SUBSTANCE ABUSE SERVICES COUNCIL
ANNUAL REPORT AND PLAN

TO THE GOVERNOR
AND THE
GENERAL ASSEMBLY

COMMONWEALTH OF VIRGINIA
JANUARY 1, 2008

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COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

Patty L. Gilbertson
Chair

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

January 1, 2008

The Honorable Timothy M. Kaine
Governor of Virginia

Dear Governor Kaine:

In accordance with §2.2-2696 of the *Code* of Virginia, it is with pleasure that I present the **2007 Annual Report and Comprehensive Interagency State Plan for Substance Abuse Services.**

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

The 2007 Annual Report also highlights:

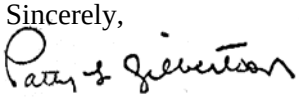
- Substance use recovery in a transformed system;
- The impact of substance exposure on infant mortality;
- The need for appropriated funding to support the activities of the Substance Abuse Services Council;

Finally, the appendices include the results of a survey of state agencies regarding the services provided to the substance use community, and a report on work the Council is addressing with the Commission on the Virginia Alcohol Safety Action Program.

The disease of addiction crosses all boundaries, gender, race, ethnicity, and socio-economic status. It not only affects the person with the substance abuse disorder but his or her family, friends, neighbors, as well as society as a whole. Although we cannot deny the social and public safety issues associated with substance use disorders, we must also focus on the public health issues associated with this disease and close the gaps in services that impede Virginians from recovering and becoming productive citizens.

On behalf of the Council, I hope this report will significantly contribute towards improving the lives of Virginians who are affected by substance use disorders.

Sincerely,



Patty L. Gilbertson

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EXECUTIVE SUMMARY

This report is provided to the Governor and the General Assembly in compliance with *Code* of Virginia § 2.2-2696, which establishes the Substance Abuse Services Council to make recommendations to the Governor, the General Assembly and the State Board of the Department of Mental Health, Mental Retardation and Substance Abuse Services on broad policies and goals related to the coordination of public and private efforts to control substance abuse. A previous report required by *Code* of Virginia § 2.2-2697, an overview of treatment programs for persons with substance use disorders provided by state agencies, has already been published and is available at http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2052007/$file/RD205.pdf. The thirty Council members include representatives of key state agencies, public and private provider organizations, consumer and advocacy organizations, and members of the General Assembly. Its chair and several of its members are appointed by the Governor for terms of three years. Staff support is provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services. This year's report focuses on four issues:

- The impact of maternal substance use on infant mortality;
- Services to people with HIV or AIDS seeking treatment for substance use disorders;
- Support to the Council; and
- The Substance Abuse Council's Vision for Substance Abuse Services Across the Commonwealth: A Template for Transformation

Two other documents are also included as Appendices:

- Survey of Agencies 2007, which is included in compliance with *Code* of Virginia § 2.2-2696.F. This survey is conducted approximately every two years, and presents the results of a survey of state agencies regarding activities and services related to use and abuse of alcohol, tobacco and other drugs.

- A report on the Council's work with the Virginia Commission on Alcohol Safety Action Programs, as directed by the report and recommendations that resulted from Governor Warner's Task Force to Combat Driving Under the Influence of Drugs and Alcohol. This document describes the progress made training providers in appropriate assessment of persons charged with driving under the influence, so that the interventions in which they participate will be clinically appropriate.

The Impact of Maternal Substance Use on Infant Mortality

The infant mortality rate (IMR) is measured by the number of live birth babies that die during the first year of life and is used to measure the health and well being of populations across and within countries. Virginia's IMR has been higher than the national average for all but one of the last 22 years. In 2004 and 2005, Virginia's IMR was 7.4 infant deaths per 1,000 live births. The Governor's Health Reform Commission proposes to lower this rate to 7.0 by the end of FY 2009. In examining strategies to achieve this goal, the impact of substance use on pregnant women is significant. Although the *Code* of Virginia §54.1-2403.1 establishes medical screening for substance use as a component of prenatal care, no standardized protocol is in place, resulting in confusion and uneven compliance

among health care providers. The Council is requesting that the General Assembly designate DMHMRSAS as the lead agency to establish a protocol and that general funds be appropriated to provide technical assistance to this endeavor.

RECOMMENDATIONS:

1. In order to implement *Code* of Virginia §54.1-2403.1, the Council recommends that the General Assembly require the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to convene a leadership team with representatives from the Department of Health, the Department of Social Services, the Department of Health Professions and other appropriate agencies to develop a universal statewide screening protocol for risks related to substance abuse, mental illness and domestic violence.

2. The Council recommends that the General Assembly should make a one-time appropriation from the general fund in the amount of $40,000 to develop and implement a protocol.

Because access to treatment for substance use disorders is crucial to good pregnancy outcomes when the mother is using alcohol or other drugs, and because there are many barriers to access, the Department of Mental Health, Mental Retardation and Substance Abuse Services has, for many years, provided access to treatment and care management funded largely with funds from the federal Substance Abuse Prevention and Treatment Block Grant, which provides more than half of the funds currently available for community treatment for substance use disorders ($42,939,145 in FY 08). Among these activities is a care management model, Project LINK, currently available in only eight sites in the state, that provides supports that improve access to treatment. In 2005, Project LINK served 2,891 women and 757 dependent children. Of the 161 babies born to these women, 75 percent achieved a healthy birth weight. The Council is, therefore, requesting funds to expand Project LINK.

RECOMMENDATION:

3. The Council recommends that the General Assembly appropriate ongoing funding from the general fund to support increased access to treatment for pregnant women and women with dependent children through case management using the Project LINK model.

Additional funding for the expansion of Project LINK

Increase funding for existing 8 sites ($25,000 GF x 8 sites) =	$200,000
Additional funding for 4 new single sites ($125,000 GF x 4 sites) =	500,000
Additional funding for 4 new collaborative sites ($150,000 GF x 4 sites)	600,000
Total to communities	$1,300,000

Project LINK Coordinator for DMHMRSAS	$100,000

Project LINK evaluation	35,000
Training funds across systems	100,000
Social marketing campaign	100,000
Administrative services total	$335,000
Total Request	$1,635,000

HIV/AIDS EARLY INTERVENTION SERVICES FOR PEOPLE SEEKING TREATMENT FOR SUBSTANCE USE DISORDERS

The Council recently learned that funds from the federal Substance Abuse Prevention and Treatment Block (SAPT) Grant, which the federal government required the Department of Mental Health, Mental Retardation and Substance Abuse Services to utilize for the specific purpose of supporting early intervention services to persons with HIV or AIDS seeking treatment for substance use disorders are no longer available for this purpose. The authorizing legislation for this grant requires states with AIDS case rates equal to or exceeding 10 per 100,000 population to expend five percent of the grant award ($2,146,957 in FY 08) to support these activities. Because injection drug use is a significant risk factor in the spread of HIV, integrating early intervention into treatment for substance use disorders is a sound public health strategy. When the legislation went into effect in 1995, Virginia's case rate was 12.1. Virginia's current case rate is 8.5 per 100,000. Federal code prohibits the Department of Mental Health, Mental Retardation and Substance Abuse Services from using these funds for this purpose now that the rate has declined. When the federal legislation authorizing the SAPT Block Grant was drafted in 1992, a diagnosis of HIV progressed quickly to AIDS and death soon followed. Considerable medical advances in the treatment of HIV, however, means that people infected with HIV often live productive lives for many years before developing AIDS. Nevertheless, infection with HIV seriously compromises quality of life and productivity.

Many communities in Virginia continue to have HIV or AIDS case rates that equal or exceed 10 per 100,000, and removal of these funds will cause these early intervention activities to cease. Community services boards do not have other funds to support these services. Therefore, the Council has requested that the General Assembly provide general funds to support these services.

RECOMMENDATION

4. The Council recommends that the General Assembly appropriate $1,666,236 annually to the Department of Mental Health, Mental Retardation and Substance Abuse Services to be allocated by DMHMRSAS to replace the federal funding that will be prohibited from use to support early intervention services for people with HIV or AIDS who are seeking treatment for substance use disorders.

SUSTAINING THE SUBSTANCE ABUSE SERVICES COUNCIL

Finally, the *Code* of Virginia 2.2-2696.E. & G. requires the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide staff and other support to the Council, including reimbursement to members for their participation. The Council meets four times per year, and makes an effort to meet at various public locations throughout the Commonwealth to enhance member understanding of regional issues and provide opportunities for public input. Currently these costs are paid for using a portion of a five percent allowance from the Commonwealth's Substance Abuse Prevention and Treatment (SAPT) Block Grant, which supports all of the administrative costs of the Office of Substance Abuse Services. However, the funding from the SAPT Block Grant has remained static for several years, and no increases are anticipated. As the costs of operating the Office have increased due to general raises granted to all state employees (which are not covered by general funds, but by the SAPT Block Grant) and other operating expenses, the funds available to support the Council are increasingly limited. Since the Council is a state mandate, the Council believes that state funds should support its operation.

RECOMMENDATION

5. The Council recommends that the General Assembly appropriate $100,000 in general funds annually to provide staff to and support the operation of the Substance Abuse Services Council. This amount covers staff salary and benefits, travel and accommodations for Council members and staff, costs associated with public hearings the Council may conduct, and publication and distribution of the Council's reports.

SUBSTANCE USE SERVICES IN A TRANSFORMED SYSTEM

The Department of Mental Health, Mental Retardation and Substance Abuse Services has embarked upon a plan to transform its service system, focusing on the cornerstone human values of self-determination, empowerment and recovery, and implemented by improving accountability, access, and quality of services, developing partnerships, enhancing coordination, managing funding, and using resources efficiently. The Council, in its advisory role to the Governor, the General Assembly, and the Board of the Department, seeks to emphasize some key components of the transformation plan, as well as to augment it. This resulting white paper is the Council's interpretation of transformation for the prevention and treatment of substance use disorders in Virginia's public systems of care. This document promotes the values of self-determination, empowerment and recovery implemented through accountability, access, quality of services, partnerships, coordination, funding, and efficient use of resources, and concludes with a vision statement for the system of care. It is the Council's intent to promote the use of this document as a compass in the development of policy and services for persons with substance use disorders in the Commonwealth.

PART I:
THE IMPACT OF MATERNAL SUBSTANCE USE ON INFANT MORTALITY

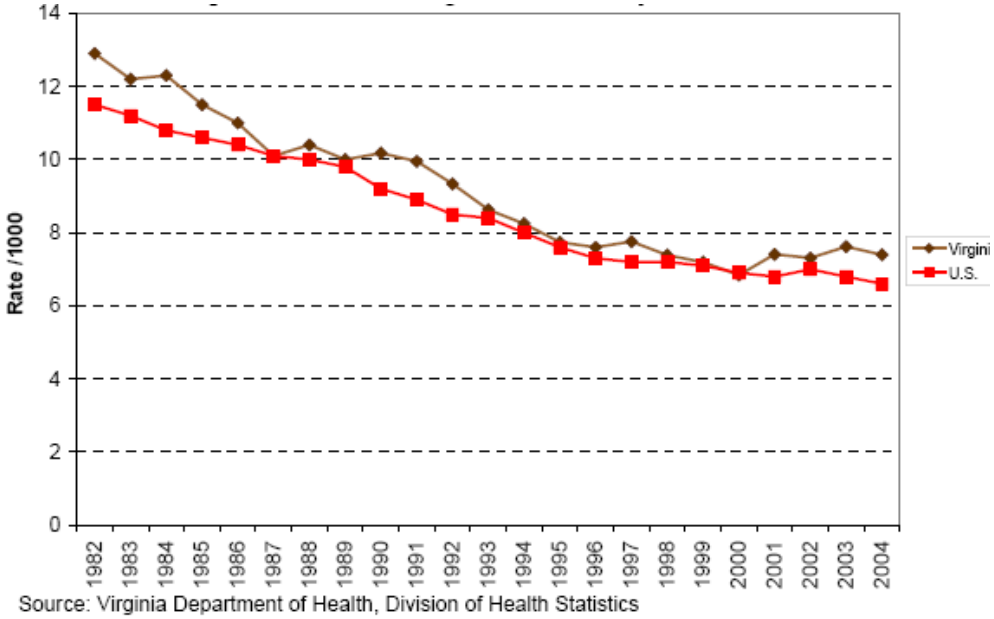
This section of the Council's report addresses the need for improved identification of women who are using alcohol and other drugs while pregnant and the need for expanded access to substance abuse treatment services while they are pregnant.

SCREENING PREGNANT WOMEN FOR SUBSTANCE USE

Infant mortality is measured by the number of live birth babies that die during the first year of life and is used to compare the health and well being of populations across and within countries.[1] The infant mortality rate (IMR) in Virginia in 2004 and 2005 was 7.4 infant deaths per 1,000 live births.[2] Virginia has consistently had a higher infant mortality rate than the national average for all but one of the past 22 years, as displayed in Figure 1. The state was ranked 33rd in the nation in 1990 and 32nd in 2006 for its infant mortality rate. The Governor's Health Reform Commission (September, 2007) proposes to reduce this rate to 7.0 infant deaths by the end of FY 2009. In order to achieve this goal, Virginia must promote reforms in preventative care.

The primary causes of infant death are premature births and low birth weight, Sudden Infant Death (SID), and other general problems associated with the complications of pregnancy. Factors associated with infant death can often be linked to maternal behaviors and lifestyle choices that include poor nutrition, lack of pre-natal care, smoking, and substance abuse.[3]

Figure 1 National and Virginia Infant Mortality Rates 1982-2004



Source: Virginia Department of Health, Division of Health Statistics

[1] Centers for Disease Control and Prevention (CDC)
[2] Virginia Department of Health, Office of Family Health Services
[3] Virginia Department of Health, Office of Family Health Services.

Average rates of infant mortality in Virginia (2001-2005) range from a high of 15 per 1,000 live births in Portsmouth to a low of 3.6 in Arlington. Rates are closely correlated to household income and access to health care, especially prenatal care. Table 1 displays average data for localities with the ten highest and the ten lowest rates in Virginia.

