand capacity for the treatment of substance use disorders for all citizens in need of those services throughout the Commonwealth. (p. 17-21)

Action Steps:

1. Implement expanded Medicaid reimbursement to include treatment for substance use disorders.

The Council recommends that General Assembly appropriate $5.8 million[3] in General Funds in the 2005 Appropriations Act to be available in 2006 to provide state match for Federal Fund Participation from Medicaid to support the full range of substance use disorder treatment services for eligible children and adults (Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, 1999).

a. The Council recommends that the General Assembly amend the *Code* of Virginia to include the Director of the Department of Medical Assistance Services (DMAS) to the Substance Abuse Services Council.

b. The Council recommends that the General Assembly require DMAS to collaborate with the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and public and private providers of treatment for substance use disorders and consumer representatives to draft regulations for the State Medical Assistance Plan. The work required to ensure successful implementation (i.e., developing or modifying regulatory language) should begin as soon as General Funds are appropriated.

Pending action on 1.b., above, the Council should assemble an implementation work group, jointly staffed by DMAS and DMHMRSAS, with appropriate representation from the provider community and consumer groups, to:

i. Ensure the successful and timely implementation of Medicaid reimbursement for the treatment of the full spectrum of substance use disorders; and

ii. Ensure that appropriate guidance is provided for reimbursement for co-occurring disorders.

2. The Council recommends that the Secretaries of Health and Human Resources, Public Safety and Education direct agencies involved in the provision of substance use disorder services explore and identify opportunities, including collaborative opportunities that cross departmental boundaries, to redirect funds for the purpose of expanding community-based

[3] The Medical CPI for Urban Consumers in the Washington-Baltimore, DC, MD, VA and WV area (Table 16A) increased 10.4% from 1999 (when the data for the original study were accurate) to 2003, with a mean average of 2.6%. This projection added the mean for 2004-2006, the earliest year regulations would likely be enacted, resulting in a total increase of 18.2%.

substance abuse treatment and prevention services in localities across the Commonwealth. DMHMRSAS should take a lead role in exploring opportunities to expand the successful concept of reinvestment of funds currently used to support persons with mental illness and substance use disorders in institutional settings. These funds should be redirected to expand the availability of community-based substance abuse treatment and prevention services in localities, and strengthen the infrastructure of the existing services system. Whenever possible these opportunities should be developed collaboratively with other agencies (p.17).

3. The Substance Abuse Services Council will undertake a detailed study of issues related to insurance coverage for the treatment of substance use disorders in Virginia and make a report with specific recommendations by December 2006. The resulting report shall include the limits of coverage, the impact on Virginians who are otherwise insured, and an estimate of the impact on both private and publicly funded programs (p.20).

RECOMMENDATION 2:

Expand the scope of substance use disorder prevention activities for youth and families of Virginia. (p. 22-25)

Action Steps:

1. The Council recommends that the General Assembly raise the user fees on tobacco products to a minimum of the national average and target a percentage of those funds to support the expansion of local prevention programs by requiring Virginia's Health Care Trust Fund to allocate a minimum of 20% of the revenues from the increased user fees on tobacco products for evidence-based prevention initiatives, to be administered by DMHMRSAS, and implemented and coordinated through local community services boards.

2. The Council recommends that the General Assembly amend the *Code* to add representatives from the following organizations to the Substance Abuse Services Council membership in order to enhance collaboration within the four cabinets (Education, Health and Human Resources, Public Safety and Transportation):

a. Department of Alcoholic Beverage Control (ABC)

b. Department of Motor Vehicles (DMV)

c. Governor's Office for Substance Abuse Prevention (GOSAP)

d. Virginia Tobacco Settlement Foundation (VTSF)

3. The Council will integrate GOSAP's 2003 *Substance Abuse Prevention Plan for Virginia's Youth: Gaining Traction* into the plan and work of the Substance Abuse Services Council.

4. The Council will integrate those elements of the *Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol* recommendations that pertain to the assessment,

treatment and prevention of substance use disorders into the plan and work of the Substance Abuse Services Council.

5. The Council recommends that the Secretaries of Health and Human Resources and Public Safety direct DMHMRSAS and ABC, working with the support of the Council, provide leadership to co-sponsor a summit on underage drinking, involving the departments of Education (DOE), Health (VDH), Juvenile Justice (DJJ), Criminal Justice Services (DCJS), DMV, GOSAP, Virginia Alcohol Safety Action Program (VASAP), the Prevention Task Force of the Virginia Association of Community Services Boards (VACSB), the office of the Executive Secretary of the Virginia Supreme Court, youth, including those representing such organizations as the Governor's Youth Public Safety Advisory Council (GYPSAC), Youth Alcohol and Drug Awareness Program (YADAP), Students Against Drunk Driving (SADD), and U-Turn, colleges and universities, Mothers Against Drunk Driving (MADD) and other organizations in the planning and execution of the event. The purpose of the summit will be to expand and capitalize on the recent, positive gains made in Virginia with regard to reducing the dangers posed by the misuse of alcohol and to better inform state and local policy makers and leaders about:

a. The nature, scope and degree of underage alcohol use in the Commonwealth;

b. The effects of underage alcohol use on youth;

c. Current efforts at enforcement, prevention and treatment, including treatment capacity for youth in the Commonwealth;

d. Policy measures that may be effective in reducing underage access to alcoholic beverages; and

e. Strategies for future exploration that may be effective in the Commonwealth to reduce youth access to alcoholic beverages, including community initiatives such as local law enforcement strategies and prevention programs, as well as legislative action that could be considered by the General Assembly.

6. The Council recommends that the Secretaries of Health and Human Resources and Public Safety direct DMHMRSAS, GOSAP and the Department of Social Services (DSS) to collaborate in the development of protocols for screening families, particularly those involved with the child welfare system, to identify children at high risk of developing substance use disorders for referral to appropriate, evidence-based prevention services.

RECOMMENDATION 3:

Expand the availability of substance use disorder treatment for youth and families throughout the Commonwealth. (p.22-25)

Action Steps:

1. The Council recommends that the General Assembly identify and establish stable funding sources for treatment for youth and families, in community-based and institutional settings.

2. The Council will work with member agencies to identify and promote model collaborative, interagency programs that identify youth with substance use disorders in the community as early as possible, promote prompt referral for needed assessment and services, and promote the use of appropriate incentives to retain those youth in the prescribed services.

3. The Council will identify and promote appropriate systems of care for youth with substance use disorders involved with the juvenile justice system, in both community-based and institutional settings, promoting those that have demonstrated effectiveness.

4. The Council recommends that the General Assembly establish adequate and stable funding for Family Drug Courts to support the recommendations arising from the *Safe Families in Recovery Project*, an 18-month in-depth technical assistance grant from the National Center on Substance Abuse and Child Welfare (NCSACW). This initiative utilized an interagency planning group, including staff from the Departments of Social Services (DSS) and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and the Office of the Executive Secretary of the Virginia Supreme Court and focused on improving outcomes for families affected by substance use who are involved in Virginia's child welfare and juvenile court system.

5. The Council recommends that the Secretary of Health and Human Resources direct DMHMRSAS and DSS to collaborate in identifying screening tools and developing training on identifying substance use disorders and making referrals for assessment and services for child welfare services staff working with families.

RECOMMENDATION 4:

Expand treatment opportunities for adults in the criminal justice system, both within institutions and in community-based settings.

Action Steps:

1. The Council recommends that the General Assembly identify adequate and appropriate funding mechanisms to implement and support effective community-based screening, assessment, prevention, education and treatment, including drug courts, for offenders with substance use-related problems (p. 28 - 30).

2. The Council recommends that the General Assembly identify an adequate and appropriate funding mechanism for in-prison and transitional work release programs.

3. The Council recommends that the General Assembly amend the *Code* to include a Virginia Drug Court Association (VDCA) representative to the Council.

RECOMMENDATION 5:

Advocate and market recovery from substance use disorders and reduce stigma throughout the Commonwealth. (p. 11-16)

Action Steps:

1. The Council, in collaboration with the Substance Abuse and Addiction Recovery Alliance (SAARA), will educate the citizens of the Commonwealth about the nature of addiction, the efficacy of treatment, the nature of recovery from addiction, and the treatment and recovery-related economic benefits for the larger community.

2. The Council will partner with relevant agencies and organizations to develop a positive social marketing campaign emphasizing "Recovery Works".

3. The Council will promote the participation of state and local elected officials in science-based training opportunities within the Commonwealth about the nature of addiction, recovery and evidence-based practices for treating and preventing substance use disorders.

RECOMMENDATION 6:

Improve the quality and effectiveness of existing services. (p. 11-16)

Action Steps:

1. The Chair of the Council will convene an *ad hoc* interagency workgroup of Substance Abuse Services Council members to develop and recommend standards and benchmarks of quality regarding clinical treatment and administrative operational aspects of services designed to address substance use disorders. This workgroup should also recommend one or more interagency agreements on how state regulatory and funding agencies would promote the adoption of these standards throughout the system of care, including the related workforce development issues.

2. The Council will plan and implement a review of state agency substance use disorder treatment programs, in an ongoing effort to fulfill its legal mandates (*Code* of Virginia § 37.1-207.1). Such a review should include:

a. A survey state agencies and organizations in order to identify current and planned programs, objectives, outcome measures, actions, and costs.

b. An estimate the extent to which these programs have met the demand for alcohol and drug treatment services in the Commonwealth.

c. Development of 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.

d. An assessment of each agency's capacity to collect, analyze, and report the following information:

   i. The amount of funding expended under such programs for the prior fiscal year;

   ii. The number of individuals served by the program using that funding; and

   iii. The extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures.

e. An assessment of the Council's needs and capacity for making meaningful cross-program and cross-agency comparisons of operational and cost effectiveness.

