Substance Abuse Services Council

Annual Report and Plan

to the

Governor

and the

General Assembly

COMMONWEALTH OF VIRGINIA

January 1, 2009

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COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

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Chair

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Feburary10, 2009

The Honorable Timothy M. Kaine
Governor of Virginia
and
Members of the Virginia General Assembly:

In accordance with § 2.2-2696 of the *Code* of Virginia, I am pleased to present the **2008 Annual Report and Comprehensive Interagency State Plan for Substance Abuse Services.**

As chair of the Substance Abuse Services Council, it is once again my honor and privilege to serve with some of the most professional, highly respected, substance use disorder and prevention experts in the Commonwealth of Virginia, and members of the General Assembly who have been appointed to the Council. Members of the Council have devoted many hours and resources to the work of the Council. This report documents the hard work of the Substance Abuse Services Council this past year and includes recommendations in several key areas:

- Abuse of prescription drugs resulting in deaths throughout the Commonwealth, and particularly in the far southwestern region;
- The need for a uniform statewide survey of youth risk behaviors that will assist administrators and policy makers in planning for and evaluating prevention initiatives, including those related to the abuse of alcohol and other drugs;
- The need for substance abuse prevention and treatment services that are targeted specifically to meet the needs of older Virginians;
- The significant role that drug treatment courts have had in treating people with substance use disorders in the Commonwealth; and
- The progress of implementing the use of Medicaid as a funding source for the treatment of substance use disorders.

I want to take this opportunity to commend the legislature for its significant support in two important efforts. The Joint Legislative and Audit Review Commission (JLARC) report, *Mitigating the Cost of Substance Abuse in the Commonwealth* (House Document No. 19 - 2008), summarized the JLARC study regarding the impact of substance abuse and dependence on the Commonwealth. The JLARC report, which focused particularly on the impact of substance use disorders in the criminal justice system, made specific recommendations to a number of state agencies and the Substance Abuse Services Council regarding improvements in accountability

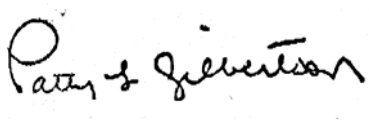
and the quality of services. Although the current economic downturn will slow down implementation of some of these efforts, the report provides valuable direction for the executive branch and courts and the General Assembly.

Following up on this opportunity, the Joint Subcommittee to Study Substance Abuse Treatment in the Commonwealth (Senate Joint Resolution 77 - 2008) chaired by Senator Emmet Hanger, provided a forum for organizations, citizens and executive branch agencies to exchange ideas with national experts about improving prevention of and treatment for substance use disorders in Virginia. Working in collaboration with Senator Hanger, the Council co-hosted two work sessions with Senator Hanger, staff and some members of his Joint Subcommittee. On behalf of the Council, I made a presentation describing the work of the Council at the last Joint Subcommittee meeting in December. The Council strongly supports continuation of this study for at least an additional year and very much appreciates the effort and time invested by the members and staff.

The JLARC report demonstrated that the adverse effects of substance abuse cost the Commonwealth and local governments at least $613 million in 2006, imposing an economic burden on the state and localities and resulting in untold personal costs to Virginia's citizens. Further, the JLARC report reinforced many of the findings and recommendations that have been made by this Council in previous Annual Reports. Simply put, we cannot continue to ignore the compelling evidence that substance use disorders are a chronic, relapsing disease with devastating medical and economic consequences and, as such require ongoing resources to support a well integrated array of prevention and treatment services. Although resources are extremely limited at this time, on behalf of the Council, I hope that you and members of the General Assembly will consider the cost of not acting to address the unmet need for additional treatment and prevention resources.

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

Sincerely,



Patty L. Gilbertson

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EXECUTIVE SUMMARY

SUBSTANCE ABUSE SERVICES COUNCIL ANNUAL REPORT AND PLAN TO THE GOVERNOR AND THE GENERAL ASSEMBLY

JLARC Report and SJR 77 Call Attention to the Impact of Substance Use Disorders

After two years of study, the Joint Legislative Audit and Review Commission issued its findings in a report, *Mitigating the Cost of Substance Abuse in Virginia* (House Document No. 19 - 2008). Concluding that substance use disorders cost the Commonwealth $613 million in 2006, the study also found that only $102 million were spent on the prevention and treatment of substance use disorders. The study found that people who completed treatment had less involvement with the criminal justice system and higher rates of employment than those who did not. The study identified substantial systemic barriers to obtaining treatment. These obstacles include not recognizing the need for help, cost or logistical barriers, inability to access the appropriate level of care due to lack of capacity, or receiving services that are less effective because they do not follow proven practices. In addition, the report indicates that prevention services need improved evaluation, coordination and direction, and better monitoring to assure that proven practices are appropriately implemented. The report concludes that the State should improve program evaluation, assure that proven practices are implemented properly and focus attention on the transition of inmates back to the community, financing these initiatives with additional revenues from the Department of Alcoholic Beverage Control.

As a means of applying the report's findings to policy, legislation and budget, the 2008 Session of the General Assembly established the Joint Subcommittee to Study Strategies and Models for Substance Abuse Prevention and Treatment. The subcommittee met four times and worked closely with the Substance Abuse Services Council. In spite of intensive effort, the Subcommittee has only begun to address its mandate.

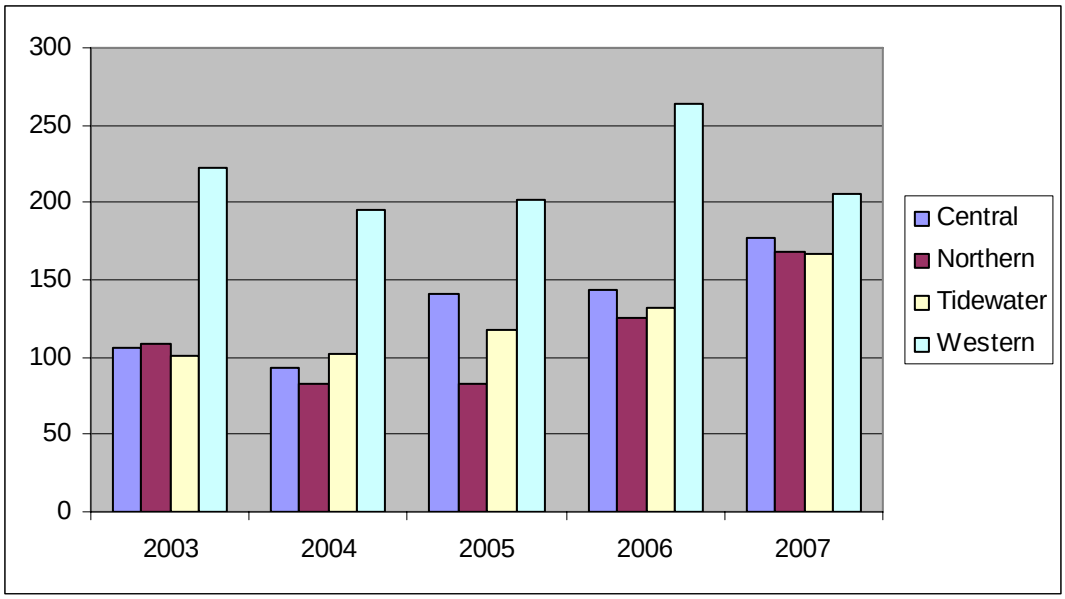
Recommendation

The General Assembly should enact legislation continuing the Joint Subcommittee to Study Strategies and Models for Substance Abuse Prevention and Treatment for at least an additional year.

Drug Caused Deaths Related to Abuse of Prescription Drugs

In four years, according to the Office of the Chief Medical Examiner, the Commonwealth has experienced a 27 percent increase in the number of drug-caused deaths, from 564 in 2003 to 717 in 2007. Many of these deaths were related to the misuse of opiate-based prescription pain medicine. Although the highest number of deaths occurred in the western region of the state, the number of deaths increased in other regions. Figure 1 displays this information.

FIGURE 1: DRUG CAUSED DEATHS BY REGION, VIRGINIA, 2003-07



The increase of abuse of prescription drugs is also occurring at the national level. Alarmingly, prescription drugs are replacing marijuana as the initiation to drug abuse for youth. Several initiatives have been implemented to address this issue. The Department of Health Professions has established the Prescription Monitoring Program to assist pharmacists and physicians with identifying patients who may be misusing prescription drugs, and has also partnered with the Virginia Commonwealth University School of Medicine to provide training in pain management to healthcare providers.

To address the need for treatment for substance use disorders related to prescription drug abuse, the Department of Mental Health, Mental Retardation and Substance Abuse Services allocated $350,000 from the federal Substance Abuse Prevention and Treatment Block Grant in 2002 to four community services boards serving the far southwestern portion of the state, where the death rates are the highest. These funds continue to be dedicated for this purpose. In 2006, the General Assembly appropriated $534,000 in ongoing general funds to support medication assisted treatment for opiate dependence, and half of these funds were allocated to these four community services boards. In October 2006, the federal Substance Abuse and Mental Health Services Administration awarded a three-year grant in the amount of $500,000 per year to the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with three community services boards, to address the problem of prescription drug abuse in southwest Virginia. Working closely with the Prescription Monitoring Program, this federally funded effort has promoted physician education about addiction and pain management, and will have provided intensive treatment services to more than 200 individuals by the time the grant ends in 2009.

Meanwhile, at the state level, the Department of Mental Health, Mental Retardation and Substance Abuse Services/Office of Substance Abuse Services, the Office of the Chief Medical Examiner in the Department of Health, and the Prescription Monitoring Program are

collaborating to share data to closely monitor trends, as drug caused deaths appear to be spreading across the Commonwealth.

