2007 Substance Abuse Services Council Response to *Code of Virginia* §2.2-2697

to the Governor and the General Assembly

Commonwealth of Virginia

October 1, 2007

Overview and Introduction

The 2004 Session of the General Assembly amended the *Code of Virginia* (§ 2.2-2697) directing the Substance Abuse Services Council to collect information about the impact and cost of substance abuse treatment provided by public agencies in the Commonwealth.

> (§ 2.2-2697) Review of state agency substance abuse treatment programs.
>
> A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also include an assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.
>
> B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance abuse treatment program: (i) the amount of funding expended under the program for the prior fiscal year; (ii) the number of individuals served by the program using that funding; (iii) the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures; (iv) identifying the most effective substance abuse treatment, based on a combination of per person costs and success in meeting program objectives; (v) how effectiveness could be improved; (vi) an estimate of the cost effectiveness of these programs; and (vii) recommendations on the funding of programs based on these analyses.

As required, this 2007 report responds to Section B and includes appendices with reports from the Department of Corrections (DOC) outcomes studies and a description of the substance use disorder (SUD) services provided by state agencies in Virginia. The 2005 Substance Abuse Services Council report included a section that responded to Section A of this code and included estimates of the large unmet need for treatment and recommendations to address this unmet need. Treatment here is defined narrowly as those services directed toward individuals with identified substance abuse and dependence disorders, and does not include prevention services for which other evaluation methodologies exist.

Treatment Services

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department of Mental Health,

Mental Retardation and Substance Abuse Services (DMHMRSAS); the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior. This section of the report provides the statistical information for each agency required by Section B of the *Code*.

Department of Mental Health, Mental Retardation and Substance Abuse Services

(i)`the amount of funding expended under the program for the prior fiscal year (FY 2006);

Treatment Services Expenditure	$ 135,294,354

This overall expenditure is an approximate sum of the following component funding sources:

Federal	$ 42,147,345
State	$ 40,794,402
Local	$ 39,576,752
Consumer fees or third party payers (e.g., insurance)	$ 12,775,855

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

Approximately 52,087.

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

In Fiscal Year 2007 DMHMRSAS began collecting the National Outcome Measures (NOMs) required by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as a condition of receiving the federal Substance Abuse Prevention and Treatment Block Grant. These measures were developed in consensus with SAMHSA and the states and form the basis upon which outcomes of services will be evaluated and compared among states. Virginia NOMS data were not available by the deadline for this report.

In 2006, the Office of the Inspector General, established in the *Code of Virginia* (37.2-423), studied outpatient substance abuse services for adults provided by the community services board system. One of the major findings of the report was that access to the full continuum of care of substance abuse treatment services was not equally available across the state. Ideally, for services to be maximally effective, the intensity and duration of service should be matched to the clinical needs of the consumer.

The Inspector General's report also found that:

- 77 percent of the consumers interviewed indicated that they were "satisfied" with the "overall helpfulness of the program." This is particularly relevant because 66 percent of persons receiving services are mandated by court order;
- Over half of the Probation and Parole offices indicated satisfaction with substance abuse treatment services provided by CSBs (services are "appropriate to the needs of the clients we refer" and services provided help "clients recover from substance abuse addiction");
- 91 percent of consumers interviewed indicated that drug and alcohol use had decreased while receiving services; 81% indicated that they had not been arrested for drug or alcohol related offenses while in treatment; 64 percent indicated that they had stayed employed or that employment had improved; 88 percent indicated that their housing situation had either become or remained "stable and safe". [1]

(iv) identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives;

While costs and effectiveness data for specific programs are not available at this time, DMHMRSAS is working with the Joint Legislative Audit and Review Commission (JLARC) on Commission Study HJR 683/SJR 395 which will identify the costs of substance abuse treatment and the costs of untreated substance use disorders (SUDs) to the Commonwealth.

(v) how effectiveness could be improved;

Improve access to the complete continuum of care. Increase the use of Evidence-Based Practices (see recommendations from 2006 Council report).