3. The Council will promote the adoption by Commission on Virginia Alcohol Safety Action Programs (VASAP) of quality standards for the delivery of substance abuse services in order to improve treatment outcomes for DUI offenders, by undertaking the following activities:

a. Development of a plan that coordinates substance abuse intervention and treatment programs and services in partnership with the Commission on Virginia Alcohol Safety Action Programs (VASAP), the Department of Mental Health, Mental Retardation and Substance Abuse Services and other partners, by September 2005. In particular, this plan will:

   i. Establish statewide goals and priorities for substance abuse intervention and treatment efforts, placing a high priority on hard core drunk drivers, and repeat offenders;

   ii. Identify and promote a standardized assessment tool that can be used by all services providers to help match individuals to appropriate intervention and treatment programs;

   iii. Recommend that VASAP adopt uniform, statewide substance abuse standards and treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness;

   iv. Identify and promote programs that have documented success; and

   v. Recommend that VASAP collect and track standardized data, as identified by the Council, collected from administration of standardized assessments to identify characteristics of at-risk populations in order to enhance the design of effective prevention, intervention and treatment programs.

b. Develop a longer-term plan designed to increase the availability of DUI and boating under the influence (BUI) intervention and treatment services and identify successful programs and approaches, no later than 2008. This plan should:

   i. Identify resources and recommend lead organizations for program implementation;

   ii. Recommend methods to increase the availability and intensity of effective intervention and treatment programs to expand the range of available options for judges;

   iii. Recommend a coordinated system to conduct or catalog substance abuse needs assessments, by locality, for youth and at-risk populations to document problems, measure progress and guide resource allocation decision-making;

   iv. Identify prevention, intervention and treatment approaches and programs that have documented success.

4. The Council will recommend that the Secretary of Health and Human Resources support the expansion of integrated/evidence-based treatment programs for co-occurring disorders in communities and institutional settings by:

a. Directing DMHMRSAS to expand the availability of training in assessment, treatment and epidemiology of co-occurring mental illness and substance use disorders for service providers and administrators through a specialized track at the 2005 Virginia Summer Institute for Addiction Studies.

b. Directing that DMHMRSAS fund the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC) to develop and provide on-line training for treatment providers specific to co-occurring mental illness and substance use disorders.

c. Directing the Council to convene an ad hoc interagency workgroup of Council members and other representatives of the service provider community to determine to what extent current public and private sector reimbursement for services policies impact the delivery and quality of services for persons with co-occurring mental illness and substance use disorders in Virginia.

Appendix A

Code of Virginia § 37.1-207

§ 37.1-207 SUBSTANCE ABUSE SERVICES COUNCIL

A. There is hereby established the Substance Abuse Services Council, hereafter referred to in this section as "the Council." The Council shall advise and make recommendations to the Governor, the General Assembly, and the Board on broad policies and goals and on the coordination of the Commonwealth's public and private efforts to control alcohol and other drug abuse.

B. The Council shall consist of twenty-four members. Four members of the House of Delegates shall be appointed by the Speaker of the House of Delegates, and two members of the Senate shall be appointed by the Senate Committee on Privileges and Elections, to serve as ex officio members of the Council with full voting privileges. The Governor shall appoint one member representing the Virginia Sheriff's 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 Superintendent of Public Instruction; the Directors of the Departments of Juvenile Justice, Corrections, Criminal Justice Services, and Social Services; 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 agency heads 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. The members of the Council shall receive no compensation for their services but shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties.

F. The duties of the Council shall be:

1. To recommend policies and goals to the Governor, the General Assembly, and the 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 control programs;
4. To define responsibilities among state agencies for various programs for persons with substance abuse problems 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.

Appendix B

Substance Abuse Services Council
Membership Roster

Substance Abuse Services Council
Membership Roster

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Appendix C

Substance Abuse Services Council Bylaws

BYLAWS
OF
THE SUBSTANCE ABUSE SERVICES COUNCIL

Adopted January 9, 2002

Amended April 25, 2003

ARTICLE I

NAME

The name of this organization shall be the Substance Abuse Services Council, hereinafter referred to as "the Council."

ARTICLE II

AUTHORITY

The authority for the Council is established and defined in § 37.1-207 of the *Code of Virginia*.

ARTICLE III

PURPOSE AND DUTIES

§ 1. The purpose of the Council shall be:

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, on goals, and on the coordination of the Commonwealth's public and private efforts to control alcohol and other drug abuse.

§ 2. The duties of the Council shall be:

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

B. To coordinate state agencies' programs and activities in order to prevent duplication of functions through review and comment on agency plans for substance abuse;
C. To combine all agency plans into a comprehensive interagency state plan for substance abuse services;
D. To review and comment on annual budget provisions regarding substance abuse and on all applications for state or federal funds or services to be used in substance abuse control programs;
E. To develop recommendations and plans for strengthening substance abuse control activities; and
F. To make investigations, issue annual reports to the Governor and the General Assembly, and make recommendations relevant to substance abuse upon request of the Governor.

§ 3. All policy recommendations, reports, plans and any other formal written products of the Council required by the Code shall be distributed, in final draft form, to all Cabinet Secretaries of the Commonwealth to provide an opportunity for review and comment, before each such document is finalized for presentation to the Governor and/or General Assembly.

ARTICLE IV

ANNUAL REPORT

§ 37.1-207 of the *Code of Virginia* requires that an annual report be made to the Governor and the General Assembly. A report shall be made available to the Governor by September 1 for consideration of budgetary and legislative recommendations formulated by the Council to address the problems of alcohol or drug abuse. In addition, a report shall be forwarded to Legislative Services by December 1 for publication and dissemination to the General Assembly.

ARTICLE V

MEMBERSHIP

§ 1. In accordance with § 37.1-207 of the *Code of Virginia*, the Council will consist of 24 members.

A. The Speaker of the House of Delegates shall appoint four members of the House of Delegates
B. The Senate Committee on Privileges and Elections shall appoint two members of the Senate
C. The Governor shall appoint;

- One member representing the Virginia Sheriff's Association;
- One member representing the Substance Abuse Certification Alliance;

- Two members representing the Virginia Association of Community Services Boards;
- Two members representing statewide consumer and advocacy organizations;
- The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services;
- The Commissioner of Health;
- The Superintendent of Public Instruction;
- The Director of the Department of Juvenile Justice;
- The Director of the Department of Corrections;
- The Director of the Department of Criminal Justice Services;
- The Director of the Department of Social Services;
- The Executive Director of the Commission on the Virginia Alcohol Safety Action Program;
- The Chair of the Virginia Association of Drug and Alcohol Programs;
- The Chair of the Virginia Association of Alcoholism and Drug Abuse Counselors;
- The Chair of the Substance Abuse Council; and
- The Chair of the Prevention Task Force of the Virginia Association of Community Services Boards.

D. Appointments of agency heads shall be for terms consistent with their terms of office. All other members shall be for terms of three (3) years except an appointment to fill a vacancy, which shall be for the unexpired term. 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.

E. The Governor shall appoint the Chairman from among the Members.

§ 2. All members shall have one (1) vote in matters brought for consideration before the general membership of the Council.

§ 3. A. The appointed member may be represented by a designee.

B. In order to be allowed to vote in Council business, the designee must be a specific individual named in official correspondence to the Council Chair and copied to the Vice-Chair.

ARTICLE VI

OFFICERS

§ 1. The officers of the Council shall consist of a Chair, a Vice-Chair, and Chairs of any standing or ad hoc committees.

§ 2. The Chair is appointed by the Governor. The Chair shall be the chief officer of the Council and shall coordinate all of its affairs. The Chair shall preside at all meetings of

the Council. In the absence of the Chair, the duties of that office will be performed by the Vice-Chair.

§ 3. The Vice-Chair shall be elected by a simple majority of the membership present, for a term of one year.

§ 4. Chairs of any standing or ad hoc committees shall be appointed by the Chair for a period to be specified at the time of appointment, not to exceed one year.

§ 5. The Department of Mental Health, Mental Retardation, and Substance Abuse Services shall provide staff assistance, to assure that all minutes of council meetings are recorded, send notices of meetings to members, and prepare correspondence as directed by the Council. Staff of the other organizations represented on the Council may provide additional support.

ARTICLE VII

COMMITTEES

§ 1. The purpose of committees is to provide the general membership of the Council with information and recommendations on the committee's designated area(s) of focus and to carry out specific tasks as assigned to them by the Chair.

§ 2. Committees will consist of a Chair and at least two other Council members appointed by the Chair. The members of the committees serve at the pleasure of the Chair. Committees may include membership from outside the Council, upon the approval of the Chair.

A. Members of the Council may nominate outside members for the committees. Appointment of outside members to the committees shall be by the Chair of the Council upon recommendation by the committee Chair. There may be a maximum of three (3) outside members per committee. Outside members may vote within the committee, but may not vote on the council. Terms of outside members shall be for one year, and appointments may be renewed.

§ 3. There shall be three standing committees:

A. A Comprehensive Planning Committee which will bear primary responsibility for the coordination and development of the Comprehensive Interagency State Plan and annual reports from the Council.
B. A Program Committee that is informed about and reviews substance abuse programming within the Commonwealth for the purpose of recommending strategies to reduce duplication of effort and to foster collaborative initiatives.

C. A Budget Committee that provides for the review of state budget requests for substance abuse reduction and control efforts for the purpose of recommending strategies for cost efficiency and effectiveness.

§ 4. Ad hoc committees may be established by action of Council or by the Chair.

ARTICLE VIII

MEETINGS

§ 1. The Council shall meet at least four (4) times annually and more often if deemed necessary or advisable by the Governor or the Chair.

§ 2. Council meetings are open to the public, provided however, that in special circumstances the Council may meet in closed session for purposes authorized by the Virginia Freedom of Information Act.