TABLE 1: AVERAGE INFANT MORTALITY RATES (2001-2005) PER 1000 LIVE BIRTHS

10 LOCALITIES WITH THE HIGHEST RATES		10 LOCALITIES WITH THE LOWEST RATES	
Portsmouth	15	Arlington	3.6
Richmond City	14.9	Loudoun	4.4
Roanoke City	13.6	Fairfax County	4.5
Hopewell	13	Albemarle	4.8
Fredericksburg	12.4	Alexandria	5
Danville	12.4	Hanover	5.2
Charlottesville	11.9	Montgomery	5.4
Petersburg	11.7	Stafford	5.8
Newport News	11.6	Prince William	6.1
Hampton	11.3	Frederick	6.4

Source: Virginia Department of Health

A 2005 online needs assessment conducted by the Virginia Department of Health's Office of Family Health Services (OFHS) indicated the following risk factors for the Maternal and Child Health (MCH) population: lack of health insurance coverage, depression and mental illness, domestic violence, and lack of prenatal care.[4] In addition, Virginia's *Maternal and Child Qualitative Health Needs Assessment (June 2005)* identified additional risk factors including access to care, need for increased reimbursement of and eligibility for Medicaid, mental health or substance abuse problems, and inadequate or lack of timely prenatal care. The combination of these risk factors and the specific effects of prenatal substance exposure on developmental outcomes make this a complex issue. However, both biological and environmental effects on the child's continued development can be addressed with the appropriate resources and interventions. These interventions are most effective when targeted to overcome barriers that inhibit healthy development of both the child and the mother.

THE IMPACT OF PERINATAL SUBSTANCE USE ON INFANT MORTALITY

Infant mortality is linked to inadequate pre-natal care, premature births, and low birth weight.[5] Research indicates that interrupting the mother's substance use and providing comprehensive services for mother and child significantly improves birth outcomes and the child's development.[6] The National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), provides information in reference to the prevalence of illicit drug, alcohol, and

[4] Virginia Department of Health, Office of Family Health Services, Virginia's Title V Needs Assessment, 2005
[5] March of Dimes
[6] Sivikis, D.S., Haug, N., Lee, J., Timpson, R., (1996). Predictors of treatment participation and retention in an intensive outpatient program for pregnant drug abusing women. In *National Institute on Drug Abuse Research monograph Series.*

cigarette use among pregnant women ages 15 to 44 years. NSDUH defines illicit drug use as the use of marijuana/hashish, cocaine, inhalants, hallucinogens, heroin, or prescription-type drugs used non-medically. This survey indicates that substance use among pregnant women poses a national problem.[7] According to the 2004 National Survey on Drug Use and Health, 4.6 percent or pregnant women aged 15 to 44 reported using illicit drugs, 11.2 percent reported alcohol use and 18 percent reported using cigarettes in the last month prior to the survey. This concern also applies to Virginia because maternal behavioral conditions such as smoking, alcohol and illicit drug use are factors that contribute to premature birth and/or impaired fetal growth.[8]

Prenatal alcohol use is one of the leading preventable causes of birth defects and developmental disabilities. Children exposed to alcohol during fetal development can suffer a combination of disorders that range from subtle changes in intelligence to profound mental retardation. Symptoms in children who are exposed prenatally to alcohol may vary with age and circumstances.[9] Although most women are aware that heavy drinking during pregnancy can cause birth defects, many do not realize that "no level of alcohol consumption during pregnancy has been determined safe."[10] Research indicates that consumption of one or more drinks (1.5 oz. of distilled spirits, 5 oz. of wine, or 12 oz. of beer) per day is associated with increased risk of giving birth to an infant with growth retardation.

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that describes the range of effects that can occur in children whose mothers consumed alcohol during pregnancy.[11] The term FASD is not a clinical diagnosis or category.[12] FASD encompasses the multiple terms that are utilized to describe the continuum of effects that result from prenatal exposure to alcohol, including fetal alcohol effects (FAE), alcohol-related birth defects (ARBD), alcohol-related neurodevelopment disorder (ARND) and Fetal Alcohol Syndrome (FAS).[13] Children with FASD have a wide range of physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.[14]

The American Academy of Pediatrics estimates that one baby with FAS can incur health costs as high as $1.4 million dollars over his or her life span.[15] Research also indicates that adolescents and adults with FAS or FASD have a life span prevalence for

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[7] National Survey on Drug Use and Health, The NSDUH Report (June 2, 2005)
[8] American College of Obstetricians and Gynecologists (ACOG). (2000). Intrauterine growth restriction. *ACOG Practice Bulletin*, 12
[9] Pediatrics (2000). Fetal alcohol syndrome and alcohol related neurodevelopmental disorders. 106(2). Retrieved November 6, 2007 from http://aappolicy.aappublications.org/cgi/reprint/pediatrics; 106/2/358.pdf
[10] US Department of Health and Human Services, US Department of Agriculture. Nutrition and your health: dietary guidelines for Americans. 5th ed. Washington, DC: US department of Health and Human Services, US Department of Agriculture; 2000.
[11] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention.
[12] Bertrand, J., Floyd R.L., Weber, M.K. (2005). MMWR Recommendations and Reports: Guidelines for identifying and referring persons with fetal alcohol syndrome. 54(RR11). 1-10
[13] Ibid.
[14] Ibid.
[15] Pediatrics (2000). Fetal alcohol syndrome and alcohol related neurodevelopmental disorders. 106(2). Retrieved November 6, 2007 from http://aappolicy.aappublications.org/cgi/reprint/pediatrics; 106/2/358.pdf

disrupted school experiences, trouble with the law, confinement (detention, jail, prison, psychiatric or alcohol/drug inpatient treatment), inappropriate sexual behavior on repeat occasions, and alcohol or drug problems.[16] The Virginia Department of Health estimates that FASD costs Virginians an estimated $189.3 million annually.[17] The societal costs, including the emotional and social impact on families, the educational system, and the loss of potential for these children are enormous.

Substance using pregnant women are at high risk for receiving late or no prenatal care. Shame, stigma, a chaotic lifestyle and fear of losing custody of their children prevent substance using pregnant women from pursuing prenatal care or acknowledging use of alcohol or other drugs to their health care providers. These women are often uninformed about the impact of their use on their unborn children. In-utero substance exposure can leave their children vulnerable to premature birth and various developmental problems. Research suggests that socio-economic factors, insufficient prenatal care and premature delivery associated with maternal drug use often directly affect infant mortality and developmental outcomes for substance-exposed children.[18] In addition, this vulnerability is made more complex by the effects of being raised by a substance-abusing mother in a high-risk home environment. Substance exposed (SE) infants, children or adolescents are affected by parental or other caretakers substance use due to neglect, potential abuse, and poor role modeling.

THE PREVALENCE OF INFANT SUBSTANCE EXPOSURE

Any alcohol or drug use during pregnancy is potentially harmful to the unborn child. If a mother is not treated and continues to use during her pregnancy, her substance exposed (SE) newborn is at high risk for:

- Premature delivery
- Low birth weight
- Neurological and congenital problems
- Increased risk of sudden infant death syndrome (SIDS)
- Developmental delays
- 2-3 times higher chance of neglect or abuse than non SE newborns
- Mental health and substance abuse problems as they age.[19] [20] [21]

A study conducted as a part of the National Survey on Drug Use & Health Report [22] examined drug and alcohol use by pregnant women ages 15-44, and found:

- 9.8% drank during their pregnancy

[16] The Journal of School Nursing. (2005). Fetal alcohol spectrum disorder. 21(3).
[17] Virginia Department of Health. (2006). VDH 06-01.
[18] Covington, C.Y., Nordstrom-Klee, B., Ager, J., Sokol, R., & Delaney-Black, V. (2002). Birth to age 7 growth of children prenatally exposed to drugs: A prospective cohort study. *Neurotoxicology and Teratology*, 24, 489-496.
[19] Governor's Health Reform Commission Final Report
[20] Virginia Health Department, Office of Family Health Services
[21] March of Dimes
[22] National Survey on Drug Use and Health, *Substance Use During Pregnancy: 2002-2003 Update* (June 2, 2005). National Institute on Drug Use.

- 6% acknowledged non-medical use of prescription drugs
- 4.3% used an illicit drug- Pregnant women ages 15-25 were 5 times more likely to use illicit drugs that those 26-44 years.

Of the 104,488 babies born in Virginia in 2005, the Virginia Department of Health estimated that:

- 10,234 infants were exposed to alcohol in-utero;
- 6,269 were exposed to the non-medical use of prescription medications and
- 4,492 were exposed to an illicit substance e.g. heroin, cocaine, etc.[23]

THE NEED FOR A COMPREHENSIVE PRENATAL SCREENING ON INFANT MORTALITY

The *Code* of Virginia §54.1-2403.1 (Attachment A) establishes the requirement for routine medical history screening as a component of every woman's prenatal care. Currently Virginia does not utilize a statewide substance abuse and mental health screening protocol or instrument for all pregnant women that addresses this unfunded mandate. The need for a standardized protocol is evident from two individual surveys conducted in 2004 and 2006.

In 2004, the Virginia Department of Health (DOH) and the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) conducted the *Survey of Perinatal Providers on Screening Practices for HIV and Substance Use*. The survey indicated that of the 581 providers surveyed only 35 percent screened their pregnant patient for substance use. Lack of knowledge of the law and lack of recognition of the need to screen were citied as reasons for not screening.

Currently, there is no standard practice, screening tool or procedure that is utilized statewide in health department services.[24] In 2006, 82 percent (28 of 35) of the Virginia Department of Health's health districts participated in an informal survey concerning psychosocial screening practices with pregnant women served in their clinics and case management programs, including screening for use of substances during pregnancy. One hundred percent of the health districts screen for tobacco use and 93 percent screen for alcohol and illicit drug use. However, 96 percent of these health districts do not use any standardized screening tool with their clients, meaning that the information they collect from these women may not be valid or comparable. All districts reported that they make appropriate referrals to community organizations for substance use treatment services utilizing their local CSBs or other services as available.[25]

Many pregnant women with substance use disorders are more motivated to seek treatment than at any other time of their lives, which makes the prenatal care setting the ideal place for discussing substance use. Often, women who have not had a sustained relationship with a health care provider are able to see the same practitioner on a regular basis, develop a trusting relationship, and are more likely to comply with advice. Once they learn that they are pregnant, they want to do everything possible to protect the health of their babies.

[23] Virginia Department of Health, Office of Family Health Services
[24] Virginia Department of Health, Office of Family Health Services
[25] Virginia Department of Health, Office of Family Health Services

Information about the use of tobacco, alcohol, and illicit drugs is requested from the mother upon admission to the labor unit and at the time of birth certificate application. Variances occur between the number of mothers who report substance use during pregnancy and the number of substance exposed infant births reported by physicians because substance use information the persons requesting the information are not necessarily trained to inquire or assess substance use in pregnancy. At this time, the Department of Health cautions against drawing conclusions or making recommendations based on the statistics aggregated by the current data collection.[26]

Through a grant recently awarded to the Virginia Department of Health (VDH) by the Centers for Disease Control and Prevention (CDC), VDH has initiated a new monitoring system. This system, the Pregnancy Risk Assessment and Monitoring System (PRAMS), is a population-based surveillance system of maternal behaviors and experiences to assist states in collecting information to supplement birth certificate data. VDH will collect information each month from 100 randomly selected mothers of two or three month old babies. The mothers will be asked about their experiences with prenatal care and whether they encountered any barriers to good care. Additionally, they will be asked about health insurance coverage, breastfeeding attitudes and practices, and "baby blues" after their babies were born.[27] This data will provide information about maternal behaviors during the preconception, prenatal, and postnatal phases. Risks data on smoking, alcohol use, domestic violence, and unintended pregnancy will be captured and utilized for needs assessment in state level planning to address infant mortality and health problems among mothers and babies. Findings from this system will be available in early 2009.

RECOMMENDATIONS

1. In order to implement *Code* of Virginia §54.1-2403.1, the Council recommends that the General Assembly require the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to convene a leadership team with representatives from the Department of Health, the Department of Social Services, the Department of Health Professions and other appropriate agencies to develop a universal statewide screening protocol for risks related to substance abuse, mental illness and domestic violence.

2. The Council recommends that the General Assembly should make a one-time appropriation from the general fund in the amount of $40,000 to develop and implement a protocol.

PUBLICLY FUNDED PERINATAL SUBSTANCE ABUSE TREATMENT IN VIRGINIA

The Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) provides support to community services boards (CSBs) for treatment services for pregnant and parenting substance using women, including technical

[26] Virginia Department of Health-Office of Family Health Services. *Virginia's Title V Needs Assessment 2005*
[27] Virginia Department of Health. (2007). *VDH 07-10 News Release*. Retrieved October 16, 2007 from http://vdh.state.va.us/news/PressReleases/PDFs/2007/051407PRAMS.pdf.

assistance for interagency collaboration at the state and local level. The Substance Abuse Prevention and Treatment Block (SAPT) Grant, which provides about half of the state-controlled funds for publicly-funded community treatment in Virginia ($42,939,145 in FY 2008), has specific requirements related to the provision of services to pregnant women and women with dependent children.[28] The authorizing legislation requires that a certain base amount, based on historical expenditures, be set-aside to support these services. In fiscal year 2006, Virginia expended $4,715,501 (or nearly 11%) of its SAPT award on services to this population. In addition, $1,385,366 in general funds for community substance abuse treatment was expended in support of services to these women.

Until July 1, 2007, the only Medicaid substance abuse treatment services in the State Plan were for pregnant and postpartum women, beginning in 1998. In FY 2006, Medicaid expended $843,600 for these services, and only $774,258 was expended in FY 2007. There are several reasons for this limited utilization. Because women who use substances during pregnancy often have complex psychiatric and psychological needs, as well as risks for medical complications, the Medicaid regulations for these services were crafted to provide an intensive level of care, which many providers are unable to make available, especially when coupled with low rates of Medicaid reimbursement. In the case of the residential service, a federal regulation restricts the use of Medicaid funds for payment of room and board for services provided to persons over 18 and under 64 years of age in facilities larger than 16 beds.[29] This restriction has a negative impact on the cost-effectiveness of these residential services.