(vi) an estimate of the cost effectiveness of these programs;

The best information available overall on Substance Abuse Programs in the CSBs is increased earnings for consumers after treatment based on Virginia Employment Commission data over the past 5 years.

Cost Effectiveness is also being analyzed through linking to other interagency databases including the Virginia State Police arrests database, the Compensation Board's records of jail time, and health care costs through Virginia Hospital Information (VHI) and Medicaid service utilization. This information will be available in the near future.

(vii) recommendations on the funding of programs based on these analyses;

According to the Inspector General's report:

- Availability to the complete array of treatment services needs to be improved;

[1] Stewart, James W. Review of Community Services Board Substance Abuse Outpatient Services for Adults. Report # 129-06, p. 37. http://www.oig.virginia.gov/documents/SS-SAOP129-06.pdf

- Timely access to services needs to be improved
- Consumer economic barriers to services need to be removed;
- CSBs lack access to psychiatric resources;
- Case management is inadequately addressed by 29 of 40 CSBs;
- CSB staff need more training in working with consumers with co-occurring mental illness and substance abuse, mental retardation, personality disorders and family engagement;
- The Inspector General found that, in addition, CSB staff need training in person-centered treatment planning and case management.

Prior to the 2007 Session of the General Assembly, appropriations to the CSBs for substance abuse treatment had remained largely level for several years, as had the federal allocation for the Substance Abuse Prevention and Treatment Block Grant. Medicaid reimbursement was limited to two services for pregnant and post-partum women, resulting in less than $1 million annually. The result was that, as costs rose, revenue remained static, resulting in declining capacity to provide services.

The 2007 Session of the General Assembly appropriated $5.2 million to the Department of Medical Assistance Services to expand Medicaid reimbursement for substance abuse treatment, which has the potential of producing $10.4 million in new revenue for CSBs, if fully implemented. However, estimates indicate that only about 10 percent of the population receiving substance abuse treatment services from CSBs are Medicaid eligible.

The 2007 Session also appropriated $2.4 million to CSBs for general expansion of substance abuse services. These funds are supporting expanding access to residential treatment through purchase of service agreements and development of consumer-run support services.

As a result of the Inspector General's report, the Office of Substance Abuse Service has developed a budget request for approval for the 2008 Session.

Department of Juvenile Justice

(i) the amount of funding expended under the program for the prior fiscal year (FY 2006)

- Community Programs
  Substance Abuse Cost Expenditures = $ 369,111

- Juvenile Correctional Center (JCC) Programs
  Substance Abuse Services Expenditures = $ 1,668,657

Estimated costs are based on the proportion of:
Behavioral Service Unit (BSU) staff dedicated to providing treatment for substance use disorders;
Screening and assessment at Reception and Diagnostic Center (RDC);
Case management or social work services for SA estimates for other JCCs;
Staff estimate of drug testing;
Proportion of support staff costs; and
Residential Substance Abuse Treatment (RSAT) grant expenditures.

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

Approximately 42 offenders participated in programs and services within the community.
Approximately 608 offenders participated in programs and services with in the correctional centers.
Per DJJ 2006 Data Resource Guide: Approximately 70% of offenders admitted in FY06 required substance abuse treatment.

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

Community - Information to address this issue is not available.

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

In FY 2005, the girls SA program (formally known as RSAT) had a 17.9% re-arrest rate. This is promising considering the overall re-arrest rate for girls in FY05 was 34.1%. It should be noted the re-arrest rate for girls who participated in the RSAT program during FY 2005 dropped from FY 2004 (20%) and FY 2003 (24%).

In FY 2005, 50.4% of boys in juvenile correctional centers who participated in SA treatment were rearrested for any crime over a 12 month period following release.
For juvenile correctional center releases as a whole, the corresponding 12 month re-arrest rate was 50.5%.

(iv) identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives;

Information to address this issue is not available.