§ 3. Committee meetings shall be held, as necessary, at scheduled times and places.

ARTICLE IX

QUORUM

The quorum for a meeting of the Council shall be ten members, one to be the Chair or Vice-Chair.

ARTICLE X

PARLIAMENTARY AUTHORITY AND VOTING

§ 1. Decisions of the Council shall be made by majority vote of the established quorum and in accordance with Roberts' Rules of Order Revised.

§ 2. Decisions of the committees shall be by a simple majority vote of the membership of the committee.

§ 3. Voting of the Council and its committees shall normally be by voice. In every instance where a vote other than a simple majority is required, or at the discretion of the Chair, the vote shall be by the show of hands. The vote of any member will be recorded in the minutes at the request of the member.

§ 4. A “majority” is defined as any number of votes greater than one half of the established quorum.

ARTICLE XI

AMENDMENTS

§ 1. These bylaws may be amended at any general meeting of the Council, provided the texts of the proposed amendments have been submitted in writing to members of the Council at least 30 days prior to the vote. Submission in writing may include electronic submission.

§ 2. Proposed amendments shall be introduced and seconded at a general meeting of the council as an order of new business.

§ 3. Amendments to these bylaws shall require a vote of 2/3 of the membership. For the purpose of obtaining votes of 2/3 of the membership, absentee ballots signed by the member may be used. Absentee ballots may be submitted electronically, utilizing the Council member's email account of record, which shall serve as the member's electronic signature.

Appendix D

Survey of State Agencies and Organizations Concerning Services for the Prevention or Treatment of Substance Use Disorders

Instrument and Compiled Responses

A. Needs Assessment

1. Does your organization conduct formal or informal needs assessments related to services for substance use disorders?		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**
DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	No	
DMAS	No	
DMHMRSAS	Yes	Summary provided; study reports available upon request
DRS	No	
DSS	No	
VDH	No	
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	
DJJ	Yes	Substance abuse services initiative document (February 2001) provided
DOC	Yes	Provided
GOSAP	No	
VSP	No	

2. Does your organization routinely screen some or all clients to determine the need for substance use problem or disorder assessment or treatment?		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**
DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	No	
DMAS	No	DMAS does not provide direct services
DMHMRSAS	Yes	CSBs use the Addiction Severity Index (ASI), the University of Rhode Island Change Assessment (URICA)

DRS	Yes	DRS Rehabilitation Counselors conduct individual interviews with clients to identify disabling conditions and barriers to employment, which may include substance abuse disabilities. Rehabilitation Counselors may arrange for formal assessments of any condition identified as a potential barrier to employment to diagnose or substantiate the existence of a condition, clarify functional limitations, treatment recommendations, etc.
DSS	Yes	CPS investigators do investigate complaints, and if substance abuse appears to be a problem in the home, then services will be arranged. There is not standard assessment instrument used in CPS for SA. VDSS has funded eleven projects (covering 35 local departments of social services) for individuals who are receiving Temporary Assistance for Needy Families (TANF) and have a substance abuse and/or mental health disorder. These projects routinely use substance abuse both pre-screening and screening tools to help identify individuals with a disorder.
VDH	Yes	Interview; urine toxicology if indicated by positive interview
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	Most local pretrial and post trial CCCP program use the Simple Screening Instrument (SSI) over 30,000 offenders annually
DJJ	Yes	DJJ uses the Substance Abuse Subtle Screening Instrument (SASSI) – Adolescent Version Revised, the Alcohol and Drug Questionnaire portion of the Adolescent Problem Severity Index (APSI), the Child and Adolescent Functioning Assessment Scale (CAFAS), the DSM-IV TR, and the clinical interview to assess substance abuse or dependence disorders on all institutional juveniles as well using the SASSI, CAFAS, and the APSI on some community based juveniles.
DOC	Yes	In reception, Simple Screening Instrument (SSI) is utilized. In the institutions, the Addiction Severity Index (ASI) is used.
GOSAP	No	
VSP	Yes	Random Testing

B. Agency/Organization Planning

1. Does your organization's strategic plan address identification, prevention or intervention of substance use problems or disorders in its service population?		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**
DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	Yes	Copy not available at this time
DMAS	No	
DMHMRSAS	Yes	Summary provided
DRS	No	
DSS	Yes	See DSS Attachment B
VDH	No	
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	
DJJ	Yes	Substance Abuse Services Initiative document (February 2001) provided
DOC	Yes	Provided
GOSAP	No	
VSP	No	

2. Do staff in your organization routinely receive training about substance use disorders related to your service populations? Direct Service Personnel (DSP), Mid-Level Supervisory/Management (MSM), Upper Level Management (ULM)		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**
DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	Yes (DSP, MSM)	
DMAS	N/A	DMAS is not a direct service provider
DMHMRSAS	Yes (DSP, MSM)	
DRS	No	
DSS	No	Courses available for child welfare staff but not

		mandated
VDH	Yes (DSP)	Occasionally
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	
DJJ	Yes (DSP, MSM, ULM)	
DOC	Yes (DSP, MSM, ULM)	
GOSAP	No	
VSP	No	

3. Please list the names of any organizations with which you collaborate in the provision of services related to substance use disorders, indicating the level of collaboration …

1 = Basic referrals to other agencies/organizations.

2 = Collaboration and joint planning with other agencies or organizations on policies, procedures, regulations. Interagency case staffing. This may require joint/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 collaborative.

Secretary of Commerce & Trade			
Agency	**Answer**		**Notes**
	Organization	**Ratings**	
VEC	No response		
Secretary of Education			
Agency	**Answer**		**Notes**
	Organization	**Ratings**	
DOE	No response		
VCCS	No response		
Secretary of Health & Human Resources			
Agency	**Answer**		**Notes**
	Organization	**Ratings**	
DHP	VCUHS	6	DHP contracts with VCUHS to provide monitoring for impaired practitioners
DMAS	DMHMRSAS	2,3,4	
DMHMRSAS	Department of Corrections	3	
	Department of Juvenile Justice	3	
	Department of Social Services	3	
	Department of Rehabilitative Services	4	
	Mid Atlantic Addiction	6	

	Technology Transfer Center		
DRS	CSBs (19 locations)	2	
	Private Treatment Providers	1	
	DMHMRSAS	6	
DSS	DMHMRSAS	2,3	2 – Child Welfare Services 3 – TANF
	VDH	2	Child Welfare Services
	DRS	3	TANF
VDH	CSBs	1	
	Project LINKs	1	
Secretary of Public Safety			
Agency	**Answer**		**Notes**
	Organization	**Ratings**	
DCJS	DJJ	2,3	
	DOC	2,3	
	CSAO	5	
	Substance Abuse Services Council	6	
	DMHMRSAS	6	
	Local Community Criminal Justice Boards	3,4	
DJJ	CSBs	1	
	DCJS	3	
	Gateway Foundation, Inc.	3	
	Mid Atlantic ATTC	Training	
	Private Service Providers	1	
DOC	DCJS	5	
	DMHMRSAS	6	
	Hegira House - BRBH	3	
	Serenity House	3	
	Gemeinschaft Home	3	
	CSBs	4	
GOSAP	N/A		
VSP	DHRM – Magellan Behavioral Health	1	

4. Are you linked to any advocacy groups?		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**

DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	No	
DMAS	Yes	
DMHMRSAS	Yes	
DRS	No	
DSS	No	
VDH	No	
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	
DJJ	Yes	In the Division of Institutions only
DOC	Yes	
GOSAP	No	
VSP	No	

C. Programs and Services

1. Does your organization provide specific programs and services to identify, prevent, or intervene in substance use problems or disorders?		
Secretary of Commerce & Trade		
Agency	**Answer**	**Notes**
VEC	No	
Secretary of Education		
Agency	**Answer**	**Notes**
DOE	No	
VCCS	No	
Secretary of Health & Human Resources		
Agency	**Answer**	**Notes**
DHP	Yes	Health Practitioners' Intervention Program
DMAS	Yes	Residential Treatment and Day Treatment for Pregnant and Post Partum Women
DMHMRSAS	Yes	See Attachment A: DMHMRSAS
DRS	No	DRS provides vocational rehabilitation services to eligible individuals with substance abuse disabilities that may include vocational guidance, counseling, vocational evaluation, vocational training, education, assistance with job placement, job seeking skills, job follow up after placement, dependent upon the individuals needs, aptitude and abilities. It is believed that an individual must be in treatment or have been successful in a treatment program in order to benefit from the services

		offered by DRS. Early orientation and introduction to DRS is encouraged as part of the treatment and recovery plan, although many services may not actually be initiated until stability is demonstrated.
DSS	Yes	For TANF population
VDH	No	
Secretary of Public Safety		
Agency	**Answer**	**Notes**
DCJS	No	Grant funds to or support, but not provide services
DJJ	Yes	See Attachment A: DJJ
DOC	Yes	See Attachment A: DOC
GOSAP	No	
VSP	No	