Recommendation

The Department of Mental Health, Mental Retardation and Substance Abuse Services/Office of Substance Abuse Services, the Department of Health/Office of the Chief Medical Examiner and the Department of Health Professions/Prescription Monitoring Program should continue to work collaboratively to monitor trends in prescription drug abuse, and should present their findings to the Council.

Uniform Youth Survey Needed to Assist Planning and Evaluation of Prevention Efforts

In order for substance abuse prevention and early intervention to be effective, data are needed to guide decision-making for communities, local agencies and state agencies to assist in identifying need, targeting resources, designing programs and evaluating the impact. This survey would collect information about factors and characteristics that indicate that youth are engaged in high-risk behaviors, including substance use. Ideally, a survey using nationally standardized questions would collect data from every student in every school, so that information could be compared across school districts and with national data. This data would not include any personally identifying information, so subject confidentiality would be protected. Virginia, however, does not utilize a uniform survey instrument across the state, so data collected from various survey instruments cannot produce reliable information about specific regional needs, nor can it be used to measure or compare the impact of prevention programming across the state.

Conducting a survey of all school districts using a uniform instrument would produce an economy of scale that would reduce the cost of compiling and disseminating the results, and would produce information useful for schools and communities to use in local planning. Several state entities have indicated support for implementation of a standard youth survey, including the Governor's Health Reform Commission, the Governor's Commission on Sexual Violence, and the Joint Legislative Audit and Review Commission. Currently, the Department of Health, in conjunction with the Department of Education, is implementing a five year grant in the amount of $42,000 from the federal Centers for Disease Control and Prevention (2009-2013) to collect data from youth about risk behaviors and attitudes using a standardized survey instrument. The initial survey, to be conducted in the spring of 2009, will collect information from a random sample of students in grades 9-12 in 26 school districts. In 2011, this effort will be expanded to collect data that will be valid for each city and county in Virginia.

Recommendation

The General Assembly should require all public school divisions to participate in youth surveys designed to assess youth-risks and attitudes towards risk behavior sponsored by the Department of Education or the Department of Health, using such funds as are available for this purpose.

Substance Abuse and Older Adults

As the population in general gets older, and the demographic bubble referred to as the Boomer generation moves into older age, the need for substance abuse prevention and treatment services designed to address the issues of older adults increases. Of the 35 million people in this

group, about 5 million will need assistance in addressing a substance use disorder, and half of these will have a problem specific to alcohol use. In addition to alcohol, the Boomer generation in its youth incorporated other drugs into recreational use, and has sustained attitudes that are highly tolerant of drug use. Problems associated with these attitudes and past use may emerge or continue as this group ages.

For a variety of reasons, substance abuse and dependence are harder to detect among older people, and are often more tolerated than for a younger generation, especially if the person is no longer employed. Psychosocial stressors triggered by bereavement, retirement, loneliness, marital problems, or economic hardship may increase susceptibility to dependence on alcohol or other drugs, and may affect other health issues as well.

In Virginia, while community services boards can expect to see increased demand for services from this age group, relatively little is known about best practices for treating these older citizens. Currently, in response to an initiative of Governor Kaine, twenty agencies and organizations have collaborated to form the Alcohol and Aging Awareness Group (AAAG). The goals of AAAG include dissemination of information and training by using the Internet, conducting media campaigns, collecting data, developing a resource guide, and training service providers. The AAAG sponsored a conference this year and has scheduled a follow-up conference for 2009.

Recommendation

The Department of Mental Health, Mental Retardation and Substance Abuse Services should identify evidence-based treatment and prevention practices and programs especially effective with older adults and disseminate information about them to community services boards and other service providers.

Drug Treatment Courts

Drug treatment courts administer specialized dockets within Virginia's existing court system, and provide comprehensive substance abuse treatment, as well as intensive supervision and frequent judicial monitoring. Drug treatment courts require collaboration and coordination among the judiciary, Commonwealth's Attorneys, defense attorneys, drug court case managers, drug court administrators, addiction treatment professionals, probation officers, and law enforcement. Only nonviolent offenders are eligible to participate. Although participants receive treatment and intensive court supervision instead of incarceration, they are still subject to legal consequences as determined by the court. In Virginia, 27 drug treatment courts are currently in operation. Four models of drug treatment courts have been implemented in Virginia: adult, juvenile, family and driving under the influence.

Drug treatment courts arose in response to the escalating number of persons arrested and incarcerated for drug offenses, which has increased 41 percent from 2000 to 2006. During the same period, the number of new court commitments to the Department of Corrections ranged between 23 percent and 26 percent.

The Drug Treatment Court Act (§ 18.2-254.1 *Code* of Virginia) directs the Supreme Court to provide administrative oversight for Drug Treatment Courts, including distribution of

funds, technical assistance, program evaluation, and reporting to the General Assembly. The statute requires the establishment of an advisory body to establish standards and develop and implement planning, evaluate efficiency and effectiveness, and encourage interagency collaboration. In addition, the *Code* requires legislative action for localities to establish drug treatment courts, regardless of the source of funding. Local courts are also required to establish advisory committees.

The *Code* outlines five goals for drug treatment courts:

1. Reducing drug addiction and drug dependency among offenders;
2. Reducing recidivism;
3. Reducing drug-related court workloads;
4. Increasing personal, familial, and societal accountability; and
5. Promoting effective planning and use of resources among criminal justice system and community agencies.

Drug treatment courts are supported with a variety of funds. Fourteen courts receive state funds: three are funded entirely by state funds and eleven are supported by additional resources. Thirteen courts are supported with nonstate funding. Because funding for drug treatment courts is not secure, their operational stability and effectiveness are undermined.

National data indicate that successful participation in a drug court reduces recidivism and drug related crime (as much as 30 percent) and that the savings associated with these benefits more than compensate for the additional expense involved in operating a drug treatment court. A study recently published by the Joint Legislative Audit and Review Commission (*Mitigating the Cost of Substance Abuse in Virginia*, House Document No. 19 - 2008*)* included a review of two drug treatment courts in Virginia, and concluded that persons who completed drug treatment courts imposed lower daily costs after completing treatment than offenders who did not complete treatment in a drug treatment court.

Recommendation

The Governor and the General Assembly should support the continuation and expansion of Virginia drug treatment court programs that meet the guidelines and approval of the Supreme Court of Virginia and the State Drug Treatment Court Advisory Committee.

Medicaid Funded Substance Abuse Services

The 2007 Session of the General Assembly appropriated $10.5 million (general fund and non-general fund), available July 1, 2007, for Medicaid reimbursement of substance abuse treatment services for children and adults. Community services boards have encountered several barriers to implementation and are collaborating with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services to address them. These efforts include conducting training seminars to acquaint providers with the regulations pertaining to the newly covered services, eligibility and billing. The Department of Medical Assistance Services has also responded to concern about the reimbursement rates by adjusting its calculations and continuing to explore the feasibility of additional increases. The Department of Mental Health, Mental Retardation and Substance Abuse Services has been working with the community services boards to address operational concerns regarding

implementation. Finally, both agencies are working to increase effective communication with providers.

Recommendation

The Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Association of Community Services Boards should continue to collaborate to maximize the utilization of Medicaid reimbursement for the provision of substance abuse services.

JLARC REPORT AND SJR 77 CALL ATTENTION TO THE IMPACT OF SUBSTANCE USE DISORDERS

In June 2008, the Joint Legislative Audit and Review Commission (JLARC) issued a report resulting from a two year study of the impact of substance abuse on the state and the localities. As directed by HJR 683 (2007) and SJR 395 (2007), the study focused on the adverse affects of substance use disorders, especially the financial impact, the potential and actual benefits of prevention and treatment, and barriers to maximizing these benefits. In conducting the study, JLARC staff visited ten areas of the state, including the community services boards, community corrections and probation and parole offices serving those regions. The resulting report, *Mitigating the Cost of Substance Abuse in Virginia*, House Document No. 19 - 2008 (*http://jlarc.state.va.us/Reports/Rpt372.pdf*) stated that substance use disorders cost the Commonwealth $613 million in 2006, with a disproportionate impact on the public safety arena. In contrast, the State and localities spent $102 million providing substance abuse services. In addition, people who completed substance abuse programs cost the State and localities less than those who did not, and they also had less involvement with the criminal justice system and higher rates of employment.

The report identified four types of barriers that impede achieving the maximum benefit of substance abuse services. Individuals who need services (1) do not seek services; (2) cannot access them due to cost or logistical barriers; (3) do not receive services appropriate to clinical need because of capacity limitations; or (4) receive services that do not follow proven practices. The report also indicates that the majority of persons under criminal justice supervision do not receive needed services. Regarding prevention, the report stressed that prevention is in need of resources and should focus on evaluation, improving coordination and direction, and ensuring that proven practices are implemented as intended. Finally, the report concludes that the State should improve program evaluation, assure that proven practices are implemented properly, and focus attention on the transition process of prison inmates back to the community. These initiatives could be financed by additional revenues from the Department of Alcoholic Beverage Control. The report included sixteen recommendations to specific state agencies designed to improve the effectiveness of services. These recommendations focused on improving infrastructure for program evaluation, addressing cost barriers to accessing treatment services in the community, assuring that proven practices are implemented as intended, improving access to screening for substance abuse in the criminal justice system, providing judges with information about substance abuse treatment available in the community, enhancing transition services for prison inmates returning to the community, interagency collaboration, and use of survey data for prevention planning.