Prior to FY 1999, no state funds were allocated to services for pregnant and postpartum women. The 1998 Session of the General Assembly appropriated $150,000[30] available July 1, 1999 to support coordination of family-oriented prevention services for substance-abusing postpartum women who are identified by hospitals pursuant to § 32.1-127, *Code* of Virginia. Effective July 1, 1999 the General Assembly also appropriated $1,000,000 from general funds to support three perinatal treatment centers for substance abusing pregnant or recently postpartum women. The 2000 Session of the General Assembly appropriated $250,000, available July 1, 2000, to provide wrap-around services to substance-abusing mothers and targeted case management for their children.[31] Although all of the appropriations are continuing, these funds were reduced by $12,634 in FY 03 for that and subsequent years. Table 2 displays funding dedicated to substance abuse services for pregnant and postpartum women, and women with dependent children.

FEDERAL LAW REGARDING SERVICES TO PREGNANT WOMEN

In addition to the required financial set-aside, federal law governing use of the SAPT Block Grant requires that the funds be used to provide specific support services to remove barriers that women commonly face when seeking treatment. The requirements include providing priority admission to treatment, including admission within 48 hours of requesting

[28] (42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)); (42 U.S.C. 300x-22(c); 45 C.F.R. 96 122(f)(1)(viii)); 42 U.S.C. 300x-27(b); 45 C.F.R. 96 131(f))

[29] 42 CFR 435

[30] House Bill 30, Item 347#18c

[31] House Bill 30, Item 329#10c

services, and interim services if the appropriate level of care is not immediately available. In addition, each of the community services boards, the providers of local services in Virginia, are required to provide the following services to pregnant women and women with dependent children:

- Primary medical care, including referral for prenatal care, and child care while the woman is receiving medical care;
- Primary pediatric care for the children, including immunization;
- Gender-specific substance abuse care, including treatment to address abuse, and child care while the woman is receiving these services;
- Therapeutic interventions for the children in the care of the woman receiving services, to address development needs and neglect and abuse; and
- Case management and transportation. [32]

TABLE 2: SUMMARY OF FUNDING BY VIRGINIA DMHMRSAS FOR PREGNANT AND POSTPARTUM WOMEN

YEAR EXPENDED	SAPT AMOUNT	STATE GENERAL FUND AMOUNT
FFY 1994	$3,903,867	$0
FFY 1995	$4,429,913	$0
FFY 1996	$5,170,456	$0
FFY 1997	$4,064,662	$0
FFY 1998	$4,184,586	$0
FFY 1999	$4,668,848	$150,000
FFY 2000	$5,173,045	$1,308,708
FFY 2001	$4,311,251	$1,314,200
FFY 2002	$4,715,501	$1,386,766
FFY 2003	$4,715,501	$1,388,598
FFY 2004	$4,715,501	$1,387,459
FFY 2005	$4,729,501	$1,387,216
FFY 2006	$4,715,501	$1,387,366

Note: FFY refers to "federal fiscal year." The SAPT Block Grant is administered from October 1 to September 30, but is allocated to CSBs by DMHMRSAS for expenditure from July 1 to June 30. Therefore, funds available from the SAPT BG in FFY 2006 were expended in state fiscal year 2007.

COST BENEFITS OF PRENATAL SUBSTANCE ABUSE TREATMENT

According to the Governor's Health Reform Commission, the average cost covered by taxpayer dollars for a baby carried to term is $3,200 in Virginia. In comparison, a premature baby who remains in the Neonatal Intensive Care Unit (NICU) for an average of eleven days costs $31,000 to $48,000.[33] As discussed in the previous section, the costs associated with abnormal fetal development, neonatal complications, and educational, health care and behavioral care costs are significant for these children as they age. Other societal costs, such as potential costs for foster care if the child is removed from the mother and placed in the custody of the Commonwealth, must also be considered.

[32] (42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)); (42 U.S.C. 300x-22(c); 45 C.F.R. 96 122(f)(1)(viii)); 42 U.S.C. 300x-27(b); 45 C.F.R. 96 131(f))

[33] Governor's Health Reform Commission. (2007). Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission

BARRIERS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN

In spite of the laws, regulations and accompanying funds dedicated to providing services to pregnant and postpartum women, and women with dependent children, access to treatment for substance use disorders is difficult. Pregnant women face additional barriers to needed treatment. Additional barriers to treatment for pregnant and postpartum women include:

- Stigma
- Fear they will lose custody of their children
- Lack of healthcare coverage
- Lack of childcare and/or transportation
- Cost
- Lack of/inability to access gender specific treatment

Due to the severity of their addiction and the complexity of their problems, many require intensive services, however, few treatment programs provide the programming and supports that pregnant women require. In addition, many pregnant women already have dependent children whose lives have been affected by their mothers' substance abuse disorders. The women need assistance with becoming better mothers and their children need care and may need additional services. The lack of services for both the mother and the baby together leads to mothers being reluctant to obtain treatment. The mothers are forced to make a choice between treatment or caring for a new infant and other children. Often these women do not have family or other appropriate caretakers for their children. Most addicted women have histories of being sexually victimized and living in violent environments. Because the needs of these women are so complex, the cost of providing quality treatment far exceeds that for treating other individuals. In addition, many traditional residential programs are reluctant to accept pregnant women due to concerns regarding liability associated with negative birth outcomes, and lack of appropriate care for the infant and other children while the mother is in treatment. [34]

TREATMENT AVAILABILITY IN VIRGINIA COMMUNITIES

Virginia's forty community service boards (CSBs) provide gender specific services for pregnant and parenting women. Services vary by CSB according to funding and community resources. Table 3 displays by region and CSB the amount of federal funding allocated to each CSB for women's substance abuse services, and the types of services provided

Project LINK – A Model to Improve Access to Services for Women

DMHMRSAS funds Project LINK in eight communities. Project LINK is a multi-agency care coordination program. Began in 1990 with five sites, Project LINK focuses on prevention, early intervention and treatment for pregnant women who are either at risk of abusing or are currently dependent on alcohol or other drugs. The goal of Project LINK is to assure that substance using women and their dependent children receive appropriate services,

[34] Lester, B.M.; Andreozzi, L.;& Appiah, L. (2004). Substance use during pregnancy: Time for policy to catch up with research.

regardless of which local agency they approach for assistance, assuring that there is "no wrong door." The project provides intensive case management services and seeks to remove administrative and logistical barriers to receiving services by proactively establishing collaborative relationships among local and state agencies these women are most likely to encounter. In the localities where Project LINK operates, the participating agencies, which include social services, health and the CSB, address the specific needs of these women, including accessing treatment for substance use disorders. In 2005, Project LINK served more than 2,891 women and 757 children. There were 161 babies born to program participants and 119 (75%) achieved a healthy birth weight of 2500 grams or more. Table 4 displays locations and funding information for Project LINK sites throughout the Commonwealth.

A critical component of Project LINK is the level of local coordination that occurs between local agencies and the CSB. The local Project LINK coordinator establishes and maintains working relationships with key staff at these agencies to identify potential operational and logistical barriers. This group may bring issues to local executive leadership for attention. When Project LINK was initially implemented at the first five sites, a state level executive leadership team was also established. A designated staff person at DMHMRSAS arranged for training and provided other support to the project.

Of the eight Project LINK sites, six are supported with SAPT funds and operate in specific localities within the CSB catchment area: Blue Ridge CSB (Roanoke), Rappahannock Area CSB (Fredericksburg), Region Ten CSB (Charlottesville), Hampton/Newport News CSB (Newport News), Virginia Beach CSB (Virginia Beach), and District 19 CSB (Petersburg). Two enhanced LINK collaborative sites are supported by state general funds and operate in Northern Virginia (Falls Church, Alexandria, Fairfax, Loudon, Arlington, and Prince William CSBs) and in the far Southwest (Planning District One, serving the city of Norton and the counties of Lee, Scott and Wise; Cumberland Mountain CSB, serving the counties of Buchanan, Russell, Scott, Tazewell, and Dickenson County CSB).

Residential Services for Pregnant and Postpartum Women and Women with Dependent Children

In addition to Project LINK, DMHMRSAS supports three publicly funded regional residential programs for pregnant women and/ or parenting women and their children through community services boards. Hampton/Newport News Community Services Board operates the Southeastern Family Project; a residential program supported by $478,520 in general funds. The Project primarily serves the following CSBs: Hampton-Newport News, Norfolk, Virginia Beach, Colonial, and the Middle Peninsula/Northern Neck. This residential facility also admits women from other communities on a sliding scale based on ability to pay. Dependent children may accompany their mothers when the appropriate accommodations are available.

Richmond Behavioral Health Authority (RBHA) provides residential services for pregnant, recently postpartum, and parenting women, supported with $406,622 in general funds, and can provide services for up to fourteen families (i.e., the parenting woman and up

to three children ages 12 or younger). RBHA contracts with Rubicon, Inc., a private nonprofit provider, to provide residential treatment services to women who are residents of the city of Richmond. These services are also available to women referred by Henrico Area CSB (counties of Henrico and Charles City), Chesterfield County Mental Health Support Services, Crossroads CSB (counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenberg, Nottoway, and Prince Edward), Goochland County CSB, Hanover County CSB and Planning District 19 CSB (cities of Colonial Heights, Hopewell, Emporia and Petersburg; counties of Dinwiddie, Greensville, Prince George, Surry and Sussex), with RBHA providing case management services. Women from other localities are accepted if funding is provided from another source.

Blue Ridge Behavioral Health (Cities of Roanoke and Salem, counties of Botetourt, Craig and Roanoke) contracts for services with Bethany Hall, a nonprofit organization. DMHMRSAS provides $102,224[35] in general funds to fund two of the available eight beds. This program accepts pregnant women as well as recently postpartum women and their newborns. Up to two children, less than 12 years of age can accompany each woman. During the period July 1, 2006-June 30, 2007, five women were served utilizing a total of 404 bed days.

Two additional programs in Virginia that accept pregnant and parenting women are New Generations and Demeter House. Fairfax-Falls Church CSB's New Generations program is limited to Fairfax County residents. Initially funded by a federal grant, sustaining funding was provided by the county when the grant ended in 1997. The program serves pregnant and postpartum women and their children. The first phase of the program has twelve beds and the second phase can accommodate eight people, four mothers and four children. Each woman can bring one child, ages from birth to four years, with her into treatment.

Demeter House, owned and operated by Vanguard Services, Unlimited, a private nonprofit, is located in Arlington. This twenty-bed residential program provides treatment services to substance abusing pregnant, postpartum women and their children. This program accepts referrals from all CSBs.

In Southwest Virginia, there are no residential treatment facilities that accept substance using women and their children, Galax Life Center a private for profit facility, will serve pregnant and recently postpartum women but cannot accommodate children. Table 5 displays the residential programs in Virginia for pregnant and parenting women.

RECOMMENDATION

3. The Council recommends that the General Assembly appropriate ongoing funding from the general fund to support increased access treatment for pregnant women and women with dependent children through case management using the Project LINK model.

Additional funding for the expansion of Project LINK

[35] This is an annual cost; multiple admissions occur during the year, resulting in several women utilizing a bed.

Increase funding for existing 8 sites ($25,000 GF x 8 sites) =	$200,000
Additional funding for 4 new single sites ($125,000 GF x 4 sites) =	$500,000
Additional funding for 4 new collaborative sites ($150,000 GF x 4 sites)	$600,000
Total to communities	$1,300,000
Project LINK Coordinator for DMHMRSAS	$ 100,000
Project LINK evaluation	35,000
Training funds across systems	100,000
Social marketing campaign	100,000
Administrative services total	$ 335,000
Total Requested	$1,635,000

Table 3: Distribution of and Services Funded by SAPT Women's Set-Aside in 2006

Board Name	Women's Set-Aside Amount	Types of Services Provided
Harrisonburg/Rockingham	21,290	Outpatient
Northwestern	78,127	Outpatient and intensive outpatient
Rappahannock Area	303,044	Outpatient, intensive outpatient and long-term residential
Rappahannock/Rapidan	43,898	Outpatient
Region Ten	252,956	Outpatient
Rockbridge	17,758	Outpatient
Valley	31,643	Outpatient
Alexandria	51,929	Outpatient and long-term residential
Arlington	77,137	Outpatient and long-term residential
Fairfax/Falls Church	444,444	Outpatient and long-term residential
Loudon County	135,080	Outpatient and long-term residential
Prince William	246,077	Outpatient
Alleghany	8,504	Outpatient
Blue Ridge	101,000	Outpatient and long-term residential
Central Virginia	74,115	Outpatient and intensive outpatient
Cumberland	30,978	Outpatient
Danville /Pittsylvania	35,088	Outpatient
Dickenson	16,000	Outpatient
Highlands	13,520	Outpatient and intensive outpatient
Mount Rogers	27,143	Outpatient
New River Valley	136,230	Outpatient
Piedmont	47,914	Outpatient
Planning District 1	25,070	Outpatient and intensive outpatient
Chesterfield	62,639	Outpatient
Crossroads	35,622	Outpatient
District 19	198,900	Outpatient and intensive outpatient
Goochland/Powhatan	54,846	Outpatient
Hanover	41,526	Outpatient
Henrico	38,294	Outpatient and intensive outpatient
Richmond	1,008,036	Outpatient and long-term residential
Southside	17,654	Outpatient
Chesapeake	68,420	Outpatient
Colonial	159,253	Outpatient
Eastern Shore	12,066	Outpatient
Hampton/Newport News	267,305	Outpatient and intensive outpatient
Middle Peninsula Northern Neck	22,494	Outpatient
Norfolk	145,392	Outpatient
Portsmouth	143,367	Outpatient
Virginia Beach	188,279	Outpatient and long-term residential
Western Tidewater	46,463	Outpatient
State Total SAPT Women's Set-Aside	4,729,501	

TABLE 4: PROJECT LINK SITES AND LOCALITIES SERVED

Locality Served	CSB	Amount and Funding Source
Roanoke	Blue Ridge	$100,000 – SAPT BG
Fredericksburg	Rappahannock Area	$100,000 – SAPT BG
Charlottesville	Region Ten	$100,000 – SAPT BG
Newport News	Hampton-Newport News	$100,000 – SAPT BG
Virginia Beach	Virginia Beach	$100,000 – SAPT BG
Petersburg	District 19	$100,000 – SAPT BG
Northern Va - *Enhanced Site* - Alexandria, Arlington, Fairfax-Falls Church, Loudon, Prince William	Alexandria, Arlington, Fairfax-Falls Church, Loudon, Prince William	$125,000 GF
Southwest Va - *Enhanced Site* - City of Norton, counties of Buchanan, Dickinson, Lee, Russell, Scott, Tazewell, Wise	Planning District One, Cumberland Mountain, Dickenson County	$125,000 GF

TABLE 5: RESIDENTIAL SUBSTANCE ABUSE PROGRAMS FOR PREGNANT AND POST PARTUM WOMEN

FACILITY	CSBS SERVED	ACCEPT PREGNANT WOMEN	ACCEPT RECENTLY POSTPAR-TUM AND NEWBORN	ACCEPT CHILDREN IN ADDITION TO NEWBORN	NUMBER BEDS OR FAMILIES	FUNDING
Bethany Hall	Blue Ridge Behavioral Health	Yes	Yes	Yes	8	Non profit State General Funds through DMHMRSAS
Southeastern Family Project	Hampton - Newport News, Norfolk, Va Beach, Colonial, Middle Peninsula-Northern Neck	Yes	Yes	If space available will accommodate-ate children	16	CSB operated State General Funds to H/NN CSB from DMHMRSAS
Rubicon	Richmond, Henrico, Chesterfield, Goochland, Hanover	Yes	Yes	Yes	14	Non profit State General Funds to RBHA from DMHMRSAS to purchase services
Demeter House	All	Yes	Yes	Yes	20	Non profit Accepts purchase of service from CSBs; Medicaid is not accepted
New Generations	Fairfax County residents only	Yes	Yes	Yes	16	Funded by the County
Galax Life Center	All	Yes	**No-cannot accept newborns**	No	0	Private for profit
Total Family Beds					74	

Attachment A

§ 54.1-2403.1. Protocol for certain medical history screening required.