D. Agency/Organization Trends

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 Commerce & Trade	
Agency	**Answer**
VEC	No response
Secretary of Education	
Agency	**Answer**
DOE	N/A
VCCS	1. The community colleges offer low cost educational programs that can lead to employment opportunities or programs that provide a foundation to pursue a college degree at a four-year institution of higher education.
	2. Community college opportunities are geographically available to all Virginians.
Secretary of Health & Human Resources	
Agency	**Answer**
DHP	1. Health Practitioners' Intervention Program – provides an avenue for all healthcare practitioners regulated by DHP (270,000+) to receive assistance with their recovery, while helping to ensure the safety of VA citizens
DMAS	1. Funds SA treatment for pregnant and post-partum women, currently making access easier
DMHMRSAS	1. A locally based service delivery system that provides services to all residents, regardless of ability to pay through 40 community services boards (CSBs).
	2. A strong systemic emphasis on human resource development
	3. An emerging focus on evidence-based standards of care and technical assistance to the CSBs
DRS	1. Successful Employment which can be seen as a goal of recovery
	2. 21 Rehabilitation Counselor positions dedicated to serving eligible

	individuals with SA disabilities
DSS	1. COV 63.2-1509 requires interagency referrals between health care, CPS, & CSBs for substance exposed newborns; COV provides a legislative framework for the interdisciplinary management of peri-natal substance use and substance exposed newborns.
	2. 6/03 DMHMRSAS, DSS, & Office of Executive Secretary of the Supreme Court received a two year federal grant from the National Center on Substance Abuse and Child Welfare Services to develop an integrated state level, strategic plan to improve child safety, parent recovery, and permanency outcomes for families with substance abuse disorders known to the child welfare and court systems.
	3. Enhanced substance abuse and mental health services in 35 localities with special projects that are resulting in improved outcomes in family functioning and employment of TANF clients. Collaboration has been the backbone of these efforts at the state level (VDSS, DMHMRSAS, DRS) and at the local level among local departments of social services, DRS field offices, CSBs, and area health offices (Stone Mountain Health Clinic, DOH centers)
VDH	1. Screening for substance use in pregnancy is a standard of care
Secretary of Public Safety	
Agency	**Answer**
DCJS	1. Agency does not provide direct services, but funds through grants programs that provide direct services
DJJ	1. Institutions – Streamlined assessment process (all youth screened at the Reception and Diagnostic Center) and on going staff training programs
	2. Institutions – Substance abuse treatment services are a function of mental health treatment services rather than correctional services.
	3. Community Programs – knowledgeable staff aware of substance abuse issues and good relationships in many localities with service providers.
DOC	1. Mandated Substance Abuse Treatment provided; treatment model based on research findings
	2. Transitional Substance Abuse Services/Continuum of Services
	3. High Quality Staff/Substance Abuse trained and credentialed
GOSAP	1. Provide resources for communities to implement substance abuse prevention services
	2. Implementation of a capacity building project for providers around best practices in substance abuse prevention
VSP	1. Random Drug Testing (Drugs/Alcohol)
	2. General Order #54 to address stress induced problems and post-traumatic stress
	3. Work Place Violence (General Order #79)

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 seen, special cultural issues, special medical issues, drugs of abuse).	
Secretary of Commerce & Trade	
Agency	**Answer**
VEC	N/A
Secretary of Education	
Agency	**Answer**
DOE	N/A
VCCS	1. Substance abuse at younger ages
Secretary of Health & Human Resources	
Agency	**Answer**
DHP	1. Increase in Opiate use/dependence
DMAS	1. Identifying pregnant women with SA treatment needs
	2. Improving access to services
	3. Special medical needs of pregnant women
DMHMRSAS	1. Increased use of opiate-type substances
	2. Increased numbers of persons with co-morbid mental illness
	3. Increased severity
DRS	1. Elimination of SA treatment programs among some CSBs or lack of access to SA treatment due to funding issues
	2. Increased severity of drug abuse/dependence and co-occurring conditions
	3. Increased incidence of criminal history backgrounds
DSS	1. Adverse affects of parental substance use on child development, safety, well-being, and employment.
	2. Service providers need to utilize a holistic, family approach to the management of substance abuse and mental health disorders, especially when there are children in the family. For those serving TANF clients, they need to link the treatment program with employment activities.
	3. Local social service staff have become far more effective in identifying individuals with potential substance abuse disorders, but still need to enhance this area and to identify individuals sooner. Once identified, TANF clients need more time (than is currently allowed) to address their issues before they enter the workplace.
VDH	1. Lack of motivation by providers to screening because of lack of services available for referral
	2. Providers report lack of time and being overwhelmed with many other priorities
Secretary of Public Safety	
Agency	**Answer**

DCJS	1. The decrease in available general funds and federal funds (Byrne) for SAS is a major issue.
	2. The general lack of rehabilitation and treatment services for substance abusing offenders is an issue.
	3. The lack of strong code structure that would allow for the ongoing funding and administration of drug court programs is a big issue.
DJJ	1. The number of youth requiring substance abuse treatment services continues to rise in Institutions, and Community Programs notes the high correlation between substance use and juvenile offending as well.
	2. Developing treatment programs, for committed youth, which coordinate with length of commitment.
	3. Institutions - Developing treatment programs for a wide scope of the juvenile population, i.e. gender, age, developmental level, range of substances used, cultural backgrounds, geographical influences, etc.
DOC	1. Co-occurring Substance Abuse and Mental Health issues being addressed.
	2. Collaborative efforts between DOC medical department, VCU, and VA Health Dept. addressing HIV and Hepatitis C; providing seamless discharge planning for medical services.
	3. Acknowledging and addressing special population substance abuse issues: i.e. youthful offenders, dual diagnosed, geriatric, women, physically challenged, and multicultural issues.
GOSAP	1. Building capacity for the evaluation of prevention initiatives and practice
	2. Fidelity and adaptation of model programs
	3. Providing resources for geographic service gaps across the state
VSP	1. Changes in ages of clients seen
	2. Drugs of abuse
	3. Special cultural issues

3. How can your agency strengthen services in order to have the greatest impact on the community?	
Secretary of Commerce & Trade	
Agency	**Answer**
VEC	N/A
Secretary of Education	
Agency	**Answer**
DOE	N/A
VCCS	Enhanced publicity about available opportunities at local community colleges.
Secretary of Health & Human Resources	
Agency	**Answer**
DHP	1. By continuing to identify and monitor impaired practitioners in order to ensure public safety.
DMAS	1. Improve access by changing service limitations
DMHMRSAS	1. Increase use of evidence-based practices through training and education of

	providers, standards, TA
	2. Increased collaboration with other agencies serving same client base to coordinate philosophy of care and resources for training of staff and treatment of clients/patients
	3. Increased resources (funding)
DRS	1. Fund all 21 dedicated Rehabilitative Counselor positions and add staff to cover all CSBs.
DSS	1. Provide more training on substance abuse and expand the use of substance abuse screening tools, which are used by TANF staff, to include use by child welfare services.
	2. Include substance abuse treatment as one of the core services in the future TANF program when this service is needed by TANF clients.
	3. Identify linkages between TANF and child welfare services in the management of substance abuse disorders.
VDH	No response
Secretary of Public Safety	
Agency	**Answer**
DCJS	1. We could receive more funding to support Law Enforcement, Court and Correctional Service agencies.
	2. Increase planning and research to better identify best practices in substance abuse treatment area to reduce crime and improve public safety.
DJJ	1. Community Programs – reinstitute screening/assessment treatment activities in court service 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
DOC	1. Develop additional transitional resources/collaborate closely with service providers
	2. Develop a community support board to assist to the involvement of advocate and untapped resources; prioritize most effective resources based on findings in program evaluations and research data
	3. Implement creative means of promoting continued staff development
GOSAP	1. Enhance evaluation capacity at the State and community levels
	2. Facilitate the coordination and collaboration of state level efforts
	3. Through a systematic process identify prevention service gaps
VSP	1. Work with courts and service agencies identifying those in need of intervention and referral (based upon enforcement).

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 Commerce & Trade	
Agency	**Answer**
VEC	N/A
Secretary of Education	
Agency	**Answer**
DOE	N/A
VCCS	1. Ensuring availability of rehabilitation/treatment opportunities
	2. Assistance to clients with medication costs
	3. Financial assistance to clients to meet tuition costs
Secretary of Health & Human Resources	
Agency	**Answer**
DHP	No response
DMAS	1. Focus on prevention
DMHMRSAS	1. Expand Medicaid to reimburse all SA treatment for all eligible populations.
	2. Reinstitute and expand SABRE (Substance Abuse Rehabilitation and Education) program for young offenders
	3. Fund drug courts statewide for General District Courts and family drug courts for Juvenile and Domestic relations courts.
DRS	1. Increase funding for treatment in the community.
	2. Ensure access to treatment including those with private insurance and in those correctional facilities
	3. Increase & repeated educational opportunities for all age groups
DSS	1. Maintain and expand Family Drug Courts recognized nationally as models for improved outcomes.
	2. Evaluate the feasibility of including children of substance abusers as a targeted population for case management services utilizing Medicaid coverage.
	3. Re-evaluate the use of Medicaid for the payment of substance abuse treatment services.
VDH	1. Fund all levels of services (residential, day care, therapy) for pregnant women.
	2. Expand Project LINK to all communities.
	3. Streamline regulations.
Secretary of Public Safety	
Agency	**Answer**
DCJS	1. Do statewide planning on the need for substance abuse services in the Criminal Justice System.
	2. Standardize and increase the funding and support of SA screening, assessment, intervention and treatment services within the Criminal Justice System.
DJJ	1. Community Programs – provide more treatment services for adolescents; and

	require community service boards (CSBs) to prioritize treatment of adolescents.
	2. Institutions – return SABRE funding, thereby creating enhanced treatment and transitional services; and enhance community support programming for recovering persons.
	3. Institutions – Enhance early intervention and prevention programming; Community Programs – require publicly funded providers (CSBs) to use more effective, evidence-based adolescent treatment approaches.
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 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	1. Identify prevention as a core service in the continuum of care
	2. Create policy around resource development and allocations for prevention services
VSP	1. Education
	2. Making service available to those in need with problems
	3. Enforcement of current laws

Department of Education

<u>Attachment A</u>: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Prevention/Intervention, Education**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Elementary, Middle and Secondary Students**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **<u>899,608</u>**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$5,951,331	$6,668,612	$6,658,953	Pending

State				
Local				
Other (fees, donations)				
Total	$5,951,331	$6,668,612	$6,658,953	Pending