Anticipating that this report was forthcoming, the 2008 Session of the General Assembly enacted Senate Joint Resolution 77 to review the report's conclusions and discuss applications to policy, legislation and budget. The Joint Subcommittee to Study Strategies and Models for Substance Abuse Prevention and Treatment met four times in 2008. Senator Emmet W. Hanger, Jr., who chairs the joint subcommittee, and its staff, as well as one of the members, met twice with the Substance Abuse Services Council. The Chair of the Council addressed the subcommittee, as did representatives of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Education, the Department of Juvenile Justice

Services, the Department of Corrections, representatives of the business community, community coalitions, provider and consumer advocacy organizations, the judiciary and a number of national experts. In spite of this very intensive and dedicated effort, the subcommittee has only begun to address its mandate.

RECOMMENDATION

The General Assembly should enact legislation continuing the Joint Subcommittee to Study Strategies and Models for Substance Abuse Prevention and Treatment for at least an additional year.

DRUG CAUSED DEATHS RELATED TO ABUSE OF PRESCRIPTION DRUGS

Significant Increase in Deaths a Cause for Concern

A recent review of the Chief Medical Examiner's data on drug caused deaths in Virginia noted a 27 percent increase in such deaths since 2003, from 564 to 717 in 2007. This increase is alarming, as it represents an unnecessary loss of life that can be prevented if treatment and other community interventions are available. Geographically, these deaths are concentrated in the far southwestern region of the state, an area also characterized by poverty, lower levels of education, and high unemployment. Figure 1 displays this data by the regions used by the Office of the Chief Medical Examiner, and Figure 2 displays a map of these regions. Although the number of deaths in the Western Region remains highest in the state, the number is declining in that region after a peak in 2006. However, the number of deaths in other regions of the state is increasing, indicating that this problem is not limited to one area but is, in fact, spreading.

FIGURE 1: DRUG CAUSED DEATHS BY REGION, VIRGINIA, 2003-07

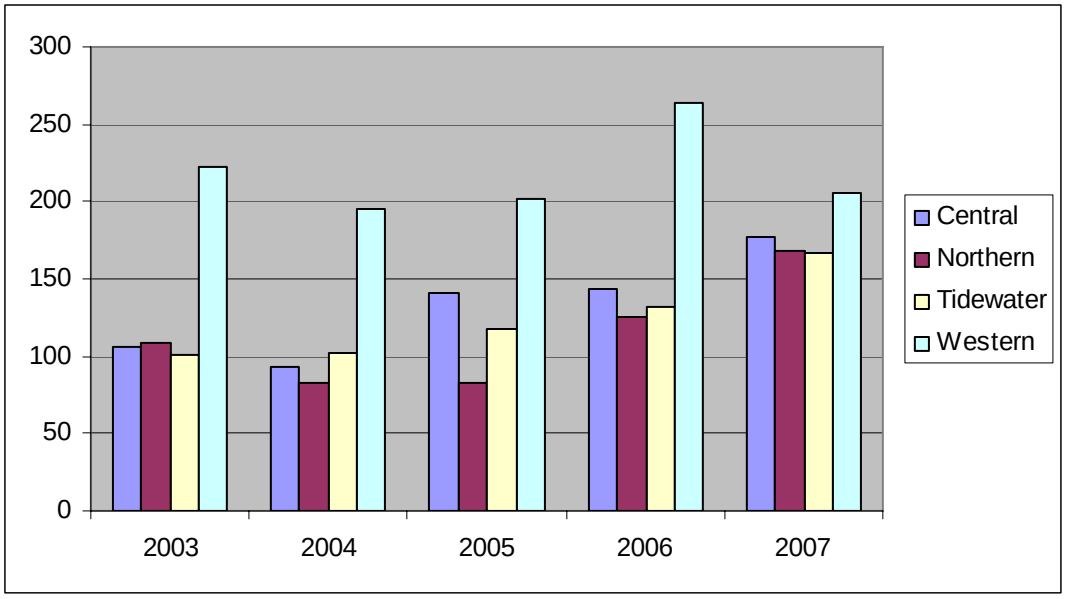
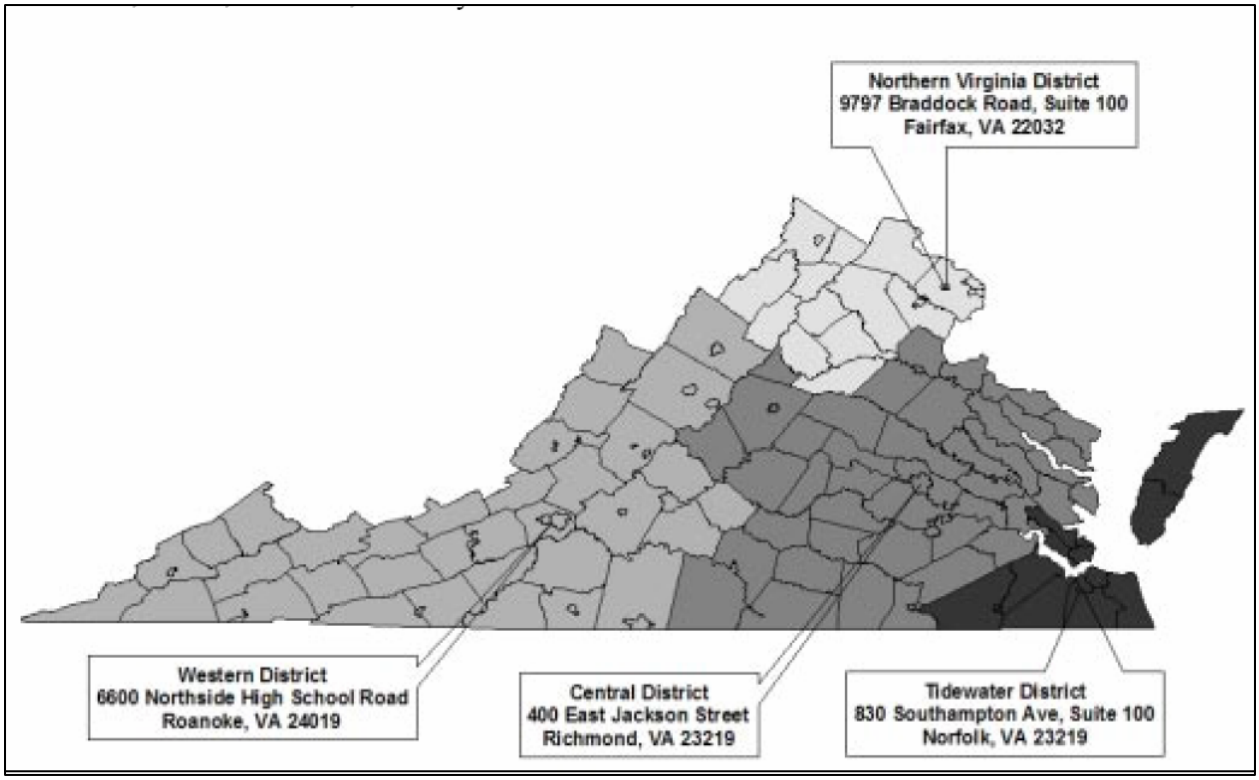


FIGURE 2: MAP OF OFFICE OF CHIEF MEDICAL EXAMINER REGIONS



Overview

Analysis of data from the Office of the Chief Medical Examiner (OCME) yields the following significant information for this period.

- In 2003, there were 564 drug-caused deaths. Drug-caused deaths were greatest in males (62.9%), and whites (86.0%). Narcotics (60.3%) were the most frequently identified class of compounds in drug-related deaths.

- In 2004, there were 498 drug-caused deaths with narcotic abuse and substance intoxication accounting for 97.3 percent of these accidental deaths. Drug-caused deaths were greatest in males (64.1%), aged 35-44 years (32.1%), and whites (84.5%). Narcotics were the most frequently identified class of compounds present in decedents (34.9%), followed by stimulants (17.6%).

- In 2005, there were 545 drug-caused deaths with narcotic abuse and substance intoxication accounting for 99.3 percent of these accidental deaths. Drug-caused deaths were greatest in males (60.2%), aged 35-44 years (34.9%), and whites (84.8%). Narcotics were the most frequently identified class of compounds present in decedents (31.3%), followed by stimulants (19.5%). Whites were 4.6 times more likely than blacks to die due to non-illicit drugs, while blacks were 1.6 times more likely than whites to die due to illicit drugs.

- In 2006, there were 669 drug-caused deaths**.** The overall rate of drug-caused deaths for Virginia residents was 8.3 per 100,000 people. Drug-caused deaths were greatest in males (61.9%), aged 35-44 years (30.8%), and whites (82.8%). Narcotics were the most frequently identified class of compounds present in decedents (32.2%), followed by stimulants (18.4%). Sixteen of the 669 or 2.4 percent of drug deaths were ethanol-only deaths. Nearly all of the increase in deaths from 2006 can be attributed to prescription drug abuse (44).

- In 2007, there were 717 drug-caused deaths from narcotic abuse and substance intoxication. The overall rate of drug-caused deaths for Virginia residents was 8.9 per 100,000 people. Drug-caused deaths were greatest in persons 45-54 years old (29.4%) and whites (83.1%). Twenty of the 717 deaths, or 2.8%, were ethanol-only deaths.