(v) how effectiveness could be improved;

DJJ is currently in the process of upgrading the male's substance abuse treatment to incorporate evidence based programming including Cannabis Youth Treatment (CYT) and Motivational Enhancement Therapy / Cognitive Behavioral Therapy (MET / CBT 12) within the institutions. The female's RSAT program will continue its current programming since re-arrest rates have been dropping. Note: the DJJ Strategic Plan has, as one of its objectives, to "increase by 5% (measured for the 60 days prior to release from supervision) above FY 2007 baseline by 6-30-09."

(vi) an estimate of the cost effectiveness of these programs;

Information to address this issue is not available.

However, the National Institute on Drug Abuse (NIDA) reports that a California study finds "$1 spent on treatment saves taxpayers $7." Another NIDA report cites, "Untreated substance abuse adds significant cost to communities, including violent and property crimes, prison expenses, court and criminal costs, emergency room visits, child abuse and neglect, lost child support, foster care and welfare costs, reduced productivity, unemployment, and victimization. The cost to society of drug abuse in 2002 was estimated at $181 billion, $107 billion of which was associated with drug related crime." Please see the discussion of the study being conducted by the Joint Legislative Review and Audit Commission.

(vii) recommendations on the funding of programs based on these analyses.

Information to address this issue is not available.

Department of Corrections

(i) the amount of funding expended under the program for the prior Fiscal year (FY 2006)

DOC-Division of Community Corrections programs state funding expenditures for FY 2006 were as follows:

Treatment Services	$ 1,852,493
Residential Transition Therapeutic Community (Community- Based 6 Month Phase)	3,343,278
Substance Abuse Testing	640,265
Total Community Division SA treatment expenditure	$ 5,836,036

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

Approximately 17,000 offenders participated in programs and services describe in the aforementioned expenditures. In addition, additional persons were served by participating in self-help groups, such as Alcoholics Anonymous.

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

A primary outcome measure for the Division of Community Corrections is "compliance with supervision plans." The most recent results (for Calendar Year 2005) show that the Successful Closure or Still Active Rate for the cases opened for supervision in CY 2002 was 72.5%. This was the fifth consecutive year of improvement. Some of this success can be reasonably attributed to Drug Screening, Assessment, Testing and Treatment (DSAT) activity.

(iv) identifying the most effective substance abuse treatment, based on combination of per person costs and success in meeting program objectives;

Each day an offender can be safely maintained in the community rather than being incarcerated approaches a per diem savings of about $62. In addition, there is a cost reduction from less victimization, social service, law enforcement and other criminal justice costs plus a gain in tax and court-ordered financial obligation receipts. Benefits have to take the long view of how offenders did throughout their stay in the correctional system and after final discharge from supervision.

(v) how effectiveness could be improved;

DOC is in the process of introducing the concept of Evidence-Based Practices (EBP) into its programs and services. EBP protocols, procedures and forms are being piloted in four (4) demonstration Probation and Parole Services District

offices – Charlottesville District 9, Winchester District 11, Lynchburg District 13 and Williamsburg District 34. These EBP pilots are being conducted in partnership with Virginia Commonwealth University and Local Community Corrections Act Programs (LCCAP) in the above communities. LCCAP are under the aegis of the Department of Criminal Justice Services. An EBP survey and site review of the ten (10) Day Reporting Programs (DRP) is underway and is being utilized to strengthen the use of EBPs in these programs as well as in the two (2) new day reporting programs (DRP) which are in start-up phase. The five (5) Diversion and four (4) Detention Centers, all of which provide substance abuse services, completed a program review and are in the process of revamping their services. Finally, DOC is modifying its purpose statement in the Memoranda of Agreements (MOA) used to provide community-based treatment as service contracts for substance abuse outpatient and residential service contracts are modified to require that the contractual services utilize EBPs.