* *In the absence of other information*, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. *Is this program based on evidence-based practices?* **[X] Yes [ ] No**

***If yes**, please describe briefly:* **The Safe and Drug-Free Schools Program supports activities that prevent violence and the illegal use of alcohol, drug and tobacco products. This program is based on the Principles of Effectiveness and requires school divisions to use programs and activities that have been proven to be effective.**

6. *Do you systematically collect outcome data on participants in this program?*
[X] Yes [ ] No

If yes, please describe briefly. **The Code of Virginia requires all school divisions to submit data annually to the Department of Education on incidents of crime, violence and substance abuse.**

Department of Health Professions

Attachment A: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct* provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.) **Screening/Assessment, Referral, Case Management, (Monitoring of Healthcare Practioners)**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Licensed, certified or regulated healthcare practioners**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **713**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal				
State				
Local				
Other –Licensing fees	$1,500,000	$1,800,000	$2,000,000	$2,200,000
Total	$1,500,000	$1,800,000	$2,000,000	$2,200,000

* *In the absence of other information*, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. *Is this program based on evidence-based practices?* **[ ] Yes** **[X] No**
If yes, please describe briefly:

6. *Do you systematically collect outcome data on participants in this program?*
[X] Yes **[ ] No**
If yes, please describe briefly. **Contractor collects data**

Department of Medical Assistance Services

Attachment A: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Residential Treatment and Day Treatment for Pregnant and Post Partum Women.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Pregnant and post partum women**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **30 for SFY 2001**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$55,000 for FY 2001	Expect expenditures to increase due to service changes		
State	$55,000 for FY 2001	Expect expenditures to increase due to service changes		
Local				
Other (fees, donations)				
Total				

* *In the absence of other information*, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. *Is this program based on evidence-based practices?* **[X] Yes [ ] No**
If yes, please describe briefly: **Recent studies by the Center for Substance Abuse Treatment.**

6. *Do you systematically collect outcome data on participants in this program?*
[ ] Yes [X] No
***If yes**, please describe briefly.*

Department of Mental Health, Mental Retardation and Substance Abuse Services

Attachment A: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **The Department allocates state general and federal funds to 40 community services boards that provide a variety of services to residents residing in their respective catchment areas. Services include prevention and early identification, screening assessment and referral, case management, outpatient (including Opioid Replacement Therapy), intensive outpatient, day treatment, and a variety of residential treatment (including detoxification) and transitional living arrangements. Many CSBs have contracts with adult probation and parole, and some provide services in local jails.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents*, women with dependent children, youth under court supervision, incarcerated adults, etc.) **Services are provided to adults and children. Requirements of the federal Substance Abuse Prevention and Treatment Block Grant designate pregnant women and persons who inject drugs as priority admissions. In addition, department policy requires that women with dependent children, adolescents, persons with co-occurring mental illness**, and any person dependent on (as opposed to abusing) alcohol or other drugs receive priority admission.

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **59,895**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$41,592,586	$39,696,499	$40,191,898	$40,193,000
State	40,202,220	39,492,092	38,357,800	38,357,800
Local	29,357,709	33,588,057	36,679,475	37,000,000
Other (fees, donations)	14,541,810	15,460,676	17,561,146	17,750,000
Total	$125,694,325	$128,237,324	$132,791,319	$133,300,800

* In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. *Is this program based on evidence-based practices?* **[x] Yes [ ] No**

If yes, please describe briefly: **DMHMRSAS requires evidence-based practices for all prevention services, and strongly encourages the use of evidence-based practices, such as motivational enhancement techniques and other cognitive-based therapies, for all treatment services.**

6. *Do you systematically collect outcome data on participants in this program?*
[ ] Yes [x] No

Department of Social Services

Attachment A1: Program/Service Information – Child Welfare

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Child welfare services provides referrals to substance use services.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Abused and neglected children in their own homes, foster care, independent living due to parental substance use. (National data indicate that substance abuse is present in 50-80% of child welfare cases.)**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* _____
366 Substance exposed newborns FY 2002.
3001 (30.5%) of Virginia children in foster care were removed from their homes due to parental substance abuse (April 1, 1999 - March 31, 2000)

4. Estimated cost and source(s) of funds (July through June): -0- Child Welfare Services

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal				
State				
Local				
Other (fees, donations)				
Total				

* *In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.*

5. Is this program based on evidence-based practices? **[ ] Yes** **[x] No**
If yes, please describe briefly:

6. *Do you systematically collect outcome data on participants in this program?*
[ ] Yes **[x] No (c.w. services)**
***If yes**, please describe briefly.*

Attachment A2: Program/Service Information – TANF

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Thirty-five localities have enhanced substance abuse/mental health services for TANF clients through 11 special projects. Projects vary in structure, but services include screening, assessment, referral, case management, and treatment services provided directly by project staff and/or community services boards' regular programs. Almost all projects have staff from the community services boards and thus, through referrals, have access to the full array of services. Two projects utilize licensed social workers (LCSW), one with the LCSW on the staff of the local department of social services and the other, with the LCSW on the staff of the health clinic. Almost all projects have clinical staff on-site full or part-time. Intensive case management is typically offered for at least a short period of time. Some offer prevention/education services.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents,* women with dependent children, youth under court supervision, incarcerated adults, etc.) **Women with dependent children who are receiving or have recently left the TANF program. In Norfolk, the CSB is also working with the children of the parents and children with substance disorders.**

Substance abuse is among the problems that can interfere with employment and job retention. Estimates of the prevalence of this problem among welfare recipients vary widely in the nation due to differences in study methodology. Many studies in the nation have found that between 10 and 20 percent of the welfare population has a substance abuse problem, though states have reported higher incidence rates. In addition, longitudinal studies indicate that rates of substance abuse are higher among recipients who remain on welfare for longer periods.

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **Estimated at least 1,255. Data on SFY 2003 will be available mid to late August and will be sent separately by Barbara Cotter.**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual) **	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$1,402,687	$1,407,243	$1,321,500	$1,321,500
State				
Local	unknown			
Other (fees, donations)	unknown			
Total	$1,402,687	$1,407,243	$1,321,500	$1,321,500

In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.* **VDSS NOTE: All are grant-based projects and end on 5/31/04 (for local departments of social services) or 6/30/04 (for state agency contract).

**** Covers expenditures in substance abuse or combined substance abuse/mental health projects. The costs are estimated as it excludes substance abuse treatment services purchased in local departments of social services that did not have a substance abuse/mental health project. In addition, reporting combined expenditures across different projects and made it impossible in all cases to separate out the substance abuse/mental health services costs.**

5. *Is this program based on evidence-based practices?* **[x] Yes [ ] No**
***If yes**, please describe briefly:* **Three projects are LINK-based. The others utilize practices that are based on research related to serving women. Staff are either part of the CSB and receiving supervision from the CSB or are LSWs (2 projects).**

6. *Do you systematically collect outcome data on participants in this program?*
[ ] Yes [x] Some [ ] No
If yes, please describe briefly.

For FY 2003, DMHMRSAS is collecting data on outcomes on the three TANF-LINK projects, utilizing Global Assessment Functioning scores and other data, including employment.

<u>Attachment B</u>: Excerpt from VDSS' Family Services Business Plan

VDSS Biennial Goal

Maximize resources.

Family Services' Objectives and Measures

Improve coordination of policies and program expectations within the Department and other state agencies.

- **The number of collateral partners involved in improving or enhancing child care and early education opportunities.**
- **The number of performance measures that are being tracked and monitored to assist the Department in carrying out its mission.**
- **The number of contracts with performance measurements that can be monitored and reported in order to assess accomplishment or progress toward the Department's mission.**
- **The number of special needs youth having appropriate service identified prior to transition from foster care.**
- **The number of coordinated services delivered to adults in various settings.**
- **Train 200 workers in how to recognize and report adult abuse.**
- **<u>The number of collaborative projects being implemented to address the co-occurrence of SA and MH in child welfare.</u>**

Below is a summary of the collaborative initiatives for substance abuse interventions and their status.

Objective 3: Improve coordination of policies and program outcomes within the Department and other state agencies.

STRATEGY	DUE	PERFORMANCE MEASUREMENT/STATUS
1) Improve coordination of policies and program outcomes where there is a co-occurrence of substance abuse or mental health issues and child welfare. a) Develop inter-agency agreement between the Dept. and the Dept of Mental Health, Mental Retardation and Substance Abuse Services to develop cooperative program initiatives and integrated policies. b) Coordinate training and technical assistance to localities.	01/04	The number of collaboration projects being implemented to address the co-occurrence of SA and MH in child welfare. *(establish a baseline)* *3/03 Reviewed OASIS data on rate of substance use in child welfare families (20%); reviewed CFSR stakeholder data on substance abuse services for child welfare families; DMHMRSAS compiled results of CSB initiative to outreach local DSS on co-occurrence; developed perinatal substance abuse pamphlet for health care providers and submitted to Secretary of HHR for endorsement; reviewed interagency best practice models recommended by SAMHSA, CSAT.* *5/09/03 DSS, DMHMRSAS, and the Executive Secretary of the Supreme Court submitted an interagency grant application to the National Center on Substance Use and Child Welfare Services (NCSACW) for in-depth technical assistance to develop an integrated state level, strategic plan to improve child safety, parent recovery, and permanency outcomes for families with substance use disorders who are known to the child welfare and court systems.* *6/03 DSS, DMHMRSAS, and the Executive Secretary of the Supreme Court were notified by NCSACW that Virginia was awarded the above strategic planning grant. The award is for 2 years.* *6/03 the Department in collaboration with MHMRSAS and the Dept. of Health distributed 42,000 copies of a new brochure to 7,200 hospitals and health care providers on "Perinatal Substance Use: Virginia Legal Requirements and Practice Implications". The brochure is part of a statewide, interdisciplinary education campaign to educate health care providers on the management of pregnant and postpartum, substance using women and their substance exposed newborns.*

Department of Juvenile Justice

Attachment A1: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **The Department of Juvenile Justice provides substance abuse treatment services in each of its eight juvenile correctional facilities. Comprehensive assessments and initial services are provided at the Reception and Diagnostic Center. The Culpeper JCC, which houses female cadets, provides prescriptive psycho-educational services and a six month intensive treatment program funded by the Department of Justices' Residential Substance Abuse Treatment (RSAT) for Prisoners funding stream.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Female adolescents between the ages of 11 and 21.**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **50**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal		$116,595	$119,510	
State		$38,865	$39,837	
Local				
Other (fees, donations)				
Total		$155,460	$159,347	

* In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. *Is* this program based on evidence-based practices? [X] Yes [ ] No

***If yes**, please describe briefly:*

Curricula and program design follow leading research based methodologies of the field (i.e. Motivational Interviewing, Stages of Change, cognitive behavioral interventions, etc.)