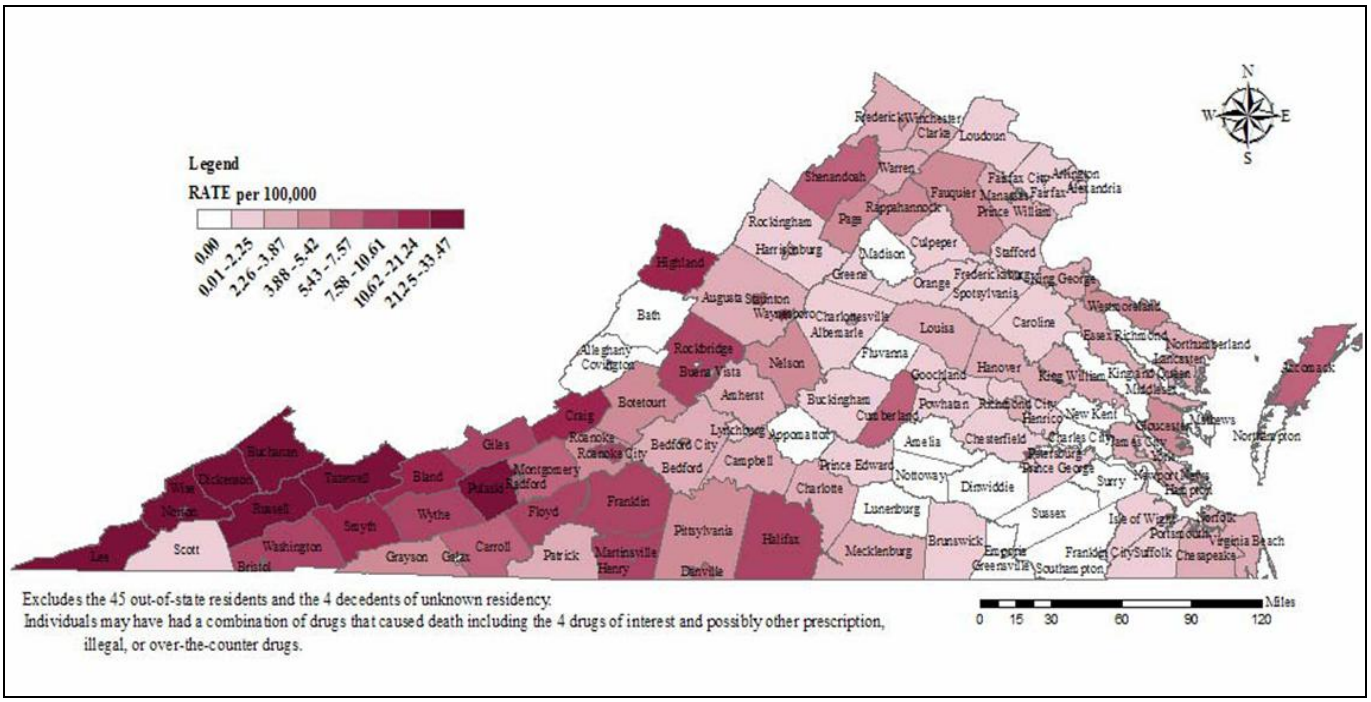
National and State Trends

The National Survey on Drug Use and Health, conducted by the federal Substance Abuse and Mental Health Services Administration, indicates that increases in abuse of prescription drugs is a national trend. Although the number of new users of pain relievers has been decreasing nationally since 2003, it has been the drug category with the largest number of new initiates, surpassing marijuana in 2002, indicating a new trend in drug abuse.

Data from the Office of the Chief Medical Examiner indicate that many of the deaths are related to misuse of prescription drugs, especially those used for pain relief that are opiate based. These drugs include fentanyl, hydrocodone, methadone[1] and oxycodone. Between 1996-2005, the Medical Examiner indicated that 228 deaths were from oxycodone, alone. As the map in Figure 3 displays, rates of death involving these drugs were considerably higher in the far southwestern part of the state during this two-year period.

[1] Methadone is also used, under highly regulated clinic administration, as a medication-assisted treatment for opiate dependence.

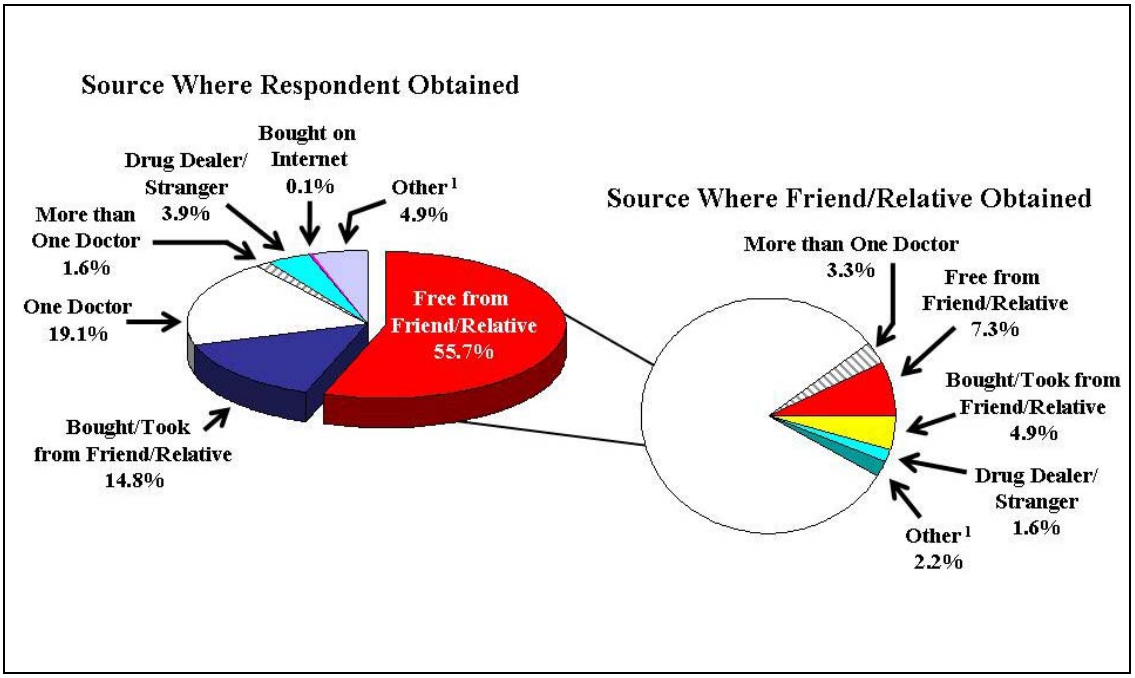
FIGURE 3: RATES OF FENTANYL, HYDROCODONE, METHADONE AND OXYCODONE DEATHS BY COUNTY/CITY, 2004-2006



Source: Office of the Chief Medical Examiner

One obvious concern is the source of these misused drugs. Data from the National Survey on Drug Use and Health indicate that most of the abused prescriptions are stolen from a friend or relative. Figure 4 displays the sources of prescription drugs that are abused. The Office of the National Drug Control Policy is focusing a major initiative on this issue aimed at adolescents and their families.

FIGURE 4: SOURCE WHERE PAIN RELIEVERS WERE OBTAINED FOR MOST RECENT NONMEDICAL USE AMONG PAST YEAR USERS AGED 12 OR OLDER: 2006



Source: National Survey of Drug Use and Health, 2006

Recent Activities

The Virginia Prescription Monitoring Program, located in the Department of Health Professions, collects prescription data for Schedule II-IV drugs into a central database that can be accessed by authorized users, such as physicians and pharmacists, to assist in deterring the illegitimate use of prescription drugs. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. Prescribers and dispensers may query the database to assist in determining treatment history and to rule out the possibility that a patient is "doctor shopping" or "scamming" in order to obtain controlled substances. A prescriber must obtain written consent from the patient before submitting an inquiry. In addition, the program has partnered with the Virginia Commonwealth University School of Medicine to develop an online pain management curriculum for physicians.

As this information indicates, many of the deaths were concentrated in the far southwestern region of the state. To provide resources to begin to resolve the problem of abuse of prescription drugs in the far southwestern region, the Department of Mental Health, Mental Retardation and Substance Abuse Services allocated $350,000 (ongoing) in 2002-03 from its federal Substance Abuse Prevention and Treatment Block Grant to enhance services and expand capacity to community services boards serving the area. Four community services boards received funding from this initiative: Cumberland Mountain CSB (serving the counties of Buchanan, Russell, and Tazewell), Dickenson County CSB, Planning District One CSB (serving the city of Norton and the counties of Lee, Scott and Wise), and Highlands CSB (serving

Washington County and the city of Bristol). Beginning in July 2006, these four CSBs also received an additional $217,000 in state general funds to increase availability of medication assisted treatment, specifically, buprenorphine, for persons addicted to prescription drugs. Of the 172 persons served to date with these funds, 47.7 percent were under 30 years of age.

That same year, the Department of Mental Health, Mental Retardation and Substance Abuse Services, in partnership with three community services boards (Planning District One, Cumberland Mountain and Dickenson County) received a competitive Treatment Capacity Expansion Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for $500,000 for each of three years to provide treatment services to persons addicted to prescription pain medication. Project REMOTE (Rural Enhanced Model for Opioid Treatment Expansion) funds were awarded October 1, 2006, and services began in April 2007. In its first and second years, a total of 121 persons have been served by this project, and an additional 90 will be served the third year. The project has also placed a particular focus on educating area physicians about addiction and available treatment, and has partnered with the Prescription Monitoring Program to provide information about pain management and the resources of the Prescription Monitoring Program. The project is being evaluated using Government Performance and Results Act (GPRA) measures specified by SAMHSA, with follow-up assessments at discharge and at six months post-intake.

Although deaths have decreased in the areas of the state where resources have been concentrated for treatment for the specific problem of prescription drug abuse, the total number of deaths due to drugs continues to increase, indicating that this problem is moving east and north.