A. As a routine component of every pregnant woman's prenatal care, every practitioner licensed pursuant to this subtitle who renders prenatal care, including any holder of a multistate licensure privilege to practice nursing, regardless of the site of such practice, shall establish and implement a medical history protocol for screening pregnant women for substance abuse to determine the need for a specific substance abuse evaluation. The medical history protocol shall include, but need not be limited to, a description of the screening device and shall address abuse of both legal and illegal substances. The medical history screening may be followed, as necessary and appropriate, with a thorough substance abuse evaluation.

B. The results of such medical history screening and of any specific substance abuse evaluation, which may be conducted, shall be confidential and, if the woman is enrolled in a treatment program operated by any facility receiving federal funds, shall only be released as provided in federal law and regulations. However, if the woman is not enrolled in a treatment program or is not enrolled in a program operated by a facility receiving federal funds, the results may only be released to the following persons:

1. The subject of the medical history screening or her legally authorized representative.

2. Any person designated in a written release signed by the subject of the medical history screening or her legally authorized representative.

3. Health care providers for the purposes of consultation or providing care and treatment to the person who was the subject of the medical history screening.

C. The results of the medical history screening required by this section or any specific substance abuse evaluation which may be conducted as part of the prenatal care shall not be admissible in any criminal proceeding.

D. Practitioners shall advise their patients of the results of the medical history screening and specific substance abuse evaluation, and shall provide such information to third-party payers as may be required for reimbursement of the costs of medical care. However, such information shall not be admissible in any criminal proceedings. Practitioners shall advise all pregnant women whose medical history screenings and specific substance abuse evaluations are positive for substance abuse of appropriate treatment and shall inform such women of the potential for poor birth outcomes from substance abuse.

PART II:
HIV/AIDS EARLY INTERVENTION SERVICES FOR PEOPLE SEEKING TREATMENT FOR SUBSTANCE USE DISORDERS

The federal law that authorizes the Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states with AIDS rates equal to or exceeding 10 cases per 100,000 to expend 5 percent of the annual allocation on early intervention services[36]. This requirement was based on two assumptions. The first is that people who use drugs, especially injection drugs, are at increased risk for contracting and spreading HIV through needle sharing and sexual contact. Data from the Virginia Department of Health indicate that, in 2004, injection drug use played a role in transmission in 7.7 percent of HIV cases, and 6 percent in 2005, the most recent year for which this information is available.[37] The second assumption was that HIV always progresses rapidly to AIDS.

When the SAPT Block Grant was initially authorized in 1992, Virginia qualified for this requirement with an AIDS case rate of 12.1 per 100,000. In order to comply, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) identified community services boards (CSBs) serving localities that were likely to serve populations needing these services and allocated the required amount to the CSBs for this purpose. The original distribution of these funds was based on a composite indicator incorporating three-year average rates for gonorrhea and HIV. A review of more recent literature identified several additional variables that are associated with HIV infection rates: percent minority population, AIDS, other STDs, hepatitis, tuberculosis, and teen pregnancy. This information was converted into a formula to calculate AIDS risk to the residents of the catchment area served by each CSB, and the CSBs were ranked based on the result.[38] DMHMRSAS has continued this required allocation until the present time. In FY 2008, Virginia received $42,939,145, resulting in an allocation of $2,146,957 million to twenty-three CSBs for this purpose. Table 6 displays these CSBs and the amounts allocated to them for this purpose in FY 08.

In 1992, when the initial legislation was passed, infection with HIV led to AIDS and subsequent death very quickly, so measuring community AIDS rates was an appropriate method of allocating funds. In 2007, however, medical gains in treating HIV have added considerably to both the span and quality of life possible for people diagnosed with HIV. The progression from HIV to AIDS has slowed significantly. Yet, in many communities, while the rate of AIDS has declined, the rate of HIV infection has not.

In September 2007, DMHMRSAS received notice from the federal Substance Abuse and Mental Health Services Administration, which administers the SAPT Block Grant, that the state is now prohibited from expending these funds for this purpose,

[36] 42 U.S.C. 300x-24(b); 45 CFR 96.128

[37] This rate is calculated by combining the "IDU" (injection drug use) rate with the "MSM & IDU" (men having sex with men and injection drug use) rates.

[38] Two CSBs, Goochland-Powhatan and Southside were removed from consideration for funding since their HIV rates are skewed by the effect of prison population rates in their catchment areas.

effective July 1, 2008 because the state's AIDS case is now 8.5 per 100,000.[39] Eliminating these funds for this purpose will result in these CSBs terminating the early intervention services to this population. This is problematic because, although the first assumption, that people who use drugs are at an increased risk, remains true, the second assumption, that HIV always progresses rapidly to AIDS, is now false, due to diligent research and improved access to health care for those with resources.

Services currently supported by the SAPT funding include collaboration with local community services for persons with AIDS; pretest counseling for HIV and AIDS; testing for HIV and AIDS, including the extent of the disease, appropriate measures for preventing and treating the effects of the disease; and, post-test counseling.[40] The Council is very concerned that removing the $2.1 million currently provided by the SAPT Block Grant will have a drastic impact on the ability of the CSBs to get HIV infected people into treatment with physicians and for substance abuse treatment, especially in areas in which either the current HIV or AIDS rate exceeds 10 cases per 100,000 population. Table 7 displays the CSBs, which receive a total of totaling $1,666,236.from the SAPT Block Grant.

RECOMMENDATION

4. The Council recommends that the General Assembly appropriate $1,666,236 annually to the Department of Mental Health, Mental Retardation and Substance Abuse Services to be allocated by DMHMRSAS to replace the federal funding that will be prohibited from use to support early intervention services for people with HIV or AIDS who are seeking treatment for substance use disorders.

[39] Letter to Kenneth Batten from LTJG Brandon Johnson, September 7, 2007. The funds are retained DMHMRSAS and must be expended on community based prevention or treatment services as defined by 42 U.S.C. 300x *et seq*.
[40] 45 CFR 96.121

Table 6: FY 08 Distribution of AIDS Set-Aside from SAPT Funds

	2003		2004		2005		2006				
CSB	HIV Rate Per 100,000	AIDS Rate Per 100,000	HIV Rate Per 100,000	AIDS Rate Per 100,000	HIV Rate Per 100,000	AIDS Rate Per 100,000	HIV Rate Per 100,000	AIDS Rate Per 100,000	HIV Rate Change 2003-06	AIDS Rate Change 2003-06	FY 08 SAPT AIDS Funding
Alexandria	42.66	65.16	31.98	39.00	36.16	28.08	33.25	30.22	(9.41)	(34.94)	$69,656
Arlington	28.74	35.13	30.09	37.07	23.98	22.45	23.15	26.75	(5.59)	(8.38)	73,504
Blue Ridge	8.28	9.53	13.68	9.95	10.39	11.62	9.01	4.09	0.73	(5.44)	105,972
Central Virginia	3.90	8.22	9.15	6.40	5.91	3.80	2.94	2.10	(0.96)	(6.12)	91,791
Chesapeake	8.54	8.54	6.05	6.05	9.59	10.96	6.49	4.17	(2.05)	(4.37)	92,242
Colonial	3.63	2.17	3.58	2.15	2.80	2.10	3.39	1.36	(0.24)	(0.81)	19,273
Crossroads	9.17	10.19	11.17	7.11	11.08	9.06	10.85	5.92	1.68	(4.27)	45,549
Danville-Pittsylvania	4.60	8.29	10.17	3.70	12.96	5.56	12.97	2.78	8.37	(5.51)	63,390
District 19	24.89	23.20	19.03	17.24	17.57	11.71	28.23	17.64	3.34	(5.56)	95,634
Eastern Shore	11.47	21.03	5.70	13.29	5.66	5.66	7.59	9.49	(3.88)	(11.54)	24,058
Fairfax-Falls Church	8.13	10.17	8.59	10.42	9.24	5.77	12.00	9.43	3.87	(0.74)	48,264
Hampton-Newport News	19.18	10.35	21.96	14.03	21.81	10.75	21.70	11.62	2.52	1.27	219,825
Henrico Area	12.28	7.51	11.03	10.70	15.80	6.91	16.44	7.73	4.16	0.22	32,124
Middle Peninsula-Northern Neck	6.53	5.80	7.17	8.61	4.99	3.56	5.04	2.88	(1.49)	(2.92)	13,335
Norfolk	32.68	22.75	43.73	18.92	27.59	16.81	35.58	11.86	2.90	(10.89)	315,580
Northwestern	1.02	6.09	2.98	3.97	1.93	4.35	2.86	1.91	1.84	(4.18)	14,746
Portsmouth	34.13	18.07	31.22	10.07	33.94	31.95	26.33	8.10	(7.80)	(9.97)	98,294
Prince William	9.91	9.64	9.80	10.10	6.03	10.06	9.77	10.01	(0.14)	0.37	56,930
Region Ten	5.25	7.15	5.72	7.15	7.78	9.61	7.77	6.86	2.52	(0.29)	75,303
Richmond	49.81	32.35	40.52	36.36	45.41	28.90	46.35	26.04	(3.46)	(6.31)	267,344
Valley	4.38	5.73	4.46	5.26	5.29	5.90	4.53	3.68	0.15	(2.05)	44,001
Virginia Beach	7.51	5.23	10.91	6.82	10.26	7.76	10.15	6.69	2.64	1.46	180,766
Western Tidewater	9.15	4.58	13.29	9.60	10.82	9.38	15.10	8.63	5.95	4.05	99,376
Statewide	10.79	10.74	11.87	10.50	11.01	8.30	11.89	7.65	1.10	(3.09)	$2,146,957

Table 7: HIV and AIDS RATE per 100,000 by CSB Boards Receiving SAPT BG AIDS Funds

	2003		2004		2005		2006		Change Rate HIV '03-'06	Change Rate AIDS '03-'06	2006 SAPT-BG FUNDING
	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS			
Alexandria	42.66	65.16	31.98	31.96	39.00	39.16	**28.08**	**33.25**	-9.41	34.93	$69,656
Arlington	28.74	35.13	30.09	37.07	23.98	22.45	**23.15**	**26.75**	-5.59	-8.38	$73,504
Fairfax-Falls Church	8.13	10.17	8.59	10.42	6.03	10.06	**12.00**	9.43	3.86	-0.74	$48,264
Prince William	9.91	9.64	9.80	10.10	6.03	10.06	9.77	**10.01**	-0.14	0.04	$56,930
Danville-Pittsylvania	4.60	8.29	10.17	3.70	12.96	5.56	**12.97**	2.76	8.36	-5.51	$63,390
Crossroads	9.17	10.19	11.17	7.11	11.08	9.06	**10.85**	5.92	1.68	-3.25	$45,549
Henrico Area	12.28	7.51	11.03	10.70	15.80	6.91	**16.44**	7.73	4.15	0.23	$32,124
District 19	24.98	23.20	19.03	17.24	17.57	11.71	**28.23**	**17.64**	3.24	-5.56	$95,634
Richmond	49.81	32.35	40.52	36.36	45.41	28.90	**46.35**	**26.04**	-3.47	-6.32	$267,344
Hampton-Newport News	19.18	10.35	21.96	14.03	21.81	10.75	**21.70**	**11.62**	2.53	1.27	$219,825
Norfolk	32.68	22.75	43.73	18.92	27.59	16.81	**35.58**	**11.86**	2.90	-10.89	$315,580
Portsmouth	34.13	18.07	31.22	10.07	33.94	31.95	**26.33**	8.10	-7.80	-9.97	$98,294
Virginia Beach	7.51	5.23	10.91	6.82	10.26	7.76	**10.15**	6.69	2.64	1.46	$180,766
Western Tidewater	9.15	4.58	13.29	9.60	10.82	9.38	**15.10**	8.63	5.95	4.05	$99,376
State Rates/Total Funds	***10.79***	***10.74***	***11.73***	***10.38***	***11.01***	***8.30***	***11.89***	***7.65***	***1.10***	***-3.09***	***$1,666,236***

PART III:
SUSTAINING THE SUBSTANCE ABUSE SERVICES COUNCIL

The *Code* of Virginia §2.2-2696 establishes the Substance Abuse Services Council (SASC) and mandates that at least four meetings be conducted annually. The Council consists of thirty members, twelve representing state agencies, six representing the General Assembly, and twelve representing provider, consumer and advocacy organizations. As directed, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) allocates "funding for the cost of expenses".

Staff is provided through the Office of Substance Abuse Services (OSAS). In addition to providing staff support for meeting logistics and activities, the Department funds the expenses incurred for producing reports and per diem for meals and travel for non-state agency representatives. The Council makes an effort to meet at locations throughout the Commonwealth to provide opportunities for citizen input and increase its understanding of regional issues. This facilitates the Councils ability to meet the mandate to identify and make recommendations that address the needs concerning substance use disorders.