6. *Do you systematically collect outcome data on participants in this program?* **[X] Yes [ ] No**

***If yes**, please describe briefly.*

The RSAT program collects recidivism and relapse data on all program participants as part of the grant process. The Department of Juvenile Justice collects outcome data on all youth committed.

Attachment A2: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **The Department of Juvenile Justice provides substance abuse treatment services in each of its eight juvenile correctional facilities. Comprehensive assessments and initial services are provided at the Reception and Diagnostic Center. The Barrett JCC is a self -contained single purpose modified therapeutic community for male cadets. These services are provided under contract with the Gateway Foundation, Inc.**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Male adolescents between the ages of 11 and 21.**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* __**203**__

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal				
State		$668,178	$668,178	
Local				
Other (fees, donations)				
Total		$668,178	$668,178	

** In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.*

5. *Is this program based on evidence-based practices?* **[X] Yes [ ] No**

If yes, please describe briefly:

Curricula and program design follow leading research based methodologies of the field (i.e. Motivational Interviewing, Stages of Change, cognitive behavioral interventions, etc.)

6. *Do you systematically collect outcome data on participants in this program?* **[X] Yes [ ] No**

***If yes**, please describe briefly.*

The Barrett JCC/Gateway Foundation, Inc. program has been evaluated by the National Institute of Justice. The Department of Juvenile Justice collects outcome data on all youth committed.

Attachment A3: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Screening/Assessment**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Youth under court order/supervision**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **8,793**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$1,000,000	$1,000,000	$0	$0
State	$950,000	$950,000	$0	$0
Local	$0	$0	$0	$0
Other (fees, donations) Special Fund	$300,000	$300,000	$0	$0
Total	$2,250,000	$2,250,000	$0	$0

* *In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.*

5. *Is this program based on evidence-based practices?* [ ] Yes [X] No
***If yes**, please describe briefly:*

6. *Do you systematically collect outcome data on participants in this program?* **[ ] Yes [X] No**
If yes, please describe briefly.

**** This program has been eliminated effective 12/1/02 due to budget reductions**

Attachment A4: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Substance abuse outpatient treatment via contract**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Youth under court supervision**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **Approx. 1,500**

4. *Estimated cost and source(s) of funds (July through June):*

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$225,000	$225,000	$225,000	$0
State	$2,375,000	$75,000	$75,000	$0
Local	$0	$0	$0	$0
Other (fees, donations)	$0	$0	$0	$0
Total	$2,600,000	$300,000	$300,000	$0

* *In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.*

5. *Is this program based on evidence-based practices?* **[ ] Yes** **[X] No**
***If yes**, please describe briefly*:

6. *Do you systematically collect outcome data on participants in this program?* **[X] Yes** **[ ] No**
***If yes**, please describe briefly.* **Recidivism**

**** The majority of this ($2,300,000) was the SABRE program. The remainder ($300,000) is a federal grant ($225,000) requiring $75,000 in state matching funds.**

Department of Juvenile Justice

Attachment A5: Program/Service Information

*Please complete this form for **each type** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.*

1. *Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)* **Services funded through VJCCCA including screening/assessment; prevention/education; outpatient treatment**

2. *Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)* **Youth under court supervision**

3. *Number of unique individuals directly served by this program/service in SFY 2002:* **1,313**

4. Estimated cost and source(s) of funds (July through June):**Source of Funds**	**FY 2002 (actual)**	**FY 2003 (budgeted)**	**FY 2004 (budgeted)**	**FY 2005 (projected)***
Federal	$0	$0	$0	$0
**State ** **	$353,217.21	$75,000	$75,000	$0
Local	$0	$0	$0	$0
Other (fees, donations)	$0	$0	$0	$0
Total				

* *In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.*

5. ***Is this program based on evidence-based practices?*** **[ ]** Yes [X] No
If yes, please describe briefly:

6. *Do you systematically collect outcome data on participants in this program?* **[X] Yes [ ] No**
***If yes**, please describe briefly.* **Recidivism**

**** The Virginia Juvenile Community Crime Control Act funding may be used for substance abuse services if the locally developed plan includes it. VJCCCA funding was reduced in FY03 by 51%. It is unknown how this reduction will impact FY03 expenditures and whether localities will continue to use VJCCCA funding for substance abuse services in FY04, FY05. Funding may include both state VJCCCA allocations and required local match funding.**

Department of Corrections

Attachment A: Program/Service Information

Please complete this form for ***each type*** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.

Type of program/service provided: (please describe, briefly; only general categories of programs or services offered, do not list every individual program or site - e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)
See Attached:

- ***Substance Abuse Services Glossary***
- ***Community Corrections Referral Guide Non-residential Options***
- ***Department of Corrections "Preparing Offenders for Release"***

Specific population(s) served: (please list the recipients of the service described above - e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)

- ***Adults under court ordered supervision***
- ***Youthful Offender Therapeutic Community***

3. Number of unique individuals directly served by this program/service in SFY 2002: _____

3. Estimated cost and source(s) of funds (July through June):

COMMUNITY CORRECTIONS

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$1,987,791	$2,138,509	$1,246,589	$1,246,589
State	$4,271,507	$2,577,836	$2,242,413	$2,242,413
Local				
Other (fees, donations) Drug Offender Assessment Fund	$ 414,909	$1,066,000	$1,066,000	$1,066,000
Total	$6,674,207	$5,782,345	$4,555,002	$4,555,002

INSTITUTIONS

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected)*
Federal	$ 975,000	$ 975,000	$ 975,000	$ 975,000
State	$2,725,000	$2,725,000	$2,725,000	$2,725,000
Local				
Other (fees, donations)				
Total	$3,750,000	$3,750,000	$3,750,000	$3,750,000

In the absence of other information, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

1. Is this program based on evidence-based practices? ***If yes***, please describe briefly:
   Community Corrections: [X] Yes [ ]No
   Our programs ad services have been developed using available research an outcome information.

   Institutions: [X] Yes
   Substance Abuse treatment follows the Therapeutic Community treatment modal as prescribed by Dr. George DeLeon; supported by national outcome research. The model is constantly managed and updated based on research findings.

2. Do you systematically collect outcome data on participants in this program?
   If yes, please describe briefly.
   Community Corrections: [X] Yes [ ]No
   Community Corrections collects standard case closing information when probation or parole cases are closed from supervision. Information is collected from the following:
   - ***Obsis***
   - ***Inmate Progress Report***

   Institutions: [X] Yes

Our evaluation methods and studies are based on CSAT's Self-Adjusting Treatment Evaluation Model (SATEM). We collect outcome data on an annual basis in our current studies with plans to follow program participants (inmates) between three and five years post-release.

The three recidivism measures used are:
- **Re-arrest**
- **Reconviction**
- **Recommitment**

In addition, we our piloting the Client Assessment Inventory (CAI) by DeLeon and Kressel. This set of instruments used by staff and inmate allow monitoring of treatment program progress and provides pre and post results.

See attached:
- ***Virginia Department of Corrections TC Program Status Form***

Governor's Office of Substance Abuse Prevention

Attachment A: Program/Service Information

Please complete this form for ***each type*** of substance use problem/disorder identification, prevention and/or intervention service or program offered by your organization.

1. Type of program/service provided: (Please describe, briefly; only general categories of programs or services offered, do not list every individual program or site – e.g.; prevention/education, screening/assessment, referral, case management, direct provider of outpatient, residential treatment services, therapeutic communities within institutions, etc.)
Prevention and Capacity Building for Substance Abuse Prevention Providers

2. Specific population(s) served: (Please list the recipients of the service described above – e.g.; middle school youth, adolescents, women with dependent children, youth under court supervision, incarcerated adults, etc.)
Youth and families

3. Number of unique individuals directly served by this program/service in SFY 2002: **To date, data has not been compiled**

4. Estimated cost and source(s) of funds (July through June):

Source of Funds	FY 2002 (actual)	FY 2003 (budgeted)	FY 2004 (budgeted)	FY 2005 (projected) *
Federal	2,804,000.00 SIG/CSAP 1,792,638.00 SDFSCA/DOE	1,790,041.00 SDFSCA/DOE	Unknown SDFSCA/DOE	Unknown SDFSCA/DOE
State	0	0	0	0
Local	0	0	0	0
Other (fees, donations)	0	0	0	0
Total	4,596,638	1,790,041.00	Unknown	Unknown

* *In the absence of other information*, assume level funding. Be sure to note grants which may be ending, or other known funding reductions, or new grants or funding increases.

5. Is this program based on evidence-based practices? [X] Yes [ ] No

If yes, please describe briefly:
All programs funded under the State Incentive Grant (SIG) and community grants issued by Safe and Drug Free Schools and Communities (SDFSCA) Governor's Discretionary fund are required to utilize a science-based process with the following logic model: needs assessment, measurable goals and objectives, activities linked to objectives, and evaluation.