(vi) an estimate of the cost effectiveness of these programs;

Research demonstrates that substance abuse therapeutic community treatment programs, when appropriately funded and implemented, can reduce offender criminal behavior. The additional cost for providing treatment while incarcerated is much lower than the cost for community-based substance abuse treatment because room and board overhead is covered by the cost of incarceration. Taking these costs into account, at least $20,000 is saved for every year that an offender remains in the community as a law-abiding citizen. This figure does not include benefits such as the individual's contributions to society such as tax revenue from gainful employment.

(vii) recommendations on the funding of programs based on these analyses.

The major issues facing the Department of Corrections, Division of Community Corrections include:

1. Replace clinical supervision staff who would have major impact on the capacity to provide clinical oversight to DOC's Certified Substance Abuse Counselors (CSAC), to enhance quality control service delivery and to offer training and technical assistance to field staff.

2. Continue funding from the Drug Offender Assessment and Treatment Fund that supports fourteen (14) FTE dedicated to substance abuse services.

3. Continue to increase the availability of "evidence based practices" (EBP) programs and services for offenders with substance abuse problems, as well as those with co-occurring mental disorders. This needs to accommodate a projected annual growth rate of about 4%.

Overviews of Treatment Services Provided by State Agencies

Department of Mental Health, Mental Retardation and Substance Abuse Services

Descriptions of substance abuse treatment services provided by CSBs follow.

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

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

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

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

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

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

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

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

Department of Juvenile Justice

DJJ provides substance abuse treatment services at six of its seven juvenile correctional centers, excluding the Reception and Diagnostic Center (RDC), to youth meeting appropriate criteria. When youth arrive at RDC they receive a series of evaluations and psychological tests. A treatment and evaluation team subsequently meets and makes initial treatment recommendations as to the level of substance abuse services needed at that time. In brief, substance abuse treatment within the facilities can best be described within two tiers: non-intensive and intensive.

The first tier, a non- intensive service line for male youth with experimental or abusive experiences with alcohol or marijuana, is administered through the Cannabis Youth Treatment Program (CYT 5) - other wise known as Motivational Enhancement Therapy / Cognitive Behavioral Therapy - 5 sessions (MET/CBT 5). This program is evidenced based with emphasis on motivation to change, drug and alcohol refusal skills and relapse prevention.

The second tier, an intensive service line for male youth, is more therapeutic in its approach and is individually tailored to youth with moderate to heavy substance abuse or chemical dependence. Generally, youth assigned to an intensive program are housed in a self-contained unit/modified therapeutic community. The program's foundation is Cannabis Youth Treatment (CYT 12). The principles of the program are evidenced based with emphasis on motivation to change, drug and alcohol refusal skills, relapse prevention, problem solving, anger awareness and control, effective communication, addiction/craving coping skills, depression management and managing thoughts about drug use. Individualized treatment planning also allows behavioral services staff (BSU) to administer additional therapies for youth with co-occurring disorders and/or other debilitating clinical issues via individual, group or family therapy. Treatment course for youth in this program generally ranges from three to four months.

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

Beaumont Juvenile Correctional Center

Beaumont has two and half BSU positions and one BSU clinical supervisor designated for substance abuse treatment services. Intensive treatment is provided in a self-contained/modified therapeutic community (24 bed maximum capacity). Non-intensive services are provided within the general population, with satellite services available to other specialized housing units on campus. Beaumont houses males 16-21 years old.

Bon Air Juvenile Correctional Center

Bon Air houses both males and females and has five total BSU positions with two BSU clinical supervisors dedicated to its substance abuse programming. The age range of males is 15 to 17. Girls of all ages are committed to Bon Air, however, girls 18 years and older are housed separately from the younger girls.

The foundation of services to Bon Air's male population are the same as those administered at Beaumont JCC, however, these services are not provided within a self-contained/modified therapeutic community, rather, they are provided within the general population. Non-intensive

services are provided within the general population, with satellite services available to other specialized housing units on campus as needed.