During 2006, the Council assembled four times for general meetings and participated in one facilitated retreat. Meetings were conducted at Pocahontas Correctional Unit, at the Fluvanna County Sheriff's Office, in Harrisonburg, and at a public library in Hampton. The retreat was held in Charlottesville at a local hotel. Subject matter for meetings in 2007 included a presentation by the Inspector General (OIG) on the Community Services Board Substance Abuse Outpatient Services for Adults and a tour of the Indian Creek Correctional Center, a therapeutic community substance abuse treatment program operated by the Department of Corrections. Council meetings are utilized to share, educate, and culminate in a meaningful report and plan to the General Assembly. All meetings are open for citizen participation and time is allotted for public comment.

Historically, the Department has utilized a portion of its five percent administrative allowance from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant to cover the costs associated with supporting the Council. This allocation also covers all administrative expense incurred by the OSAS. As the total amount of the SAPT Block Grant has remained static for several years, the allowance has also remained static. Meanwhile, staff salaries and other costs have increased. Given that the Council is a state mandate and is not a requirement of the SAPT Block Grant, it is logical to have the costs associated with the Council covered by general funds.

RECOMMENDATION

5. The Council recommends that the General Assembly appropriate $100,000 annually to staff and support of the thirty-member Substance Abuse Services Council. This amount covers staff salary and benefits, travel and accommodations for Council members and staff, costs associated with public

hearings the Council may conduct, and publication and distribution of the Council's report.

PART IV:
THE SUBSTANCE ABUSE COUNCIL'S VISION FOR SUBSTANCE ABUSE SERVICES ACROSS THE COMMONWEALTH: A TEMPLATE FOR TRANSFORMATION

PURPOSE

The Department of Mental Health, Mental Retardation and Substance Abuse Services has embarked upon a plan to transform its service system, focusing on the cornerstone human values of self-determination, empowerment and recovery, and implemented by improving accountability, access, and quality of services, developing partnerships, enhancing coordination, managing funding, and using resources efficiently. Documents including the Department's strategic plan (January 2006) provide structure and direction for the system, and include many items that focus specifically on substance use disorders. The Council, in its advisory role to the Governor, the General Assembly and the Board of the Department, seeks to emphasize some key components of the transformation plan, as well as to augment it. This white paper is the Council's interpretation of transformation for the prevention and treatment of substance use disorders in Virginia's public systems of care.

PRINCIPLES OF TRANSFORMATION FOR TREATING SUBSTANCE USE DISORDERS

SELF-DETERMINATION

The consumer accepts personal responsibility for his or her recovery, participates in the development of treatment goals and expectations, and agrees to pursue these goals and expectations within a therapeutic framework. Consumers maintain their commitment to personal responsibility, convey pride in their recovery, and express hope for their future.

EMPOWERMENT

Consumers are empowered to define their treatment goals in the context of their whole lives, as well as and in making decisions about the treatment services they receive. Consumers are informed about various treatment options and are involved in selecting treatment approaches, services and supports, including employment, education and training, health care and legal supports.

RECOVERY

Free of addiction to alcohol and drugs, an individual is able to pursue his or her full human potential and to seek a meaningful, productive and satisfying life in the community of his or her choice. Recovery from Substance Use Disorders is traditionally community-based and enhanced by involvement in structured programs, including Twelve-Step programs and faith-based organizations.

Implementation

Accountability

Accountability addresses the fiscal management of resources as well as the effective use of resources. Sound policies, procedures and management with integrity have been watchwords in most community services boards and in the Department. Assuring that resources are used effectively is more difficult, especially in evaluating prevention and treatment services. Nationally, there is a strong emphasis on measuring outcomes. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has adopted the National Outcome Measures (NOMs) to capture data on ten domains: reduced morbidity, employment/education, crime and criminal justice, stability in housing, social connectedness, access/capacity, retention, perception of care, cost effectiveness, and use of evidence-based practices. The specific outcome measures for these domains were developed with input from states. As a condition of receiving federal funds from the Substance Abuse Prevention and Treatment Block Grant, all states and territories are required to collect and report on these measures beginning July 2006. This obligation has required the Department and CSBs to collaborate more closely about data collection, and has strained resources dedicated to information technology, both human and technical. In addition, the 2004 Session of the General Assembly passed legislation requiring all state government agencies that provide substance abuse treatment services to report outcome measures, costs and the extent to which these programs met demand for services (*Code* of Virginia § 2.2-2697). No resources were allocated to support these requirements, however.

A transformed system has resources to support not only required data elements, but to support the use of this information in improved management of resources. Such a system focuses on mutually agreed upon benchmarks, and supports the development of change processes that will help to achieve them.

Treatment services promote positive change in the individual, evidenced by sustained cessation of alcohol or drug use, improved health and social functioning, increased self-esteem and confidence, improved performance at work or in school, and success in personal, family and community relationships. Recovery is a common outcome of treatment and leads to improved quality of life for consumers, their families and significant others.

Through mutual accountability, the consumer and the service provider are consistent in maintaining an agreed upon therapeutic process. Both parties are open and truthful with each other. The consumer is accountable for mutually agreed upon new behaviors and is honest about relapse into destructive behaviors. The clinician is accountable for providing appropriate, professional interventions, for addressing lapses without disrespect or punitive sanction, for devising flexible and supportive options for renewed efforts, and for acknowledging and celebrating progress. Consumer outcomes are measured and monitored to assure that services are effective.

The expected outcome for an individual in recovery from a substance use disorder is a functional return to society. Treatment for substance use disorders has traditionally stressed personal responsibility and accountability, to achieving interdependence. Expectations are high, therefore, regarding long-term stability and contribution to society.

Access

According to the National Survey on Drug Use and Health[41], more than 704,000 people in the Commonwealth suffer from substance use disorders, but 562,000 of them are not receiving needed treatment. In 2006, CSBs served only nine percent of those in need. People who suffer from substance abuse and addiction experience a significant amount of denial as a way of coping with the perceived hopelessness of addressing their problems. When treatment is not available on demand, the sense of hopelessness is magnified. No matter what degree of systems re-engineering occurs to better engage people seeking services, the lack of service capacity creates the untenable situation of people not receiving the care they need when they need it.

The Office of the Inspector General for the Department of Mental Health, Mental Retardation and Substance Abuse Services issued a report in August, 2006, *"Review of Community Services Board Substance Abuse Outpatient Services for Adults,"* which identified significant shortcomings in access and availability of the continuum of treatment available through the community services board system. One of the most critical findings was that consumers must wait an average of 25 days between the first call for assistance and the initiation of active treatment. [42] In addition, many services in the array of the treatment continuum are not equally available across the Commonwealth, including detoxification services, use of medications to treat opiate and other drug dependence, case management.

The current range, variety and capacity of treatment services for substance use disorders are not adequate to meet the needs of the numbers of persons with abuse or dependence in Virginia communities. Gaps in the array and limited capacity of available services restrict consumer choice and do not allow sufficient individualization of treatment programs, including the ability to provide treatment and support to persons with both a substance use disorder and mental illness. Until capacity adequate for the complete continuum of services, consumers will not be empowered to determine a course of treatment that fully promotes recovery.

In the transformed system, there is a complete array of services available to address the clinical needs of the person in need of treatment. These services are "unbundled" from "programs" so that treatment is designed from a selected menu of services. Services are provided in a way that is sensitive to the cultural and gender issues

[41] Rates based on figures from the National Household Survey of Drug Use and Health, Substance Abuse and Mental Health Services Administration; population for Virginia population ages 12+ extrapolated from U.S. census data.

[42] Stewart, James W., III. Review of Community Service Board Substance Abuse Outpatient Services for Adults. Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services; Report: #129-06; August, 2006; p. 21

of each individual, including sexual orientation, language and adaptation for those with hearing, vision or mobility impairments.

As research identifies medications effective in the treatment of abuse and dependence, consumers need access to appropriate information to make informed decisions about including medication as a part of treatment, along with appropriate psychosocial interventions and supports. In a transformed system, medication assisted treatment is provided by appropriately trained health professionals using approved protocols. Third-party payers include these pharmaceuticals in their formularies, and the Department facilitates their use by addressing administrative systemic barriers and seeking funding resources. Education and training concerning the appropriate use of these medications will be available for counseling and professional health providers. Community physicians will be encouraged to form collaborative relationships with substance use disorder treatment providers to increase appropriate utilization of these medicines.

Access to an array of services supports a whole person approach to addiction that produces improved outcomes for prevention, early intervention and treatment. Access in a transformed system is characterized by an Open Door approach. Services should be accessible from multiple system entry points, including the health care system, the public safety and criminal justice system, social services and education. A full range of services and supports is available ***whenever the person or significant others seek services.*** A consumer's need for housing, employment, child-care, or healthcare is assessed at point of entry into the system and addressed immediately. Elements of a continuum of care specific to the individual consumer are available and coordinated through a case manager using and evidenced-based practices. Information and referral to community-based support groups, such as Twelve-Step programs, consumer-run organizations and faith-based organizations, is readily available.

For adolescents needing treatment, developmentally appropriate services are available on demand and involve key support adults and systems, including schools, social services, juvenile justice and health care providers. Services are comprehensive and address the holistic needs of the child, including addressing co-occurring mental illness and learning disorders. Early identification and intervention are primary. Treatment shall be available in juvenile justice settings and accessible in educational settings.

Although lack of funding is a key component, funds for services alone will not provide an instant solution. Skilled professionals, both in the behavioral and healthcare arenas, are needed to deliver treatment and prevention services. Experienced professionals need to be trained in treatment and prevention practices that are evidence-based, and clinical supervisors must be trained, as well. Implementing these practices system-wide requires that a systematic process for supporting these changes be developed and maintained. In addition, professional training for social work, psychology and counseling rarely provides education or training in treating or preventing substance abuse or dependence. Physicians and nurses receive extremely limited training in addictions,

even those specializing in behavioral health disorders. Curricula needs to be developed and incentives need to be offered to interest these professionals in training to enter the fields of preventing and treating substance abuse and dependence.

In the transformed system, there is a partnership between the formal educational and research community and providers of services. Curriculum includes information about the genetic and neurological components of addiction, as well as treatment options, including screening and assessment, medication, the treatment continuum, psychosocial interventions and case management.

Quality of Services

The technological advances in treatment and prevention of substance use disorders have exerted a rapid change in both arenas. The focus of these changes is improved matching of the approach to the needs of the specific populations (prevention) and individuals (treatment). Measurement of outcomes is the preferred approach to assessing quality, however, the careful selection of appropriate outcome measures is crucial for these measures to be meaningful.

Recent research provides sound evidence that addiction is a brain disease that, like other chronic diseases, requires ongoing management and may require repeated treatment. This discovery has significantly altered the perception of people with substance abuse disorders, as well as the development of effective treatment. For the best result, treatment is holistic, addressing the person's physical and mental health, as well as his or her social and physical environment.

An effective system that truly has an Open Door acknowledges both public health and public safety concerns. This approach protects society from those engaged in unsafe or criminal activities, such as driving under the influence or committing criminal acts to support the addiction, provides various ranges of prevention services specific to community need, and makes treatment available to afflicted persons at their present level of need for services and readiness to accept intervention.

In a transformed system, services are provided by clinicians specifically trained in the treatment of substance use disorders, including those who are in recovery themselves. Treatment practices are science-based, and training, supervision and coaching are available to practitioners on an ongoing basis, supported by systems to support technology transfer. The Department provides incentives to publicly funded treatment providers to achieve quality benchmarks, and provides support for their achievement. In order to assure quality services for youth, the Department of Health Professions promulgates core professional competencies for the treatment of youth with substance use disorders and co-occurring disorders. Core program standards currently promulgated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for youth services incorporate specific practice standards focused on co-occurring disorders.

Services are person-centered, utilizing a menu of services and supports designed to address the specific needs of the consumer for treatment and supports. Overall, services are culturally sensitive, strength-based, self-directed, empowering, holistic, peer-supported and representative of the full continuum of care from *detox* through treatment to ongoing support. Substance abuse treatment in a transformed system protects the rights of consumers, foster responsibility, and involves mutual accountability between the consumer and clinician.

Partnerships

Because the impact of substance use disorders crosses all societal boundaries, individuals in need of treatment interact with a variety of systems, including healthcare, criminal justice, mental health, welfare and social services, and juvenile justice or educational. Approaches to these individuals within these systems can vary considerably, even taking into account inherently disparate missions. In a transformed approach to treatment, these systems have developed coherent and coordinated approaches to ensure a high quality continuum of care. Inter-system coordination fosters effective use of limited resources. The principal partnership in recovery from a substance use disorder is the mutual cooperation among service providers, consumers, and their family members and community support structure. Professional partnerships are enhanced and maintained with the following systems:

- local Virginia Alcohol Safety Action Programs;
- behavioral health professional organizations;
- judiciary;
- law enforcement;
- local jails and detention centers;
- local departments of social services;
- local departments of health;
- providers of primary healthcare;
- local emergency departments;
- community services boards;
- private providers of addiction and mental health services;
- local homeless shelters;
- local advocacy groups; and
- other local support services.

Concomitantly, relationships among state level organizations that represent these local agencies are strengthened to address policy and resource barriers. These include:

- Commission on Virginia Alcohol Safety Action Programs;
- Department of Alcoholic Beverage Control;
- Department of Criminal Justice Services;
- Department of Corrections;
- Department of Education;
- Department of Health;

- Department of Health Professions;
- Department of Juvenile Justice;
- Department of Mental Health, Mental Retardation and Substance Abuse Services;
- Department of Medical Assistance Services;
- Department of Motor Vehicles;
- Department of Rehabilitative Services;
- Department of Social Services;
- Governor's Office of Substance Abuse Prevention;
- Medical Society of Virginia;
- Substance Abuse and Addiction Recovery Alliance (SAARA) and other consumer advocacy groups;
- Substance Abuse Certification Alliance of Virginia;
- Virginia Association of Community Services Boards;
- Virginia Association of Alcohol and Drug Abuse Counselors and other behavioral healthcare professional associations;
- Virginia Association of Drug and Alcohol Programs;
- Virginia Drug Court Association;
- Virginia Hospital and Healthcare Association;
- Virginia Sheriffs' Association; and
- Virginia Tobacco Settlement Foundation.