6. Do you systematically collect outcome data on participants in this program?
   [X] Yes [] No
   If yes, please describe briefly.

SIG funded programs are required to report and input outcome data into a web- based data collection system- Performance Based Prevention System (PBPS).

SDFSCA grantees report outcomes when they pursue continuation funding for a 2nd and 3rd year of funding.

Appendix E

Focus Groups Agenda and Compiled Responses

COMMONWEALTH of VIRGINIA

SUBSTANCE ABUSE SERVICES COUNCIL

James C. May, Ph.D.
Chairman

P. O. Box 1797
Richmond, Virginia 23218-1797

2003 Regional Focus Groups

July 17, 2003
Richmond Behavioral Health Authority
3rd Floor Conference Room 1:00-3:00 p.m.

A G E N D A

12:30 p.m.	Lunch (provided)	
1:00 p.m.	Welcome and Brief Overview of Purpose	James C. May, Ph.D. Chair, SASC
1:15 p.m.	Focus Group Process Overview	Mary Nash Shawver Staff to the SASC
1:30 p.m.	Participant Introductions: *Please describe a high-point (peak) experience in your work in the area of education, prevention, intervention or treatment of substance use problems/disorders, a time when you have been most alive and engaged*	
	First Round of Dialogue: *What are the most important issues currently facing your organization/the SASC/your region/the Commonwealth in regards to substance use problems and disorders?*	
	Second Round of Dialogue: *What three wishes do you have to enhance the health and vitality of the Commonwealth, in relation to prevention and/or recovery?*	
	Third Round of Dialogue: *Imagine having maximum positive impact on the Commonwealth in relation to prevention and/or recovery. What does that look like?*	
2:40 p.m.	Closing Remarks	Jim May
	Closing Round: *Anything further you would like to add?*	
3:00 p.m.	Thanks and Adjournment	Jim May

Focus Group Participants:

Position Held	Organization
Assistant Commonwealth's Attorney	Commonwealth's Attorney office
Captain	Sheriff's office
Manager	Department of Juvenile Justice
Detective	Sheriff's office
Director of Community Services	Community Services Board (CSB)
Director of Prevention Assessment and Counseling	CSB
Director of Youth Services	CSB
Director	Drug court
Director	Private alternative program
Director/Manager of Substance Abuse Services	CSB
Executive Director	Private treatment provider
Executive Director	SAARA of Virginia
Executive Vice President	Private healthcare corporation
Judge	Juvenile and Domestic Relations Court
Mentor	Private treatment provider
Outreach worker	Private treatment provider
Participant	Drug court
Planning Coordinator	DMHMRSAS
President	SAARA of Virginia
President	Virginia Drug Court Association
President	Virginia Sheriff's Association
Prevention Director	CSB
Prevention Specialist	CSB
Regional President	SAARA of Virginia
Resident Services Manager	Private treatment provider
Senior U.S. Probation Officer	U.S. District Court
Sheriff	County
State SA Director	DMHMRSAS
State SA Manager	DMHMRSAS
Substance Abuse Counselor	CSB
Substance Abuse Liaison	CSB
Teacher	Local school system
Victim/Witness Assistance	Commonwealth's Attorney office
Youth Services Specialist	CSB

Fairfax, July 15, 2003
Fairfax County Government Center

Peak Experiences:
- "Celebrations of recovery"
- Enhanced bilingual services
- Enhanced advocacy

Issues of Concern:
- Put a more public face on recovery
- Leverage more funding
- Change society's view of addiction
- Advocacy for recovery
- Increased bilingual services, particularly in jails
- Housing
- Creation of a regional "super detox" or crisis stabilization
- Minority staff
- Staff development
- Rebuild/expand coalitions
- Social marketing – the concepts of recovery, disease
- Preservation of continuum
- DMHMRSAS and GOSAP – funding, diluting of priorities, lack of strategy, lack of collaboration, lack of prevention knowledge at Public Safety
- Gaps in services for adolescents
- Need for adolescent drug court
- Languages

Wishes:
- Strong regional partnerships
- Strong advocacy presence
- Support for training
- Move away from put away in jails – tighter with courts
- Good clear definition/presence of SA in state
- Strong state leadership in SA and SA prevention
- Strong state leadership in strategic planning
- Strong commitment to maintain funding
- Capacity building
- Better collaboration/less competition between education and CSB
- More attention to special (ex: Hep C) populations
- Medicaid reimbursement (criteria "discriminatory")

Richmond, July 17, 2003
Richmond Behavioral Health Authority

Peak Experiences:
- Comprehensive screening and SABRE
- Leveraged care program – marriage of criminal justice and substance abuse treatment – probation/parole side
- Achievement of "legitimacy"
- Data
- Development of successful treatment facility/program
- Letter received from person completed treatment: "saved my life"
- SAARA, advocacy moving forward
- Grant collaborative with CSB and Sheriff's office: "None for the Road"
- SA treatment, anger management provided in jails
- Sheriff's office working with schools – school resource officers
- Collaboration among DMHMRSAS, DSS, DCJS
- Revitalization of SA Services Council
- SAARA
- Advocacy to save drug courts
- Good folks we have in Virginia
- "Millenium Group" collaboration
- Family drug court – birth of first drug-free baby after both parents completed drug court
- SAARA – "put a face on recovery"
- Summer Institute

Issues of Concern:
- Workforce issues – "lot of us getting older"
- Waiting lists
- Funding/money
- Stigma
- Right to work law
- VA 12th wealthiest state, 40-something in spending
- Adolescent services
- ERs overloaded with SA patients – unmet need for Tx
- No longer reimbursement for detox in med-surg
- Financial resources
- Faith-based
- Allocation of state dollars
- Medicaid
- Insurance – parity
- Advocacy
- AA into jails
- Treatment into jails
- Education effort
- Need for collaboration – partnering instead of fighting
- Take prevention seriously – get it into the continuum

- Validity and credibility of treatment
- Length of time it takes to bring good science to good practice
- Publicize, educate re: advances in treatment
- Sustaining/growing SAARA and general advocacy movement
- Public re-education
- Increased quality in SA Tx programs
- Statewide strategy for funding SA Treatment/funding formula problems
- Medicaid
- Waiting lists
- Lack of resources
- Lack of credibility
- Funding allocation – Richmond "donut" more funding than city
- Coordination – probation and parole with family; jail/SA Tx/courts

Wishes:

- Housing - doubled
- Prevention – front-loading services
- Immediate services without 6-month waiting list
- Funding/Medicaid/insurance – parity
- Public validation that treatment works
- Adequate capacity – HR + bricks and mortar
- Each locality treated as a separate entity
- Education re: SA and prevention
- Genetic counseling in the addictions field
- Education re: disease, treatment does work
- Insurance pay for treatment
- Public/private partnerships
- Crime, economic development, money re-channeled "looks like a different place"
- Treatment on demand
- One stop in jail enough stops
- Medicaid funding
- Continue to build advocacy
- "honor the process' – lose three battles, win one – focus: keep on keeping on; long term commitment
- SA Services Council step in creating "no wrong door"
- Dialogue more with other agencies and organizations
- Parity
- Case management
- Subsidy from private sector – pay kids to stay in school
- Think of funding argument at government level – "capital investment" – make investment pay off financially
- Big money in up front – one time money not annual
- Incentive programs to draw people into the field

Wytheville, July 18, 2003
Wythe County Community Hospital

Peak Experiences:
- Stages of change model of treatment – meet people where they are
- Participating on a federal task force
- Working with kids – caving experience
- Client with clean drug screen
- "transition celebration" – testimonials very powerful, emotional
- Centara(sp?) coalition – collaboration

Issues of Concern:
- Budget cuts
- Drugs – cocaine, raging alcohol, ecstasy, methadone
- HIV
- Hepatitis
- Property crimes "out the roof"
- Overdose deaths and suicides
- Domestic violence
- Child abuse
- Foster care case loads
- High potency marijuana
- Intensive outpatient (IOP) capacity
- Adolescent treatment services
- Enforcement, probation
- Waiting lists/lack of capacity
- Women's services
- Residential treatment capacity
- Crank, methamphetamine
- Funding
- Follow-up
- Programs for kids (i.e.; enrichment, mentoring)
- Medicaid
- Drug court funding
- Substance use disorder treatment and funding decisions based on sound public policy rather than political issues

Wishes:
- Any locality in Commonwealth engage team for drug court not worry about funding
- Recognition of efficacy of prevention and treatment – elevated dramatically
- Adequately fund all – education, prevention, intervention, treatment, enforcement – "womb to the tomb"
- Medicaid
- Drug court funding
- Core service capacity funding/building

- Jobs in the community
- Vocational/educational enhancements
- School suspension – state rules
- Education – abuse/dependence
- Drug courts
- Statewide planning and policy development – ex: GOSAP – hard to track money, funding diluted/inefficient
- Social marketing – effectiveness and cost effectiveness of treatment
- Coordination/collaboration public/private sector
- Thank the Governor for paying attention and providing the opportunity for input
- Community education forums
- More of “this”
- Kids’ services
- Medicaid

Harrisonburg, July 28, 2003
Eastern Mennonite University

Peak Experiences:
- "One morning woke up and shaved, without cutting myself"
- Getting people into programs
- Seeing someone get out of jail, turn around, never come back
- Opportunity to start drug court
- The positives of participating in drug court – recognition for doing the right thing

Issues of Concern:
- Money – budget cuts
- Waiting lists
- Education – "more than just using is the problem – it's the lifestyle – I don't know any other life than using drugs – teach me how to feel…. give me a schedule – something to do every minute of the day"