The Department of Mental Health, Mental Retardation and Substance Abuse Services has recently entered into an agreement with the Virginia Department of Health/Office of the Chief Medical Examiner to share data pertaining to the abuse of prescription drugs, and is also working closely with the Prescription Monitoring Program in this regard.

RECOMMENDATION

The Department of Mental Health, Mental Retardation and Substance Abuse Services/Office of Substance Abuse Services, the Department of Health/Office of the Chief Medical Examiner and the Department of Health Professions/Prescription Monitoring Program should continue to work collaboratively to monitor trends in prescription drug abuse, and should present their findings to the Council.

UNIFORM YOUTH SURVEY NEEDED TO ASSIST PLANNING AND EVALUATION OF PREVENTION EFFORTS

Data Needed for Planning and Evaluation

In any business, industry or governmental enterprise, planning performance and monitoring implementation require consistent, objective data. Similarly, in order for substance abuse prevention and early intervention efforts to be effective, data are needed to:

- Enable communities to assess their needs, plan and target programs and strategies that address specific risk factors, allocate resources, and monitor effectiveness toward improving the well-being of children, youth and families in their communities;
- Provide local agencies and organizations objective data to support grant applications and other funding requests to private foundation and governmental entities;
- Assist state agencies in allocating funding, targeting resources to areas with greatest need, developing statewide initiatives, planning technical assistance, monitoring local programs and strategies, and evaluating outcomes;
- Permit state and local agencies to compete for federal and foundation funding, to meet federal reporting requirements and to monitor performance measures; and
- Provide information about specific community risk factors that contribute to negative behaviors of at-risk populations so that appropriate prevention services can be designed to intervene.

When critical data are lacking, prevention resources must be managed by educated guesses instead of objective data. Further, it is not possible to monitor and hold prevention efforts accountable for their performance. Finally, Virginia's localities and the Commonwealth are at a disadvantage when competing for resources with other states that have data to document needs and results.

Generally, it is possible to obtain data that show the consequences of substance use, including measures of criminal justice activity, traffic fatalities, substance-related school incidents, and even immediate and long-term impact on death. However, Virginia lacks data in two critical areas:

1. Substance abuse-related *injury* not severe enough to require in-patient hospital care, (i.e., an injured person is treated and released from an emergency department in a hospital or another emergency care facility); and
2. *Attitudes and perceptions* that indicate a developing problem in a community.

Local Efforts to Collect Data Vary Widely

A recent study conducted by the Governor's Office for Substance Abuse Prevention found that some Virginia localities have impressive local survey data and monitor trends to improve the well-being of their communities, while others have no survey information at all. Local entities may create their own surveys, or change the wording of statistically validated survey instruments. These changes reduce comparability of the results of that survey with other state and national data, or leave critical gaps in information needed for planning, addressing and monitoring problem behaviors. When different survey instruments are used, comparison with other localities, states or the national data may not be valid. Comparisons of survey data are also

limited if surveys target different age groups or are administered during different times of the year.

Reported costs of local survey efforts vary widely and are probably not comparable because administration of the survey and analysis of the results differ greatly. Frequently, funding for local surveys is not stable, resulting in sporadic survey efforts or fundraising activities specifically to obtain survey funding.

Statewide Youth Survey is Optimal Tool

Because behavioral habits and attitudes are formed in childhood, monitoring these behaviors and beliefs for youth in the Commonwealth is a critical component of any effective statewide prevention planning, yet not all communities participate in surveys that can be utilized in a statewide planning or evaluation database. These data could be collected using a uniform survey of youth that collected information about youth attitudes, perceptions and behaviors that research indicates are correlated with engaging in risky adolescent behaviors. Such a survey would allow youth to provide information in a completely anonymous format, and would include no information that would personally identify specific children or their families. In order to ensure that youth surveyed represent the broad community, not just a specific neighborhood or social group, youth surveys are typically conducted in the classroom during the school day. Conducting a survey of youth within a public school building does not imply that the school is the cause of the attitudes, perceptions, behaviors or conditions, or that the school is responsible for addressing any problems found. Surveys are the most efficient and effective way of obtaining information on youth attitudes, perceptions and behaviors.

Data collected from youth surveys provide an opportunity to educate and engage the community in identifying, prioritizing and addressing community needs in a non-threatening, non-political way. Any risk factors, behaviors, or conditions that are identified by the survey can only be addressed by key community organizations working together to reduce and prevent problems. Therefore, it is vital to have objective, comparable community youth survey data for each city and county in Virginia. This requires that students in every public school division answer the same questions, during the same time of year, using the same overall research methodology.

Coordinating a single survey effort statewide produces an economy of scale that provides a substantial cost savings to localities that currently complete surveys, especially for compiling and disseminating survey results. A uniform survey administered throughout Commonwealth school districts would provide data to cities and counties that are currently unavailable. If entire school systems were surveyed, the data would be available to individual schools for use in school safety plans.

Youth Risk Behavioral Survey Monitors Priority Health Risk Behaviors

The Youth Risk Behavioral Survey (YRBS) is an instrument developed by the federal Centers for Disease Control that collects information about priority health risk behaviors that contribute markedly to the leading causes of social problems, disease and death among adults. These behaviors include nutrition, exercise, sexual behaviors and attitudes, and attitudes towards and use of alcohol and other drugs. Since these behaviors are often established during youth, monitoring them while the behaviors are being established as lifelong habits and attitudes would

provide policy makers and administrators with much needed information about the need for education, training and other resources.

The Governor's Health Reform Commission has indicated its support for participation in the YRBS in its 2007 report, *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission*, stating, "Statewide and locally representative YRBS (Youth Risk Behavior Survey) data would support core public health functions of surveillance, data-driven program planning, and evaluation of program effectiveness. Analysis of the YRBS data would determine the prevalence of health risk behaviors, assess trends of such behaviors over time, and examine the co-occurrence of health risk behaviors." (*http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingMats/FullCouncil/Health_Reform_Comm_Final_Report.pdf. September 2007, p. 14 and p. 93*)

Other entities are also invested in participating in a survey such as the YRBS. The Governor's Commission on Sexual Violence recommended that "The Governor's Office for Substance Abuse Prevention (GOSAP) should develop and implement a statewide youth risk behavior survey that includes questions relating to sexual violence and victimization." *(Report and Recommendations to the Honorable Timothy M. Kaine, Governor of Virginia, from the Governor's Commission on Sexual Violence, November 2007, pages 20-21, found at http://www.publicsafety.virginia.gov/Initiatives/SexViolence/CSV-Final-Report.pdf)*

A recent Joint Legislative Audit and Review Commission recommended that "The General Assembly may wish to consider requiring all Virginia school divisions to participate in a statewide youth survey, and supplementing the federal Centers for Disease Control and Prevention grant secured by Virginia so that a youth survey that is sufficiently comprehensive to capture regional and local-level information on substance use and abuse can be administered." (*Mitigating the Costs of Substance Abuse in Virginia*, House Document No. 19 - 2008, p. 114*)* Likewise, a number of state and local substance abuse-related coalitions, advisory groups and work groups also support the implementation of a local-level survey.

The Virginia Department of Health, in partnership with the Virginia Department of Education, is implementing a 5-year grant for $42,000 from the federal Centers for Disease Control and Prevention that provides extensive technical assistance to coordinate the implementation of a random sample survey of students to provide state-level data. The Virginia Youth Survey will be administered in spring 2009 to a sample of 1,531 students in grades 9-12 in 31 schools representing 26 school divisions. However, the results of this survey will not provide comprehensive or comparison data at the state or local level. In 2011, this effort will be expanded to include the collection of data that will be valid for each city and county in Virginia.

RECOMMENDATION

The General Assembly should require all public school divisions to participate in youth surveys designed to assess youth risks and attitudes towards risk behavior sponsored by the Department of Education or the Department of Health, using such funds as are available for this purpose.

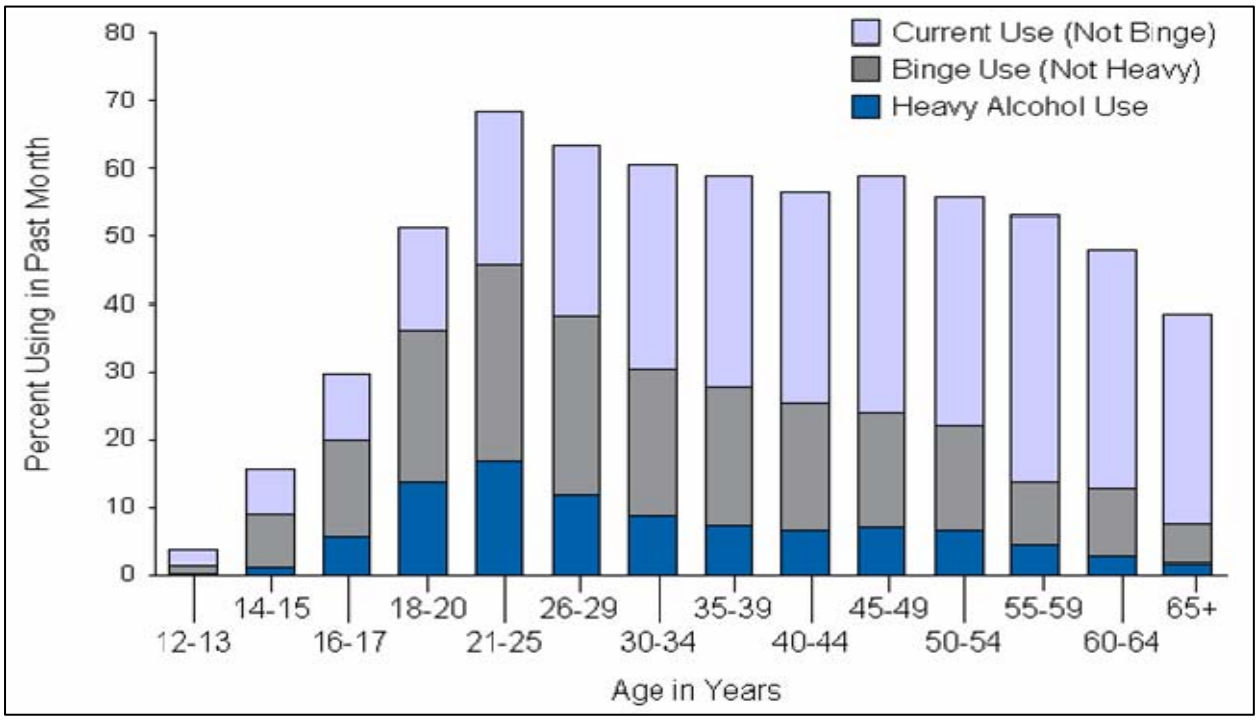
TREATMENT AND PREVENTION NEEDS OF OLDER ADULTS ARE UNMET

Need for Specialized Services for Older Adults

The substance abuse treatment and service needs of Older Adults will have a significant impact on the existing service delivery system within the next decade. Two trends, the general aging of the U.S. population and the arrival into older age of the generation born between 1946 and 1964, are focusing attention on this issue.