In addition to partnerships defined in the strategic plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services, relationships are maintained with advocacy organizations, recovery houses, employment counselors, childcare providers, and attorneys to meet consumers' needs during and after treatment. The academic community is engaged to support training and education for future providers of addiction treatment and prevention, as well as to assist in technology transfer to current providers. Partnerships with state and local policy makers and community leaders provide information and combat stigma. As part of the transformation process, a centralized advocacy organization provides support, education and advocacy training for consumers and family members.

Coordination

Coordination of all relevant service providers, volunteer organizations, and institutions are maintained on an ongoing basis at a state and local level. The focus of service, however, should remain on the individual consumer. In addition to coordination of services specifically related to treatment, consumers may require coordinated assistance in seeking or maintaining healthcare, employment, housing, and supportive relationships.

A coordinated system of care encourages physicians and other healthcare workers in hospital emergency departments, primary care centers, prenatal clinics, and STD clinics, to employ screening and brief intervention techniques to identify and refer individuals in need of treatment. In addition, the impact of infrastructure initiatives such

as Project TREAT (a federally funded project focusing on mental health and substance abuse services for adolescents) should be studied so that lessons learned can be applied to other populations. Additionally, a statewide interagency workgroup shall be established to link public agencies and private organizations in working together to enhance substance abuse services for youth and adolescents.

Within the Recovery Community, coordination of treatment with participation in Alcoholics Anonymous and other Twelve-Step programs foster successful recovery from substance use disorders. Because recovery focuses on positive changes in behavior, values, social supports, a transformed system of care shall acknowledge the concepts, principles and ideals of Twelve-Step programs.

Funding

To a limited degree, implementation of the expansion of Medicaid to reimburse providers for substance abuse treatment will address, the need for additional system resources, but Medicaid is not a panacea. Funds are needed for non-Medicaid eligible populations as well as for services not covered by Medicaid to ensure that persons needing services have timely access to services, along with needed support services.

Substance abuse services shall be appropriately funded to ensure sufficient capacity to address consumer needs in the Commonwealth. A combination of governmental funding sources, from federal, state and local government, are needed to assure access and maintain capacity and access to the appropriate level of care in Virginia's communities. In a transformed system, funding to treat substance use disorders follows the consumer. Payment for services is billed on a sliding scale based on a consumer's ability to pay, but services are not being denied to those unable to pay. Official discharge from treatment is not contingent upon final payment. Service providers work with consumers to develop a manageable payment plan before discharge as a part of learning accountability and responsibility, and to encourage consumers to meet their obligations and to protect their future finances and credit rating.

The transformed system includes funding for adolescent-specific services for non-Medicaid eligible youth. The Department of Education is allocated funding to conduct a statewide youth risk behavior survey. The data is used for assessment, planning and accountability by multiple local and state agencies. A Student Assistance Program (SAP) infrastructure is sustained to manage alcohol and drug abuse prevention programming and to address early identification, intervention, and referral for assessment, case management and support. Such a statewide infrastructure minimizes the service gaps within the educational system and creates a continuous system of care with community agencies.

Efficient Use of Resources

Treatment and prevention that incorporate science-based practices and programs produce positive results for individuals and communities. Studies consistently demonstrate that treating substance use disorders is cost-effective. In contrast, untreated substance abuse increases not only the costs across education, public safety and public

health, which are borne by the taxpayer. For every $1 spent on addiction treatment programs, research indicates a $4 to $7 reduction in societal costs, including community violence and crime, criminal justice costs, lost productivity, and social services. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.

System investments include funding prevention programs, training and other staff support for utilizing evidence-based practices, funding higher education to educate more addictions services professionals, hiring additional staff to decrease waiting times for treatment services, and streamlining case management.

THE VISION PROFESSIONAL ADDICTION SERVICES IN A WELCOMING ENVIRONMENT

Recognizing that a transformed system shall welcome consumers into Virginia's programs of community-based care, the Council suggests incorporating the following values and practices.

SERVICES FOR CONSUMERS AND FAMILIES SHALL BE WELCOMING: 1) Services are available at times and places convenient to consumers; 2) facilities reflect consumer's interests, special needs and cultural affiliation; and, 3) staff are respectful, mindful of individual needs and sensitive to client confidentiality.

SERVICES ARE PROVIDED IN FACILITIES THAT ARE ACCESSIBLE FOR CONSUMERS AND FAMILIES: 1) facilities are in proximity to the areas client population and are accessible by affordable, convenient, reliable transportation; 2) Facilities are barrier-free and safe for all users including those with limited mobility, individuals using wheelchairs and parents pushing strollers.

SERVICES FOR CONSUMERS AND FAMILIES ARE INTEGRATED: Community service providers 1) approach consumers and their families as *partners* in assessing needs, making informed choices, and developing a course of treatment or plan for service; 2) develop and operate programs in collaboration with all other appropriate community resource providers; and, 3) facilitate consumer access to other necessary and significant resources provided by community partners, including housing, physical and mental health care, and employment and educational opportunities.

SERVICES FOR CONSUMERS AND FAMILIES ARE CONTINUOUS: Treatment is designed to be continuous and coordinated so that 1) services are oriented to address individual needs that will change over the course of care; 2) case management is emphasized to prevent consumers from getting "lost", especially when in transition between levels of care or treatment services.

SERVICES FOR CONSUMERS AND FAMILIES ARE COMPREHENSIVE: Community service providers shall develop and operate programs that meet the needs of the *whole person* including 1) a thorough assessment that addresses all major life areas (medical, psychological, financial, housing, employment, legal); 2) a detailed service plan is developed in partnership with the consumer and significant others; 3) the consumer is re-evaluated at critical junctures in the care plan, and when significant crises occur.

SUMMARY

The service delivery system adopt a broad policy of valuing the worth of each individual, creating a No-Wrong-Door environment, welcoming consumer participation, developing evidence-based treatment programs, providing a continuum of high-quality care, and encouraging, supporting and celebrating all members of the Recovery Community.

APPENDICES

SUBSTANCE ABUSE SERVICES COUNCIL
SURVEY OF AGENCIES 2007

OVERVIEW

The *Code* of Virginia §2.2-2696.F. requires the Council to develop an interagency plan. A review of state agency substance abuse treatment programs is conducted in an effort to develop this plan. The Substance Abuse Services Council utilized a survey of state agencies represented on the Council to provide assistance in the development of the interagency state plan. In addition, survey responses were requested from Virginia Parole Board and the Office of Executive Secretary of the Supreme Court of Virginia. This respondent request was in accordance with Virginia statue § 37.2-310. A similar survey was issued in 2003 and 2005 and reported in the respective Substance Abuse Services Council (SASC) report and plan.

SUMMARY OF AGENCY PRIORITIES

In this current survey, as well as prior surveys, the following agencies were included: Department of Education (DOE); Department Mental Health Mental Retardation Substance Abuse Services (DMHMRSAS); Department of Health (VDH); Department of Social Services (DSS); Department Criminal Justice Services (DCJS); Department Juvenile Justice (DJJ); Department of Medical Assistance Services (DMAS); Department of Corrections (DOC); Governor's Office for Substance Abuse Prevention (GOSAP); and the Commission on Virginia Alcohol Safety Action Programs (VASAP). As the Virginia Tobacco Settlement Foundation (VTSF), not included in the 2003 or 2005 survey, its responses are an addition to the 2007 survey.

DMHMRSAS substance abuse services are provided by forty community services boards (CSBs) and, to a limited degree, by state mental health facilities. DJJ operates seven institutional facilities. DOC Division of Operations includes 40 institutions. These are the only three agencies that actually provide treatment services. A more detailed examination of their services, required by *Code* of Virginia § 2.2697 is available at http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2052007/$file/RD205.pdf.

I. NEEDS ASSESSMENT

Currently DMHMRSAS and DJJ conduct a formal needs assessment related to services for substance use disorders (SUD). GOSAP is in the process of compiling an epidemiological profile. DOC through the Comprehensive Organizational Matrix for Program Activities and Service Systems (COMPASS) Task Force is addressing treatment, programming and delivery of aftercare services.

DMHMRSAS, DSS, DOC, and DJJ, routinely screen clients to identify substance use problems. No standardized approach is utilized by all four agencies. VDH does not utilize a standardized screening instrument, however clients are interviewed for services and urine drug screens are completed if indicated. DOC and VASAP are the only reporting agencies that procedurally assess all clients. In 2005, DJJ responded that the agency procedurally assessed all clients; however, in 2007, they only assess some clients. DMHMRSAS is the

only agency that indicated specific screening for co-occurring mental health/substance abuse disorders.

Although DOE does not directly provide treatment to students, the agency does provide materials, training, and technical assistance to the Safe and Drug Free School Coordinators. DOE also collects data on Alcohol, Tobacco and Other Drug (ATOD) offenses. Currently there is no standardized process to link student violators of the ATOD discipline code with assessment and appropriate services.

As a means of prioritizing need, agencies were requested to identify three populations that were underserved by their organization. Adolescents were identified in the 2005 survey as an underserved population and this trend is again recognized with the 2007 survey responses. VASAP specifically indicated the scope of services for Young Offenders as limited. In addition to adolescents, VDH identified pregnant women and women of childbearing age prior to pregnancy as having limited access to services.

VTSF, DOC, and DJJ specifically identified youth with mental health disorders as an underserved population. DOC also identified adults with co-occurring disorders as underserved by the agency. Appropriate treatment programs and re-entry programs that prepare inmates to return to the community are not readily available. Additionally DMHMRSAS, DCJS and DJJ identified both adults and adolescents that are incarcerated or on community supervision as underserved populations. The scope of options available for opiate dependent/addicted adult services is also limited.

AGENCY RESPONSES:

NEEDS ASSESSMENT		
1. Does your organization conduct formal needs assessments related to services for substance use disorders?		
Secretary of Education		
DOE	NO	
Secretary of Health & Human Resources		
DMAS	NO	
DMHMRSAS	Yes	Prevention needs assessments are conducted locally by CSBs on an annual basis. The Dept relies on the National Household Survey of Drug Use and Health for treatment information. CSBs submit "wait list" data biannually
VDH	NO	
DSS	NO	
VTSF	NO	
Secretary of Public Safety		
DCJS	NO	
DJJ	YES	This needs assessment is informal and includes reviewing results of substance abuse screenings and evaluations conducted on committed juveniles, data from screenings conducted on detained juveniles, and informal information gathering from court service unit staff. There is not an official needs assessment document or summary that can be provided. The data is used for internal planning for services.
DOC	NO	Currently developing compass to complete service statewide
GOSAP	YES	In the process of compiling an epidemiological profile
Legislative Agencies		
VASAP	NO	
2. Does your organization routinely screen clients to determine the need for substance use problem or disorder assessment or treatment? If yes, what screening instrument?		
Secretary of Education		
DOE	NO	
Secretary of Health & Human Resources		
DMAS	NO	
DMHMRSAS	Yes	Some providers are using standardized screening instruments (SASSI and Oklahoma Co-Occurring MH/SA Disorders Screening Instrument) and some use screening methods that are developed internally
VDH	NO	No standard screening instrument; patients are interviewed and urine drug screen (UDS) completed if indicated
DSS	YES/some	All participants registered for VIEW are offered screening using the Substance Abuse Screening Inventory, CAGE questionnaire, Simple Screening Instrument (SSI), other State approved screening tools.
VTSF	NO	

Secretary of Public Safety		
DCJS	NO	
DJJ	YES /some	When clients are screened the SASSI-A2, modified Adolescent Problem Severity Index (APSI) and clinical interviews are employed
DOC	YES- all clients	Simple Screening Instrument (SSI) and Addiction Severity Index (ASI)
GOSAP	NO	
Legislative Agencies		
VASAP	YES- all clients The Simple Screening Instrument (SSI) and the Michigan Alcohol Screening Test (MAST) are routinely utilized	

3. Please list the three populations needing intervention for substance abuse most underserved by your agency.

Secretary of Education	
DOE	The definition of "intervention" used in an educational environment differs from its use in a treatment setting. In a school division "intervention" may simply be used as a descriptor of the act of placing a student in a group or class to provide education and skills on remaining or becoming alcohol and other drug-free. In contrast, in a clinical setting, it may be used to describe a "treatment intervention" need substantiated by diagnosable classification according to the Diagnostic Statistical Manual (DSM). DOE does not directly serve students but provides material, training, and technical assistance to 134 school division Safe and Drug-free school coordinators in Va. DOE collects data on ATOD but has no structured process to link violators with assessment and services. (1) Adolescents- 9th-12th graders 7,136 out of 372,317 students were reported for ATOD violations during school hours or while attending a school. 1, 958 females and 5,178 males committed the offenses (2) Pre-teens 6th-8th graders 2,133 out of 284,142 students were reported for ATOD violations during school hours or while attending a school related activity. 675 females and 1,458 males committed the offenses. (data from 2005/2006 Discipline Crime and Violence Report, VA DOE)
Secretary of Health & Human Resources	
DMAS	Not a service provider
DMHMRSAS	1. Opiate dependent/addicted adults 2. Adolescents 3. Persons incarcerated in local jails
VDH	1. Pregnant Women 2. Adolescents 3. Women of childbearing age-prior to pregnancy
DSS	1. TANF is the only population receiving screening
VTSF	1. Youth with mental health disorders
Secretary of Public Safety	
DCJS	1. Local Probationers, supervised by the Local Probation Programs in Virginia 2. Regional Jail Inmates 3. Local Jail Inmates
DJJ	1. Juveniles in community-settings needing residential treatment for substance use disorders 2. Juveniles in community-settings needing non-residential (outpatient) treatment for substance use disorders. 3. Juveniles with co-occurring mental health and substance use disorders in both institutional and community settings.