Wishes:
- Drug courts – funding
- Funding for treatment and enforcement
- Peer role model
- Inpatient treatment
- Different models of drug courts in VA – "post adjudication model"
- Day reporting
- Psych evals available immediately when needed
- Jobs
- Detention and diversion program
- More training – recognize addiction, nature of addiction
- Officer safety
- Recognize in order to save a life – incarcerate, hospitalize
- Promote drug courts
- More time in Tx or transition
- Social marketing
- Community sense of responsibility, sense of safer community, community development
- Recognize that one type of treatment doesn't work for everyone – stop fighting each other
- Fewer people failing on probation, coming back to court time and time again
- Home incarceration and monitoring programs - $10.00 per day, pay for self
- Social marketing plan – legislators, prosecutors, councils, media, corrections, law enforcement, churches, community
- "allow CSB to function for a full freakin' year" – haven't had programs the last 6 months
- Medicaid reimbursement

Newport News, July 29, 2003
Hampton/Newport News Community Services Board

Peak Experiences:
- Bringing services to people who would not have accessed (public housing) – development of a "model" program
- Totally blended program (SA and MH)
- Client/patient celebrations
- Drug counseling in the jails
- Drug courts – "some of these kids, older people, I've been seeing for years – well, they're clean – been clean for a year now!"
- Collaboration

Issues of Concern:
- Adolescent services
- Work involved in applying for grants
- Turf battles for funds
- Determine/ID/stabilize funding base for drug courts
- Local level – who steers drug courts
- Restore criminal justice, other treatment programs that have been cut
- Waiting lists
- Money/funding
- Education - community as well as sheriff's office
- Social marketing – "it works"
- Too little counseling (treatment) in jails
- Catch 22 income level
- Availability of services
- Intensity of services
- Waiting lists
- Transportation
- More chronic patients
- Housing
- HIV population
- Need for collaboration
- Medicaid
- Parity
- Co-occurring d/o
- Stigma/education
- Short-term residential
- Case management
- Young people not entering the field – paperwork/documentation, stress
- DMHMRSAS needs more coordination between SA and MH – inefficiencies, leadership re: dual diagnosis, women's Tx, adolescent Tx; white papers, institutes, best practices guidance
- State contributes next to nothing (general fund) for prevention

Wishes:

- Drug problem decrease
- More and effective prevention services
- Treatment services available and affordable
- More/better jail services
- Housing
- Jobs
- Opportunities for positive experiences
- Recidivism rate goes down
- Housing, services, jobs immediately upon release from jail/treatment
- Manageable case load for staff
- Waiting lists decreased or eliminated
- Education – "everyone in Commonwealth understand what addiction is all about from a biological as well as psychosocial standpoint"
- Health insurance
- Universal access for SA Tx without access through the criminal justice system
- Public/private partnerships (ex: church owns rental property)
- Recruitment – well qualified, experienced, well paid
- Success for the Council
- Political leadership at the state level
- Collaborate with the medical community
- Funding for SA testing at hospitals
- Cooperation with education system
- SDFS money – what services provided?
- 2 term governor
- University – applied research, best practices

Appendix F

Diagnostic and Statistical Manual 9DSM IV) Criteria

Diagnostic and Statistical Manual (DSM IV) Criteria The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), is the current edition of the American Psychiatric Association's compendium of mental disorders, including the substance use disorders. According to the DSM IV, there are two distinct substance use disorders: Substance Dependence, and Substance Abuse. Substance Abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by the indicators listed below.

Indicators of Substance Abuse

One or more within a 12 month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

The essential feature of Substance Dependence is that the individual continues to use the substance despite significant substance-related problems, such as cognitive, behavioral, and physiological symptoms (see below). There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior. Tolerance is the need for greatly increased amounts of the substance to achieve intoxication or a markedly diminished effect with continued use of the same amount of the substance. Withdrawal is a combination of negative or uncomfortable behavior, physical, and mental changes that result when the concentrations of a

Indicators of Substance Dependence

Three or more occurring at any time in the same 12 month period:

1. Tolerance
2. Withdrawal
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
6. Important social, occupational or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

substance decline in an individual who had maintained prolonged heavy use of the substance. Upon experiencing unpleasant withdrawal symptoms, an individual is likely to take the substance to relieve or avoid those symptoms.

Appendix G

Principles of Effective Treatment (NIDA)

Principles of Effective Treatment - National Institute on Drug Abuse (NIDA)

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** When an individual is ready for treatment, it is very important that treatment services be available at that time to that individual. Potential treatment applicants can be lost if services are not immediately available or are not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services at times throughout the treatment process.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs (see pages 11-49). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. (Approaches to Drug Addiction Treatment section discuses details of different treatment components to accomplish these goals.)

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is

also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (see Drug Addiction Treatment Section).

10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be continuously monitored. Lapses to drug use can occur during treatment.** The objective monitoring of a patient's drug and alcohol use during treatment, through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

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Appendix H

Scientifically Based Approaches to Drug Addiction Treatment

Scientifically Based Approaches to Drug Addiction Treatment

This appendix presents several examples of treatment approaches and components that have been developed and tested for efficacy through research supported by the National Institute on Drug Abuse (NIDA). Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. The approaches are to be used to supplement or enhance (not replace) existing treatment programs.

This is not a complete list of efficacious, scientifically based treatment approaches. Additional approaches are under development as part of NIDA's continuing support of treatment research.

Relapse Prevention, a cognitive-behavioral therapy, was developed for the treatment of problem drinking and adapted later for cocaine addicts. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

The relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

Research indicates that the skills individuals learn through relapse prevention therapy remain after the completion of treatment. In one study, most people receiving this cognitive-behavioral approach maintained the gains they made in treatment throughout the year following treatment.

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The Matrix Model provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse,

receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.

Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain work sheets for individual sessions; other components include family educational groups, early recovery skills groups, relapse prevention groups, conjoint sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of projects have demonstrated that participants treated with the Matrix model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission. These reports, along with evidence suggesting comparable treatment response for methamphetamine users and cocaine users and demonstrated efficacy in enhancing naltrexone treatment of opiate addicts, provide a body of empirical support for the use of the model.

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Supportive-Expressive Psychotherapy is a time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components:

- Supportive techniques to help patients feel comfortable in discussing their personal experiences.
- Expressive techniques to help patients identify and work through interpersonal relationship issues.

Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

The efficacy of individual supportive-expressive psychotherapy has been tested with patients in methadone maintenance treatment who had psychiatric problems. In a comparison with patients receiving only drug counseling, both groups fared similarly with regard to opiate use, but the supportive-expressive psychotherapy group had lower cocaine use and required less methadone. Also, the patients who received supportive-expressive psychotherapy maintained many of the gains they had made. In an earlier study, supportive-expressive psychotherapy, when added to drug counseling, improved outcomes for opiate addicts in methadone treatment with moderately severe psychiatric problems.

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Individualized Drug Counseling focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning, such as employment status, illegal activity, family/social relations, as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. The addiction counselor encourages 12-step participation and makes referrals for needed supplemental medical, psychiatric, employment, and other services. Individuals are encouraged to attend sessions one or two times per week.

In a study that compared opiate addicts receiving only methadone to those receiving methadone coupled with counseling, individuals who received only methadone showed minimal improvement in reducing opiate use. The addition of counseling produced significantly more improvement. The addition of onsite medical/psychiatric, employment, and family services further improved outcomes.

In another study with cocaine addicts, individualized drug counseling, together with group drug counseling, was quite effective in reducing cocaine use. Thus, it appears that this approach has great utility with both heroin and cocaine addicts in outpatient treatment.

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Motivational Enhancement Therapy is a client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Clients are sometimes encouraged to bring a significant other to sessions. This approach has been used successfully with alcoholics and with marijuana-dependent individuals.

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Behavioral Therapy for Adolescents incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control:

- **Stimulus Control** helps patients avoid situations associated with drug use and learn to spend more time in activities incompatible with drug use.
- **Urge Control** helps patients recognize and change thoughts, feelings, and plans that lead to drug use.
- **Social Control** involves family members and other people important in helping patients avoid drugs. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.

According to research studies, this therapy helps adolescents become drug free and increases their ability to remain drug free after treatment ends. Adolescents also show improvement in several other areas, employment/school attendance, family relationships, depression, institutionalization, and alcohol use. Such favorable results are attributed largely to including family members in therapy and rewarding drug abstinence as verified by urinalysis.

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Multidimensional Family Therapy (MDFT) for Adolescents is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decision making, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

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Glossary of Acronyms Used in this Report

ABC	Alcoholic Beverage Control
CJS	Department of Criminal Justice Services
DCE	Department of Correctional Education
DHP	Department of Health Professions
DJJ	Department of Juvenile Justice
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services
DMV	Department of Motor Vehicles
DOC	Department of Corrections
DOE	Department of Education
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSP	Department of State Police
DSS	Department of Social Services
GOSAP	Governor's Office of Substance Abuse Prevention
NCADI	National Clearinghouse for Alcohol and Drug Information
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration
SASC	Substance Abuse Services Council
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors

VACSB	Virginia Association of Community Services Boards
VADAP	Virginia Association of Drug and Alcohol Providers
VASAP	Virginia Alcohol Safety Action Program
VDH	Department of Health

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Additional Web Resources

Brainplace.com – www.brainplace.com

Department of Mental Health, Mental Retardation and Substance Abuse Services – http://www.dmhmrsas.state.va.us/

Faces and Voices of Recovery – http://www.efavor.org/

Join Together Online – http://www.jointogether.org

NCADI – http://www.health.org/

NIAAA – http://www.niaaa.noh.gov

NIDA – http://www.drugabuse.gov

SAMHSA - http://www.samhsa.gov/

Substance Abuse Services Council – http://www.dmhmrsas.state.va.us/sasc/

University of Texas Addiction Science Research and Education Center – http://www.utexas.edu/research/asrec