Approximately 35 million people in the United States are over 65 years of age, constituting about 12 percent of the current population. About 16 percent of those 35 million older adults, 5 million people, are confronting the effects of substance use disorders. Of the 35 million adults over 65, 5.6 percent are binge drinkers, 1.2 percent are heavy drinkers, and 0.5 percent are alcohol dependent. (Figure 5) The significance of these statistics is that more than 2.5 million older adults currently experience some type of alcohol problem.

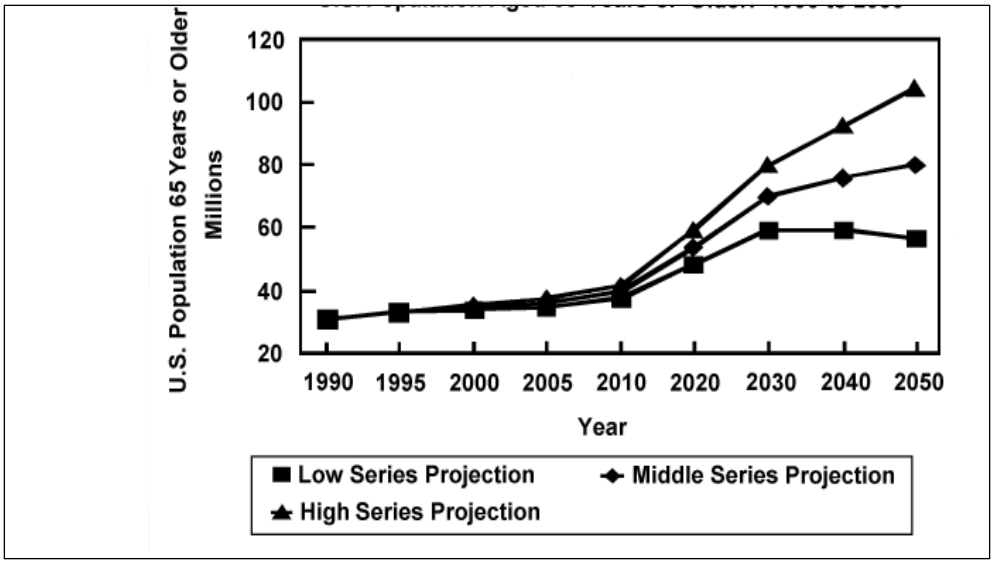
FIGURE 5: Current Binge and Heavy Alcohol Use Among Persons Aged 12 or Older, 2006



Source: National Survey on Drug Use and Health, 2006

By 2030, it is projected that citizens over 65 will number 71 million, increasing to more than 20 percent of the country's population (Figure 6). Out of that 71 million, 16 percent (11 million people) will be in need of substance abuse services.

FIGURE 6: GROWING US POPULATION AGED 65 AND OLDER: 1990 TO 2050



Coupled with the sheer growth in overall population numbers is the unprecedented impact of the "Baby Boomers," those Americans born between 1946 and 1964, who are now entering into older age. By 2010, it is projected that there will be almost 1.6 million older Americans in Virginia (Figure 7). A significant proportion of them can be expected to require substance abuse services.

FIGURE 7: AGING OF VIRGINIA'S BABY BOOM POPULATION

Year	Age Range of Year 2000 Baby-Boom Group	"Survived" 2000 Baby-Boom Cohort	"Survived" 2000 Age 60 & Over Cohort	Ratio
2000	36 - 54	2,078,199	1,065,502	1.950
2003	39 - 57	2,057,052	1,291,378	1.593
2006*	**42 - 60**	**2,030,373**	**1,418,238**	**1.432**
2010	46 - 64	1,983,501	1,592,044	1.246
2020	56 - 74	1,789,340	1,865,056	0.959
2030	66 - 84	1,390,393	2,139,359	0.650

* 2006 = oldest Baby-Boomers, born in 1946, turn age 60

This older identified cohort was the first to witness, if not experience, widespread casual drug use as well as decreased societal censure for significant consumption of all mood-altering substances. More people used more substances, and more different kinds of substances, than in preceding generations, and more aging adults carried their consumption patterns into their mature years.

As substance-related problems are identified in older age, these older adults are significantly more open to seeking professional mental health assistance and substance abuse counseling than were previous cohorts. As consumers, the Boomer generation carries a sense of entitlement to needed services and an expectation of access, respect and success. Empowered and informed, this cohort will expect to be partners in their care with service providers, perceiving their treatment as a collaborative process between clinicians and clients.

Since the 1970s there has been a growing awareness that large numbers of older adults would be in need of substance abuse services when they began moving into old age. Initially referred to as an "invisible epidemic," the phenomenon's epidemic nature is evidenced by both population statistics and societal trends. Its invisible characteristics are becoming increasingly apparent as expanded research projects focus on substance use patterns in older adults.

Problem is Hard to Detect

Substance abuse in older adults is hard to detect under routine circumstances. It can remain as undetectable to an individual's family, friends and health care providers as it does to the larger community. In the older adult population, as in other age groups, substances include alcohol, street and recreational drugs, and both prescribed and over-the-counter medications. Particularly dangerous in older adults is potential interaction between alcohol and other drugs, including legitimately prescribed and appropriately used medication. The most widespread pattern of abuse among older adults, however, is the misuse of prescriptions and over-the-counter medications coupled with continued or increased consumption of alcohol. Frequently substance abuse in older adults mimics symptoms of other health problems (e.g., confusion and agitation), or its signs are perceived as normal aspects of aging (e.g., unsteadiness and falls). Family members and others sometimes choose to ignore or enable an older person's substance misuse due to ignorance, shame or misplaced "kindness."

Because older people suffering from substance abuse are particularly stigmatized, many desiring help hesitate to discuss their problem, even with health care providers. Paradoxically, stigma against older people can result in situations in which senior services are denied due to the person's admitted substance abuse, and substance abuse treatment is denied because the potential client is deemed "too old" to benefit from the expenditure of limited resources.

Aging individuals are especially vulnerable to misuse of mind-altering substances. Research has identified some of the psychosocial stressors facing older persons, including depression, bereavement, retirement, loneliness, marital stress, economic hardships, and physical illnesses. Alcohol, which may have been a source of both comfort and stimulation through the years, can become, through misuse, a serious hazard to an aging person's physical and mental health. An aging person's body and mind will become more vulnerable to the cumulative effects of alcohol's habitual use. The physical, psychological, behavioral, and social effects of untreated

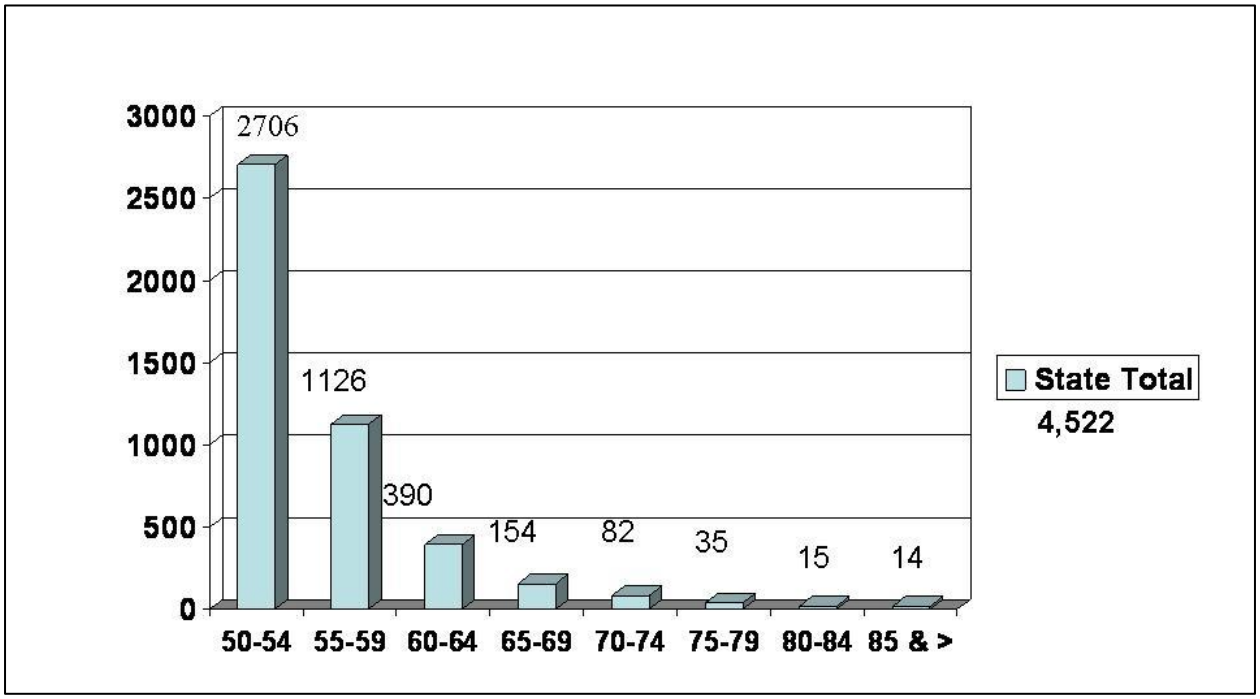
substance abuse on older adults are, in fact, profound. From worsening medical conditions, falls, injuries and accidents to personality changes, depression and increased anxiety to isolating behaviors and deteriorating relationships, an older person's quality of life is greatly diminished by substance use disorders.