DOC	1. Persons with Co-occurring Disorders 2. Developing in level 4 thru 6 institutions EBP Cognitive Behavior Treatment Programs and Re-entry programs to prepare inmates to return to the community 3. Develop in Work Centers' level 1 thru level 3 EBP Cognitive Programs (excluding Therapeutic Communities)	
GOSAP	N/A	
Legislative Agencies		
VASAP	1. Repeat DUI offenders (treatment services not available in all areas) 2. Young offenders	

II. AGENCY ORGANIZATION AND PLANNING

All three agencies that provide treatment services as well as GOSAP, VASAP, and VTSF address substance use disorders in their strategic planning. DOE, DSS, DCJS, and GOSAP staff do not receive any routine training about substance use disorders, but VDH direct service personnel occasionally do receive training. DMAS staff that work directly with specific programs receive some continuing education in reference to substance use disorders. DMHMRSAS direct service staff at CSBs and facilities and mid-level supervisor staff receive training. VASAP is the only agency that reported all levels of staff receives routine training about to substance use disorders. DCJS, DMAS, and DMHMRSAS collaborate at some level that includes partnership around organizational infrastructure, written agreements for information sharing and some state level association. DMAS and DMHMRSAS report being linked to an advocacy group.

AGENCY RESPONSES:

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 Education		
DOE	NO	
Secretary of Health & Human Resources		
DMAS	NO	DMAS is not a service provider
DMHMRSAS	Yes	Identified in the agencies current products and services as well as noted as factors impacting agency products and services.
VDH	NO	
DSS	NO	
VTSF	YES	
Secretary of Public Safety		
DCJS	NO	
DJJ	YES	Expressed in agency Goals to improve successful community functioning of juveniles involved with DJJ by coordinating substance use interventions when needed.
DOC	YES	SA service programming is identified as a critical issue. SA programming identified as a measure of success of community re-entry and lowering recidivism
GOSAP	YES	Addressed in Agency Strategic Plan in Service Area Description
Legislative Agencies		
VASAP	YES	
2. Do staff in your organization routinely receive training about substance use disorders related to your service population?		
Secretary of Education		
DOE	NO	
Secretary of Health & Human Resources		
DMAS	NO	DMAS does not have direct service providers, but staff working with programs attend continuing education.
DMHMRSAS	YES	Direct Service Personnel, Mid-level Supervisory/Management
VDH	YES	Direct Service Personnel -occasionally
DSS	NO	
VTSF	Yes	Mid-level Supervisory/Management and Upper Level Management receive training in SA
Secretary of Public Safety		
DCJS	NO	
DJJ	YES	Direct Service Personnel and Mid-level Supervisory/Management
DOC	YES	Direct Service Personnel and Mid-level Supervisory/Management
GOSAP	NO	
Legislative Agencies		
VASAP	YES	Direct Service, Mid-level Supervisory/Management, Upper Level Management

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 using the category codes below.

1- Basic referrals to other agencies/organizations. 2-Collaboration and joint planning with other agencies or organizations on policies, procedures, regulations. Interagency case staffing, may 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 Education		
DOE	1. Governor's Office of Substance Abuse (GOSAP) Collaborative 2. Virginia State Health Department 3. DMHMRSAS 4. Virginia Center for School Safety, DCJS 5. Center for School Community Collaboration, VCU 6. Juvenile Services Section, DCJS	6 5 5 5 5 5
Secretary of Health & Human Resources		
DMAS	1. DMHMRSAS 2. VACSB & private providers	2,3,4,5,6 2,3,5,6
DMHMRSAS	1. 40 CSBs (treatment and prevention) 2. All GOSAP Collaborative Members (for prevention) see list below under Programs and Services 3. Department of Health (treatment) 4. Department of Rehabilitative Services 5. Mid Atlantic Addiction Technology Transfer Center-VCU 6. Department of Medical Assistance Services	1,2,3,4,5,6 (all levels) 2,3,5,6 - 1,2 3,4 3,4 2
VDH	1. CSB's 2. Project Link	I I
DSS	1. Local substance abuse assessment & treatment providers 2. Department of Rehabilitative Services (DRS)	I 6
VTSF	1. Virginia Department of Health 2. Governor's Office on Substance Abuse Prevention 3. American Lung Association 4. American Cancer Society 5. American Heart Association	2,6 2,5,6 5,6 5,6 5,6
Secretary of Public Safety		
DCJS	1. Department of Corrections 2. Department of Juvenile Justice 3. DMHMRSAS 4. Substance Abuse Services Council 5. Consortium of Substance Addiction Organizations (CSA0) 6. Local Community Criminal Justice Services Boards	2,3,6 2,3,6 2,3,5,6 5,6 5 3,4

DJJ	1. Community Services Boards/Private Providers 2. Mid-Atlantic Addiction Technology Transfer Center (ATTC) Training Provider 3. DMHMRSAS-support for training activities through Project TREAT 4. Adolescent Substance abuse Interagency Workgroup	1 . . . 5,6
DOC	1. Geimeinschaft Home 2. Bethany Hall 3. Hegira House 4. Serenity House 5. Rubicon 6. Vanguard	2 2 2 2 2 2
GOSAP	N/A-Not a direct service provider	
Legislative Agencies		
VASAP	1. Community Services Boards 2. Licensed Private Treatment Providers 3. Supreme Court Advisory Committee on Drug Courts 4. Interagency Drug Offender Screening and Assessment Committee	1 1 2 2

4. Are you linked to any advocacy groups?

Secretary of Education		
DOE	NO	
Secretary of Health & Human Resources		
DMAS	YES	
DMHMRSAS	YES	SAARA
VDH	NO	
DSS	NO	
VTSF	YES	
Secretary of Public Safety		
DCJS	NO	
DJJ	NO	
DOC	NO	
GOSAP	NO	
Legislative Agencies		
VASAP	NO	

III. PROGRAMS AND SERVICES

VDH, GOSAP, and DSS do not directly provide substance abuse programs and services. DOE, DMHMRSAS, VTSF, and VASAP all provide differing degrees of training for professional, prevention and education programs. These services are supported and funded by coalitions, the SAPT Block Grant, and other federal grants and state general funds. DCJS does not provide direct services, but the agency assists with programs at the local and regional jails with funding provided by grants. DJJ and DOC receive general funds for residential, prison and jail based services. General funds and coalition funds support therapeutic communities.

AGENCY RESPONSES:

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 Education		
DOE	YES	Provides Technical Assistance and Consultation to Safe and Drug-Free School Coordinators in Va's 134 school divisions-Training for Professionals training to enhance prevention and intervention science, evidence-based practices, programs (EBP); and education on various drug-specific issues, truancy, disruptive behaviors and student assistance programs
Secretary of Health & Human Resources		
DMAS	YES	Reimburses for services provided, such as general exams and SA services for pregnant and postpartum women. Day treatment and residential treatment. As of July 2007, outpatient, intensive therapy, day treatment, opioid treatment, assessment and evaluation, crisis services will be added. SA case management. All services State and Federally funded.
DMHMRSAS	YES	All clinical services $33,981,516, Treatment (tx), 8,957,629 prevention, Coalition support-some financial report through the local CSB; Training for professionals-OSAS $283,118, TREAT $154,000, COSIG- $384,000 during FY2007; Prevention/ED-Substance Abuse Prevention & Treatment (SAPT) for prevention; Screening -included in tx; Early intervention-included in prevention; TX SAPT for TX (minus OSAS training)
VDH	NO	
DSS	NO	
VTSF	Yes	1. Science based programming- funding support, training for professionals, prevention education, early intervention, treatment 2. Workshops and Seminars funding support, training for professionals, prevention and education 3. Statewide Marketing Campaign-funding support, prevention and education 4. Enforcement of Underage Tobacco access laws-funding support 5. Collaborative Research Projects- funding support, training for professionals
Secretary of Public Safety		
DCJS	NO	Grant funds to local or regional jails, but agency does not provide direct services
DJJ	YES	Residential Services (prison/jail based) funded by State General Funds, Professional development training, Prevention Education through the Phoenix Curriculum, Screening, Early Intervention, Treatment
DOC	YES	Funding for all services, Phase 1,2,3 and TC are supported through General Funds, TC has Coalition Support; All three phases provide training for professionals; Phases 1, 2 & TC offer prevention and education; TC provides screening; Phase 2 and TC provide treatment
GOSAP	NO	

Legislative Agencies		
VASAP	YES	Grants support training for professionals in the areas of screening and assessment. Grants and agency funds support training for appropriate classification and public information and education campaigns. Offender fees fund alcohol and drug education, treatment and referrals

IV. AGENCY/ORGANIZATION TRENDS

The agencies present a variety of strengths. Several agencies noted the capacity to appropriately screen clients and to provide services that use evidence-based practices. Common themes among the agencies include the need for additional funding and the lack of capacity and dearth of services to serve an increasingly younger population with more severe and multiple health issues. Also noted is the prevalence of gangs and changes in youth trends that require new approaches. Agencies continue to report challenges in collecting and adequately processing useful data to provide performance measures due to inadequate support for data collection and management.

Agencies report that collaboration at both the state and local levels improve efficient use of resources and continuity of care. The agencies collaborative ability to consistently update available resources and treatment trends, as well as increase the availability of public information, education and prevention programs facilitates a stronger positive impact on the community.

The common theme for recommendations to the Governor and General Assembly include increased funding to provide treatment on demand for a full continuum of care. The increased funding would be utilized for Student Assistance Programs, expansion of services for women of childbearing age and adolescents, the implementation of evidence-based practices, and development of an infrastructure to integrate and sustain substance abuse services.

AGENCY RESPONSES:

AGENCY/ORGANIZATION TRENDS	
1. Please list your organization's greatest strengths related to providing identification, prevention, and/or intervention services for individuals with or at risk of substance use problems or disorders.	
Secretary of Education	
DOE	1. Brokering information and collaborating with other state agencies and higher education institutions 2. Producing educational materials and trainings 3. Providing technical assistance to safe and drug-free school coordinators
Secretary of Health & Human Resources	
DMAS	NO Not a service provider
DMHMRSAS	1. Statewide coverage 2. Provides technical assistance and significant levels of training to CSBs 3. Strong emphasis on evidence-based programs and practices
VDH	1. Knowledge of public health approach to chronic disease prevention and experience in health promotion 2. Screening for substance use during pregnancy is a standard of care
DSS	1. Mandatory screening for participants in TANF employment program 2. Mandatory assessment and treatment, if indicated, for TANF employment program participants
VTSF	1. Decentralized, regional funding process utilized by VTSF 2. Strong relationship with youth serving agencies 3. Effective, multi-faceted, statewide tobacco prevention marketing campaign aimed at Virginia's youth.
Secretary of Public Safety	
DCJS	1.Grant funds to programs that provide treatment services, as funds are available 2. DCJS does not directly provide SA treatment services
DJJ	1. Implementation of evidenced based treatment modality (MET-CBT) in juvenile correctional centers 2. Significant staff training activities related to substance use disorders 3. Community programs staff generally knowledgeable and have good relationships with community service providers.
DOC	1. Educating and training staff to conduct specialized groups 2. Providing clinical supervision for State and National Certification 3. Improved communication and developing EBP programs
GOSAP	1. GOSAP and the Collaborative, which consists of all of the above agencies, provides strategic statewide leadership to improve communication, foster agreement, facilitate cooperation and partnerships, share resources, increase consistency, simplify processes and increase accountability in Virginia's prevention community 2. GOSAP and the Collaborative leverages and administers funding, on behalf of the Governor, to support local implementation of proven, evidence-based prevention programs 3. GOSAP and the Collaborative provides tools and training to practice evidence-based prevention, including: the Community Profile Database that provides consistent data for assessing needs, planning, and monitoring trends; provides a prevention information clearing house website for linking communities to training events, funding opportunities, and news and resources, statewide training events

Legislative Agencies	
VASAP	1. Screening and classification of offenders 2. Alcohol and drug education/public information and prevention 3. Treatment referral services/probation monitoring
2. Please list the three most important trends or issues related to meeting the identification, prevention and/or intervention needs related to substance use problems or disorders in the populations served by your organization (examples: increased severity of drug abuse/dependence, changes in ages of clients seen, special cultural issues, special medical issues, drugs of abuse).	
Secretary of Education	
DOE	1. Funding continues to be a central concern of many Safe and Drug -free School Coordinators particularly in smaller localities that receive very modest levels of funding. Coordinators expressed concern about declining funding and challenges of attempting to provide supplemental programming with such limited resources 2. The need for publications and training for Student Assistance Programs 3. The need for publications and training for drug education selection and implementing research based curricula and drug information on specific types
Secretary of Health & Human Resources	
DMAS	While not a service provider DMAS recognizes that the severity of drug abuse is increasing. Also, DMAS recognizes the importance of integrating medical and Mental Health & Substance Abuse care
DMHMRSAS	1. Implementation of Medicaid expansion of covered SA services 2. Emphasis on screening, assessment and integrated treatment for people with co-occurring SA/MH 3. Emphasis on collecting, processing and using outcome data to improve treatment quality
VDH	1. Lack of treatment referral options-especially for pregnant women 2. Identifying pregnant women with substance use treatment needs
DSS	1. Growing methamphetamine problem
VTSF	1. The lack of proven tobacco cessation methods for youth 2. Changes in youth trends that require new messages and interventions to remain effective.
Secretary of Public Safety	
DCJS	1. The decrease in available general funds and federal funds for substance abuse services in the Criminal Justice System 2. The general lack of rehabilitation and/or treatment services for SA offenders 3. The lack of strong code structure to support the ongoing funding of SA treatment
DJJ	1. Increased level of youth gang involvement complicates service in juvenile correctional facilities. 2. Applying the appropriate treatment duration and intensity to incarcerated juveniles with varied institutional lengths of stay 3. Lack of coordination between institutional and community based treatment approaches make effective transitional services challenging.
DOC	1. Increased gang and drug usage 2. Co-occurring disorders 3. Change in age of inmates (younger)