The girls housed at Bon Air JCC receive intensive, as well as non-intensive substance abuse treatment services in a residential program. Clinical services provided may encompass individual, group and family therapies with emphasis placed on relapse prevention, psycho-education, emotional, physical and sexual trauma, grief and loss, co-occurring disorders and gender specific issues. Treatment course is generally six months. Substance abuse satellite services are provided to girls ages 18 and older in separate housing.

Culpeper Juvenile Correctional Center
Currently there are two designated BSU staff members for substance abuse treatment services. Intensive services are provided within a self-contained/modified therapeutic community (12 bed maximum capacity), while non-intensive services are provided within the general population. Satellite substance abuse services are provided to other specialized housing units as needed. Culpeper houses males 18 – 20 years old.

Hanover Juvenile Correctional Center
Currently there is one BSU staff member and one BSU clinical supervisor assigned to provide substance services. At this time, a part –time (WE-14) position has been allocated to assist in the delivery of services. Both intensive and non-intensive services are provided within a self-contained/modified therapeutic community (24 bed maximum capacity). Satellite substance abuse services are provided to other specialized housing units as needed. Hanover houses males aged 14-17 (middle school aged youth).

Natural Bridge Juvenile Correctional Center
Currently there is one BSU clinical staff member assigned to substance abuse treatment services. Both intensive and non-intensive services are provided, however, all services are administered within the general population, rather than a specialized housing unit. Natural Bridge houses males 16-20 years old.

Oak Ridge Juvenile Correctional Center
This center serves males with developmental and intellectual disabilities. A BSU staff member provides modified substance abuse services to youth in need of treatment. Oak Ridge houses males 15 – 20.

Department of Corrections

Within the Department of Corrections, the Division of Operations includes 40 institutions across the state with a population in excess of 33,000. Incoming prisoners are typically screened for substance abuse during reception and classification with about 80% indicating some substance abuse history. The facilities range from maximum security, housing the most serious offenders, to minimum security and work centers housing less violent offenders. About 11,000 offenders are released to the community annually.

There are five (5) programming tiers to DOC institution-based substance abuse treatment services: Orientation; Psycho–Education; Substance Abuse Counseling; Support Programs, such as Alcohol Anonymous and Narcotics Anonymous; and, Therapeutic Community (TC) and Residential Transition Therapeutic Community (TTC).

DOC Institutions continue to operate prison therapeutic communities (TC) and have consolidated the women's TC programs at the Virginia Correctional Center for Women. As successful TC participants near release, they are screened for placement in the 6 DOC-DCC community-based TTC stay mentioned earlier. This program was expanded in FY 2005. The TC and TTC program is designed to address substance addiction, criminal thinking and antisocial behaviors, and is an evidence-based treatment model. The program lasts at least 18 months including the institutional phase (12 months) and the community-based phase (6 months). This is the only institutional substance abuse program that receives designated state funding. In FY 2006, the total Institutions expenditures for TCs was $ 990,908.

The Institutional TCs include: Botetourt Correctional Center (capacity 352); Indian Creek Correctional Center (capacity 781); Lawrenceville Correctional Center (private, capacity 160); Virginia Correctional Center for Women (capacity 274). The total capacity of the Institutional TCs is 1,567. The Residential Transitional Therapeutic Communities include: Bethany Hall (Women, capacity 13); Gemeinshchaft Home (Men, capacity 60); Hegira House (Men and Women, capacity 14)[2]; Serenity House (Men, capacity 63); Rubicon (Men, capacity 34). The total capacity of the Residential Transitional Therapeutic Communities is 184.

In September 2005, the Department of Corrections submitted *Report on Substance Abuse Treatment Programs* which addressed Institutional Therapeutic Communities (TC), Community-Based Residential Therapeutic Communities (TTC) and contractual Residential Substance Abuse Treatment. The findings from these studies suggest that DOC's substance abuse treatment programs – when properly funded and implemented – are able to reduce recidivism for the substance abusing offender population.

[2] This facility closed in 2007.

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude ▶
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment ▶
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime ▶
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use ▶
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message ▶
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.