Society, too, is adversely impacted by the "invisible epidemic." At a recent National Governors' Association Conference, the needs of older adults, especially their health care, was outranked only by national security as one of the country's priorities. Policy-makers and decision-makers at all levels of government must be prepared to address the economic, political and social implications of addiction on an aging population. Issues affecting older adults, which are becoming increasingly political, need to be addressed through strategic planning, funding and social marketing.

Effects on Virginia's Treatment System

In Virginia, the community services boards (CSBs) are beginning to experience effects of the "invisible epidemic." According to 2006 data, of a state total of 4,522 persons aged 50-80+ receiving substance abuse services from the CSBs, 3,832 (84.7%) were in the 50-59 age group. (Figure 8) As that cohort ages and advances through the system, followed by additional older adults, there will be a crucial need for both expanded geriatric services and appropriately trained service providers.

FIGURE 8: CSB CONSUMERS AGE 50-85+



Source: DMHMRSAS CCS II, 2006

Current Activities

In 2007, the Department of Alcoholic Beverage Control formed the Alcohol and Aging Awareness Group in response to a Governor's initiative by convening a meeting of key state stakeholders and various agency heads who service the aging population. The group initially focused on developing an inventory of services available concerning older adults and alcohol education/prevention, identifying gaps in these services, and establishing points of collaboration. This group evolved into the Alcohol and Aging Awareness Group (AAAG) with representation from more than 20 public and private organizations representing health, mental health, and senior advocacy.

Among AAAG's initial goals were to disseminate educational materials, maintain an active speakers bureau, and train geriatric physicians and Area Agency on Aging staff. After a successful service provider conference in 2008, the group expanded its goals to include designing web-based curricula, maintaining data collection, developing a statewide media campaign, enhancing AAAG's Resource Guide and Referral List, and training service providers with a DVD produced from its 2008 conference.

In addition the AAAG plans a follow-up conference, "The Hidden Epidemic, Alcohol, Medication and the Older Adult, Best Practices," in the spring of 2009 at Virginia Commonwealth University, that will feature national experts in the field of older adults and substance abuse. This conference will demonstrate the best practices recommended for service providers to address the public health concern of alcohol and medication misuse in older adults.

RECOMMENDATION

The Department of Mental Health, Mental Retardation and Substance Abuse Services should identify evidence-based treatment and prevention practices and programs especially effective with older adults and disseminate information about them to community services boards and other service providers.

DRUG TREATMENT COURTS ARE COST EFFECTIVE

Purpose of Specialized Courts

Drug treatment courts are specialized court dockets within Virginia's existing court system. The programs provide comprehensive substance abuse treatment, intensive supervision, and frequent judicial monitoring. The courts involve a collaborative effort between:

- judges
- commonwealth's attorneys
- defense attorneys
- drug court case managers
- probation officers
- law enforcement officers
- drug court administrators
- addiction treatment professionals.

Eligible offenders are non-violent substance abusers who receive community-based treatment and intensive court supervision instead of incarceration. Public safety, legal consequences, community service, and treatment are all an integral part of drug treatment courts. Additionally, many drug treatment court offenders are required to pay court costs, restitution, and on occasion a portion of their program fees.

The drug treatment court model is a response to escalating numbers of drug related court cases and expanding jail and prison populations. In Virginia, the number of adults arrested for drug offenses in 2000 was 20,806 and increased to 29,352 remanded in 2006, an increase of 41 percent. During that same period, twenty-three to twenty-six percent of all new court commitments to the Virginia Department of Corrections were related to drug offenses (Virginia Criminal Justice System Environmental Scan, 2008). Figure 9 displays this information.

FIGURE 9: DRUG ARREST RATES PER 100,000 POPULATION FOR 2007 BY REGION

Region	Drug Arrests per 100,000 Population
Hampton Roads	826.8
West Central	621.3
Valley	433.8
Southside	393.7
Southwest	550.2

Source: Department of Criminal Justice Services

Drug Treatment Courts in Virginia

Virginia utilizes four drug treatment court models: adult, juvenile, family and driving under the influence. These drug treatment courts have specialized court dockets that combine intense substance use treatment and probation supervision with the court's authority to mandate responsibility and compliance.

Virginia's first drug treatment court, established in 1995, serves Roanoke County and the cities of Roanoke and Salem. Between 1997 and 1999 an additional eight drug courts were established, prompting legislative action. The success of these courts, coupled with continuing prevalence of drug-related crime in Virginia resulted in two legislative efforts. In 1999, the Virginia General Assembly adopted Senate Joint Resolution 399 which culminated in recommendations to guide the appropriate sequence of federal and state funding requests, as well as policies for new and continuing programs. An additional fourteen drug treatment courts were established in Virginia between 2000 and 2003. Since 1995, Virginia has implemented twenty-eight (28) operational drug treatment courts and one planning drug court. There are currently twenty-seven (27) active operational drug courts still in existence. The only drug court to date to close or be eliminated is the Richmond Family Drug Court, which terminated services on June 30, 2007.

The Drug Treatment Court Act (§18.2-254.1 *Code* of Virginia) enacted in 2004, directed the Supreme Court of Virginia to provide administrative oversight for the state's drug treatment courts, including distribution of funds, technical assistance to local courts, training, and program evaluation. The Supreme Court is also responsible for developing a statewide evaluation model for use in conducting assessments of effectiveness and efficiency of local drug treatment courts, and making an annual report to the General Assembly. In addition, the statute requires legislative action for localities to establish drug treatment courts, even if no funding is requested.

The Drug Treatment Court Act outlines five goals for drug courts:

1. Reducing drug addiction and drug dependency among offenders;
2. Reducing recidivism;
3. Reducing drug-related court workloads;
4. Increasing personal, familial, and societal accountability; and
5. Promoting effective planning and use of resources among criminal justice system and community agencies.

The Drug Treatment Court Act also established the state drug treatment court advisory committee to (1) evaluate and recommend standards for planning and implementation; (2) assist in evaluation of effectiveness and efficiency; and (3) encourage and enhance interagency cooperation. The committee is chaired by the Chief Justice and includes representatives from a range of state agencies and organizations, as well as local court representatives. Local drug courts must establish local advisory committees to create criteria for offender participation, and to establish policies and procedures for the court. The statute specifies the required membership.

Funding Drug Courts

Often, drug courts are initiated with competitive grants from the federal government that are limited to demonstration programs. These grants are time limited and are intended to support

the initial phases of implementation and evaluation. Additional resources, such as state general funds, local funds, participant fees and/or private foundations, are necessary to sustain these courts.

Fourteen drug treatment courts receive state funds. Newport News Juvenile, Roanoke and Portsmouth Adult drug courts are funded 100 percent by state general funds, and the other eleven are supported with a combination of state general funds and other resources. The additional thirteen drug treatment courts are funded utilizing a combination of resources that do not include state general funds. Because drug treatment courts must secure funding annually, their stability and effectiveness are undermined.

Drug Treatment Courts Reduce Recidivism and Are Cost Effective

A report published by the U.S. Government Accountability Office (GAO-05-219) analyzed recidivism data from 23 drug courts and found that a lower percentage of drug court program participants were rearrested or reconvicted and that drug court participants who completed the program but were rearrested or reconvicted had longer periods before recidivating. The report concluded that drug courts are an effective tool in reducing substance abuse and related crime. Although the report concluded that drug courts were more expensive to operate, these costs are outweighed by the savings produced by reduced recidivism and crime, as well as cost-savings to potential crime victims and longer-term health costs.

Other studies have come to similar conclusions. The National Drug Court Institute-National Research Advisory Committee (NRAC) found that drug courts reduce criminal recidivism by approximately 15 to 20 percent as compared to the traditional adjudication of drug related offenses (Drug Court Review, Vol. V, 2, 2006).

New York State conducted an evaluation of six adult drug courts (Bronx, Brooklyn, Queens, Suffolk, Syracuse, and Rochester) which tracked offenders at least three years after the initial arrest and at least one year after program completion. The six drug courts generated an average 29 percent (range 13% to 47%) recidivism reduction over the three-year post-arrest period and an average 32 percent (range 19% to 52%) reduction over the one-year post-program period. This study provides strong evidence that drug courts can produce lasting changes concerning participants even after the period of active judicial supervision (New York State Drug Court Evaluation, 2003).