GOSAP	1. Reduced availability of federal prevention funding (Safe and Drug Free Schools and Communities Act (SADFSC) and Center for Substance Abuse Prevention (CSAP) funding cuts 2. Increased specificity in federal reporting requirements Office Management Budget (OMB)-driven federal performance measures
Legislative Agencies	
VASAP	1. Repeat DUI offenders 2. Increases in the number of clients needing treatment 3. Incidences of young offenders (persons charged with underage possession of alcohol classified as needing treatment)
3. How can your organization strengthen services in order to have the greatest impact on the community?	
Secretary of Education	
DOE	1. Provide materials, training and technical assistance to school divisions to implement Student Assistance Programs (SAP's) 2. Increase Virginia Department of Education student support capacity 3. Continue collaboration with other state agencies and entities
Secretary of Health & Human Resources	
DMAS	Not a service provider
DMHMRSAS	1. Increase access to services to address needs of special populations (adolescents, elderly, women, culturally diverse populations, MH/SA co-occurring) 2. Expand access to the continuum of care 3. Continue to train on and implement current evidence based programs and practices
VDH	1. Identify and use a standardized screening tool 2. Increase knowledge of direct service staff
DSS	1. Increase knowledge of staff 2. Develop state level agreements to preclude need to develop independent local programs 3. Make screening services available to more clients
VTSF	1. Develop additional methods to provide cessation for youth. 2. Collect and analyze regional data to better target prevention efforts.
Secretary of Public Safety	
DCJS	1. Additional available funding would allow for funding in the target population (substance abuse offenders) 2. Increase staff that facilitates planning, research and analysis of target substance abuse service needs in Criminal Justice System 3. Develop more specialty plans and evaluations on CJS trends to identify issues in offender rehabilitation
DJJ	1. Continue to implement evidence based programming. 2. Continue staff development. 3. Improve continuity of institutional and post-release services, including enhanced collaboration with public service providers.
DOC	1. Focus on developing more cognitive EBP TX programs in level 4-6 institutions 2. Better prepare and develop more re-entry programs for inmates to return to the community 3. Focus on addressing our other populations with SA TX program (other than Therapeutic Communities)

GOSAP	1. Continue strategic statewide leadership to capitalize on common prevention goals and strategies shared by initiatives within the current administration. 2. Continue developing and enhancing tools and training to practice evidence-based prevention
Legislative Agencies	
VASAP	1. Being consistently updated on available resources and treatment trends. 2. Increase the number of public information, education and prevention campaigns
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 use problems or disorders?	
Secretary of Education	
DOE	1. Provide funding for training and materials for school division to implement SAPs 2. Set statewide change indicators, monitoring and accountability measures 3. Implement university based substance abuse prevention research and best practice centers to work with and support local school divisions and communities
Secretary of Health & Human Resources	
DMAS	No response
DMHMRSAS	1. Provide funding to support "treatment on demand" for the full continuum of care 2. Emphasize formal regionalization to improve cost-effectiveness of providing full continuum of services 3. Provide funding to support community coalitions
VDH	1. Expand Project Link 2. Continue increase in funding for all levels of substance use disorder services-especially for women of childbearing age and adolescents. 3. Conduct a media campaign relating to substance use prevention, decreasing the stigma, and showing that treatment works.
DSS	1. Make assessments more readily available 2. Treatment on demand by increasing treatment capacity 3. Medicaid coverage
VTSF	1. Offer cessation services to youth and adults. 2. Implement an education campaign for families on tobacco prevention. 3. Work with health care and insurance systems to expand coverage for cessation services.
Secretary of Public Safety	
DCJS	1. Do more planning and program development at Regional and Local Jail level. 2. Increase general funds to DCJS for new best practice rehabilitation programs in corrections generally. 3. Increase available General Funds to replace federal funding decreases for best practice treatment programs.
DJJ	1. Increase community-based treatment capacity, through appropriate mechanisms such as Medicaid dedicated CSB funds. 2. Increase expectations for the use of effective, evidence based treatment modalities wherever public funds are being utilized.
DOC	1. Increase treatment funds to develop more programs to help reduce recidivism 2. Increase awareness on gangs and substance use 3. Increase awareness on co-occurring disorder and provide more funding

GOSAP	1. Make evidence-based prevention the top priority in funding and policy to reduce the high cost, long-term consequences of problem behaviors. 2. Implement mandatory city/county-level data collection to monitor attitudes, perceptions and behaviors that contribute to the health and well-being of Virginia's youth, families, schools and communities. 3. Develop infrastructure to sustain and integrate prevention into practice.
Legislative Agencies	
VASAP	1. Readily available access to substance abuse treatment services. 2. Increased resources and availability of substance abuse treatment services in rural communities.

REPORT TO THE
GOVERNOR'S TASK FORCE TO COMBAT DRIVING UNDER THE INFLUENCE OF DRUGS AND ALCOHOL

PLAN TO COORDINATE
SUBSTANCE ABUSE INTERVENTION AND TREATMENT PROGRAMS AND SERVICES

SUBSTANCE ABUSE SERVICES COUNCIL
SEPTEMBER 2007

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

Plan to Coordinate
Substance Abuse Intervention and Treatment Programs and Services
September 2007

Executive Summary

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

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

The plan identifies four goals: (1) reinforcing the use of the Simple Screening Instrument as the standard approach to screening offenders by all local safety action programs by providing training; (2) identifying an assessment instrument appropriate for Repeat Offenders and Hardcore Drunk Drivers and recommending that its use be incorporated into service agreements between local safety action programs and local treatment providers; (3) developing and adopting common definitions of types of treatment and standards for treatment services for uniform application by all VASAP service providers; (4) develop recommendations for data collection to assist in identifying persons likely to become Repeat Offenders and Hardcore Drunk Drivers. The first two goals have already been accomplished. Training on the Simple Screening Instrument has been provided to all 24

ASAP locations and the ASAP programs are using this instrument as a standard. A standard assessment tool has been identified and training provided to both the ASAP staff and treatment providers in all ASAP regions.

Activities in 2005, 2006 and 2007 were supported by National Highway Transportation Safety Action funds granted by the Department of Motor Vehicles to the Department of Mental Health, Mental Retardation and Substance Abuse Services on behalf of the Substance Abuse Services Council.

Report to the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol Substance Abuse Services Council Plan to Coordinate Substance Abuse Intervention and Treatment Programs and Services September 2007

Background

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

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

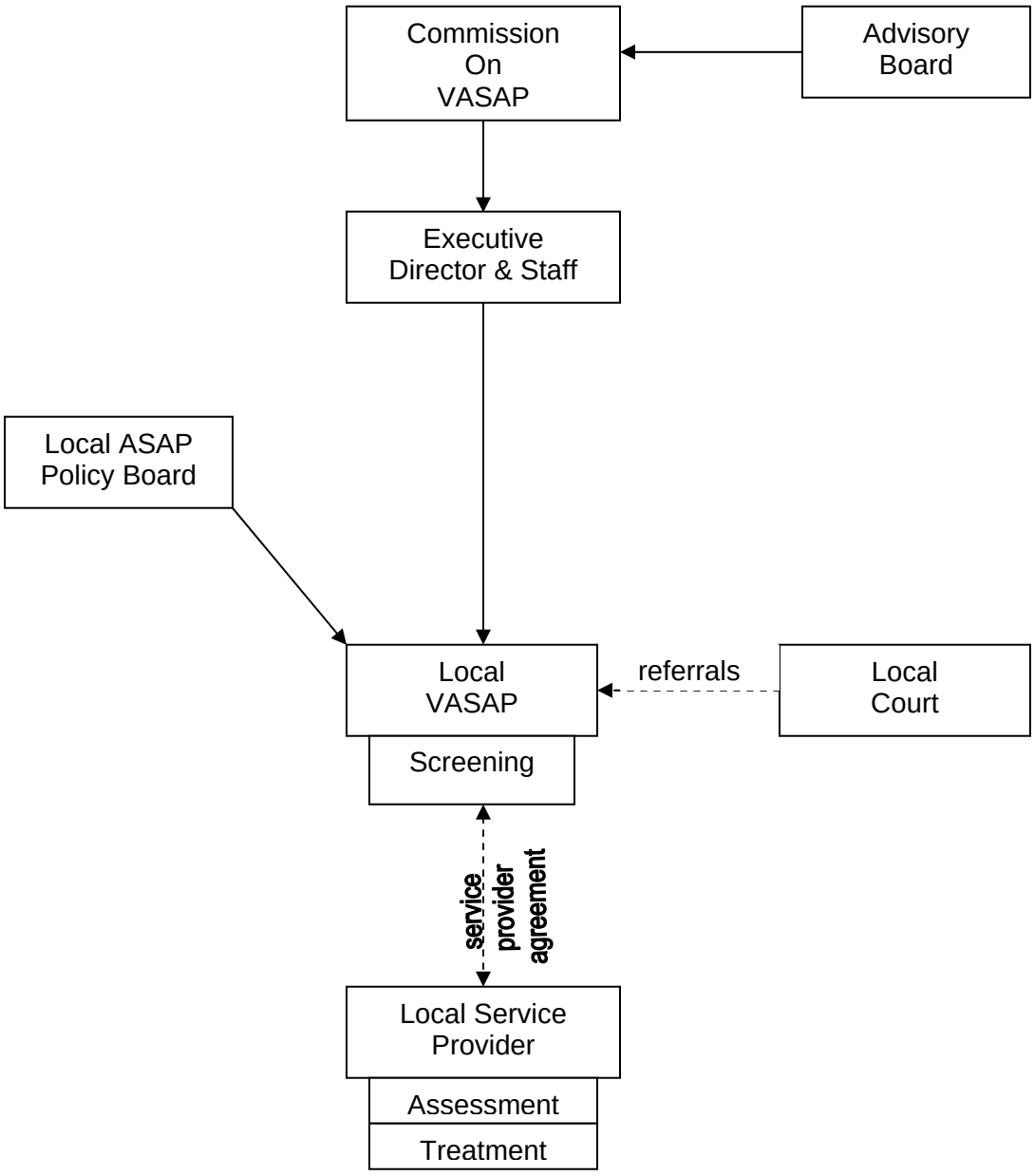
The Commission is supported by an administrative staff, and provides oversight to local ASAP programs, each of which is responsible to its own policy board. [*Code* of Virginia § 18.2-271 *et seq*]. Local courts refer offenders to local safety action programs, where they are screened using the Simple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

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

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

Figure 1: State and Local Reporting and Referral Relationships

STATE AND LOCAL REFERRAL RELATIONSHIPS



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

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

Plan
This plan includes certain goals, objectives and action steps to coordinate VASAP substance abuse intervention with treatment programs. In addition, working on behalf of the Council, DMHMRSAS applied for and secured a grant from the Department of Motor Vehicles (DMV) using National Highway Safety Action Funds to support the costs incurred in developing and implementing the plan. DMV awarded the grant to DMHRSAS for a third year and the funds were used to continue to meet the requirements of the Task Force.

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

Issue 1: Reinforce the use of the Simple Screening Instrument. Screening and assessment are separate activities with separate goals. Screening indicates whether or not the individual has a significant substance abuse problem, and screening results provide the local VASAP with information to determine whether or not the person would benefit from education or would require treatment to address the substance abuse behavior that preceded the arrest. Screening activities generally require limited training or time to administer or score.

Assessment instruments provide detailed information about the nature, duration and severity of the substance abuse problem and usually require some sophistication to

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

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

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

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

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

Plan: Using grant funds from the Department of Motor Vehicles (National Highway Transportation Safety Administration funds) the Department of Mental Health, Mental Retardation and Substance Abuse Services will contract with the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC) to identify assessment instruments most suitable for assessing the Repeat Offender and Hardcore Drunk Driver population and for administration in treatment environments that vary significantly in infrastructure. Mid-ATTC will produce a report that will include, at a minimum, the following information: the clinical utility for diagnosis, treatment placement, treatment planning, treatment outcome; the types of measures reported; the amount, intensity and estimated cost of training required to administer and interpret the results of the assessment; the cost of the instrument (if proprietary); the accuracy (validity, reliability, cultural,

language or gender issues, cut-off scores); complexity of and time required to administer, score and interpret; and the suitability of the instrument for the general service delivery system utilized by local VASAPs. The report will also recommend a limited number of assessment instruments and provide rationale for selection using the information specified above. The Substance Abuse Services Council will make a recommendation to the Commission and Mid-ATTC will provide training about the instrument to local VASAP case managers to assist them in using the information produced by the assessment to incorporate into service agreements with local treatment providers, and to assist them in monitoring services to assure that offenders referred for treatment receive services that are appropriate in intensity and duration. This may include training to provide familiarity with patient placement criteria of the type developed by the American Society of Addiction Medicine.

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

During 2007, the grant supported 3 regional training sessions for approximately 75 public and private treatment providers servicing ASAP clients. These sessions were conducted in Richmond, Newport News and Charlottesville and included a Saturday date to minimize disruption to the client treatment schedules. Scott Reiner, Manager of Programs for the Department of Juvenile Justice and recognized expert in the area of screening and assessment was the facilitator. The 5 hour training concentrated on administering the Comprehensive Drinker Profile (CDP) and introduced a briefer assessment instrument, the Drinker Inventory of Consequences. The CDP is a structured clinical interview that provides an intensive and comprehensive history and status with regard to the clients' use and abuse of alcohol. It covers a broad arrange of relevant information to include severity of dependences, motivations for drinking and explores other life problem areas. The CDP also yields quantitative indices of problem duration, family history, alcohol consumption and dependence. This information is crucial to matching appropriate services to persons having been identified as repeat offenders and hard core drinking drivers. Although many of the treatment providers have their own internal data collection and reporting procedures, the training provided them with instances of relevant information that should be collected for appropriate treatment of this special population of offender.

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

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

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

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

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

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

Plan: The Chair of the Substance Abuse Services Council will establish a work group with the assigned task of developing recommendations for clinical quality benchmarks for use in VASAP contracting and monitoring of treatment services. These benchmarks will be based on evidence and consensus-based practices, and will address outcome measures identified in the Council's report on outcomes as required in §2.2-2691 of the *Code* of Virginia. The work group will also identify programs that have proven to be effective with the Repeat Offender and Hardcore Drunk Driver. The work group will include representatives from state agencies currently providing treatment services (DMHMRSAS, DOC, DJJ) and a representative from VASAP. The work group will report its recommendations by 2008.

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

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

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

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

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

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

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

Attachment A

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

INPATIENT SERVICES include:

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

OUTPATIENT SERVICES include:

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

DAY SUPPORT SERVICES include:

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

RESIDENTIAL SERVICES include

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

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

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

§ 2.2-2696. Substance Abuse Services Council.

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

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

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

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

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

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

F. The duties of the Council shall be:

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

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

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

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

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

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

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

§ 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.

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

(2004, c. 686, §

Appendix D

Substance Abuse Services Council2007 Membership Roster

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