The Virginia General Assembly Joint Legislative Audit and Review Commission Study, *Mitigating the Cost of Substance Abuse in Virginia* (House Document No. 19 - 2008), reviewed Richmond City and Chesterfield County drug court programs and found, during the 18 month period after treatment, no offenders convicted of a felony or violent offense, as compared to 9 percent of those not completing the program and 18 percent of participants that completed jail treatment who were convicted of either a felony or violent offense. The JLARC study also concluded that persons who complete these two drug court programs cost less after treatment then comparison groups (drug court offender, probationer, jail inmate), as follows:

- $18.78 less than each offender who did not complete drug court treatment,
- $10.16 less than each probationer who completed treatment, and

- $13.84 less than each jail inmate who completed treatment.

The report also found that participants who completed drug court experienced significantly better outcomes in the criminal justice system after treatment ended than the three comparison groups.

RECOMMENDATION

The Governor and the General Assembly should support the continuation and expansion of Virginia drug treatment court programs that meet the guidelines and approval of the Supreme Court of Virginia and the State Drug Treatment Court Advisory Committee.

MEDICAID FUNDED SUBSTANCE ABUSE SERVICES ARE IMPLEMENTED

Implementation Occurs in Stages

The 2007 Session of the General Assembly appropriated $10.5 million (general fund and non-general fund), available July 1, 2007, for Medicaid reimbursement of substance abuse treatment services for children and adults. The initial utilization process has encountered several barriers that community services boards, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services are collaborating to overcome. Barriers to implementation included lack of knowledge about regulations and billing procedures, and the perception that reimbursement rates were too low to justify the cost of the service.

As a general rule, newly covered services require start up time for providers to become familiar with the regulations pertaining to the covered services and to develop systems to support billing Medicaid. To assist in this effort, the Department of Medical Assistance Services conducted four training seminars in September 2007 throughout the state. Training included reviews of the regulations addressing newly covered services, Medicaid eligibility and billing. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services sponsored a training focused specifically on services for youth and for providers of opiate treatment services.

As an interim measure for the first year, Medicaid substance abuse treatment reimbursement rates were initially established by benchmarking them with similar mental health treatment services. However, the payment structure for the new substance abuse services is different from the structure for mental health services, due to requirements of the federal Centers for Medicare and Medicaid Services (CMS) for newly approved services. Effective July 1, 2008, the preliminary reimbursement rate calculations have been adjusted. In response to a Joint Legislative Audit and Review Committee (JLARC) recommendation in its recent report (*Mitigating the Cost of Substance Abuse in the Commonwealth*, House Document No. 19 - 2008), the Department of Medical Assistance Services is exploring the feasibility of an additional reimbursement rate increase. These efforts are expected to address the concerns from providers regarding the low reimbursement rates.

Given the different billing structures, some providers are electing to render substance abuse services as part of covered mental health services, using the familiar structure for claim submission and mental health rates, which are higher. Although providing integrated substance abuse and mental health services is allowed under certain circumstances, this practice masks the provision of substance abuse services. This method of billing may contribute to the appearance of slower than actual utilization.

Agencies and Providers Collaborate to Address Problems

The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services are working together with the community services boards to monitor utilization. In addition, these two agencies are designing methods to increase communication and timely technical assistance to community services boards to

improve understanding of the regulations and billing processes. Utilization of Medicaid reimbursement for substance abuse treatment is increasing.

RECOMMENDATION

The Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Association of Community Services Boards should continue to collaborate to maximize the utilization of Medicaid reimbursement for the provision of substance abuse services.

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APPENDICES

APPENDIX A

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

November 2008

Executive Summary
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
November 2008

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, 2007 and 2008 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
November 2008

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.

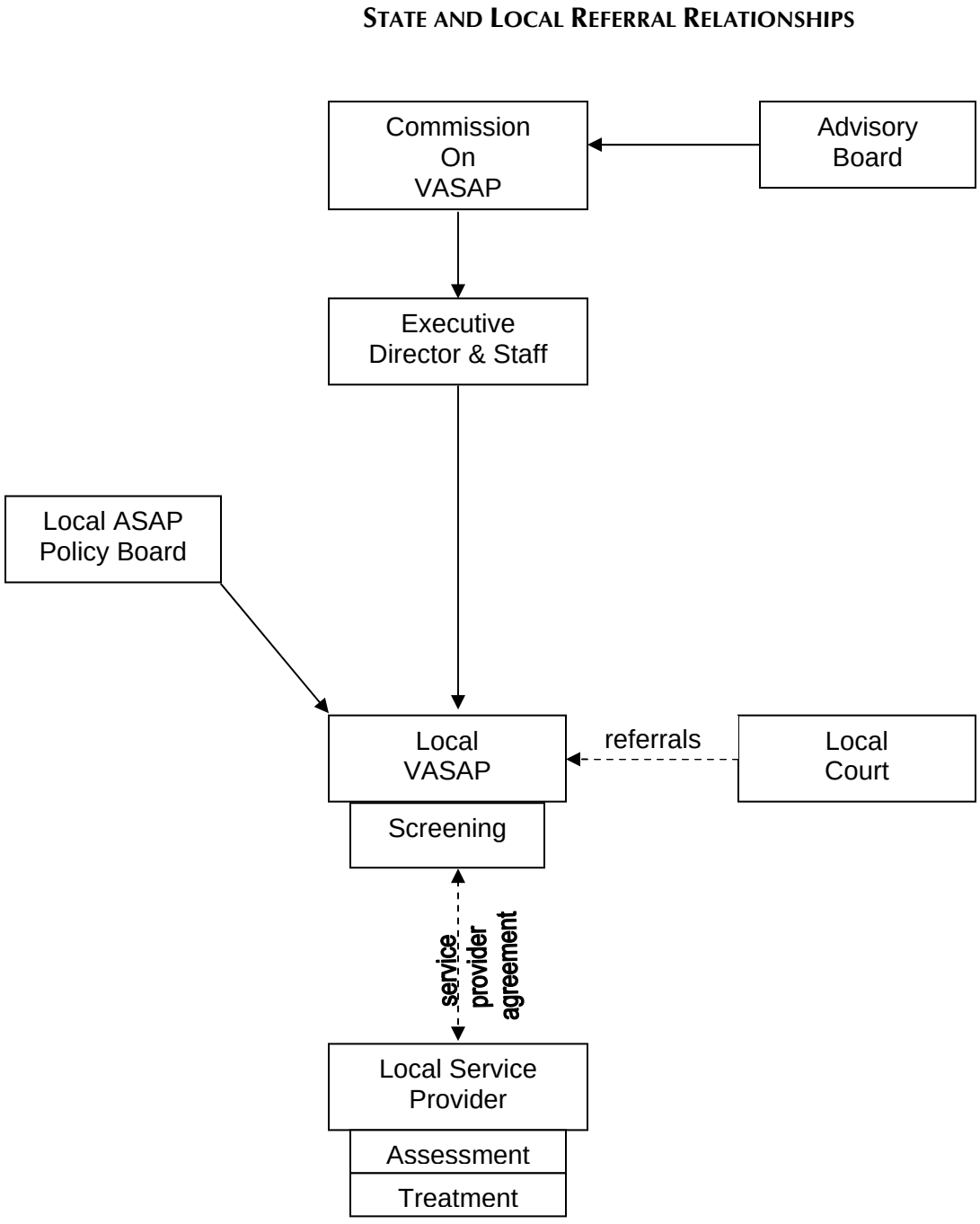
The Commission is supported by an administrative staff, and provides oversight to local ASAP programs, each of which is responsible to its own policy board. [*Code of Virginia* §

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.

Figure 1: State and Local Reporting and 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 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.

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.

Throughout 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.

During the year of 2008, the grant supported a statewide training activity to familiarize ASAP staff and treatment providers with using the American Society of Addiction Medicine placement criteria in working with high risk DUI offenders. The training, held in Charlottesville, was conducted by Gerald Shulman, a recognized expert in ASAM placement criteria. Participants developed skills in the use of ASAM

criteria from the point of intake through placement, discharge and referral for continuing care. Since the ASAP staff's primary responsibility with the high risk DUI offender is appropriate service referral and case management, Mr. Shulman spent a significant amount of class time exploring these roles. A five level risk rating system was used to determine the severity of problems with the high risk DUI offenders and the use of assessment forms was demonstrated by the instructor. The latter portion of the training provided participants with the opportunity to receive hands-on experience through the use of a case study. The case study determined the severity of the problems with the high risk DUI offenders, selected the services needed and finalized with making an appropriate placement. The class composition of case managers and treatment providers afforded an additional opportunity to network and gain a greater understanding of the operations of the two agencies as they relate to the 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 attached as Appendix A.

Plan: These definitions will be used by VASAP staff to determine evidence and consensus based practices. They will also be utilized as a guide in the development of standards and service agreements between local ASAPs and 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.

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. The information will be used as a base for identifying programs that are proven effective with Repeat Offenders and Hardcore Drunk Drivers.

*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.

Appendix A-1

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.

APPENDIX B

Funding Sources and Location of Virginia's Drug Treatment Court Programs					
Locality	*Funding Source(s) by Percentage	CSB	Region	Model	*Total Capacity
Albemarle County, Charlottesville	63% State, 37% Local	Region 10	1	Adult(felony)	50-60
Albemarle County, Charlottesville	100% Federal		1	Family	15
Rappahannock Regional	45% State, 33% Local, 22% Existing Agency Funds	Rappahannock Area	1	Adult(felony)	75
Fredericksburg, Stafford, Spotsylvania & King George (Rappahannock Regional)	75% State, 21% Local, 4% Existing Agency Funds		1	Juvenile	20
Fredericksburg, Stafford, Spotsylvania (Rappahannock Regional)	100% Participant Fees		1	DUI (misd.)	300 or more
Staunton	90% Federal, 10% Local	Valley Community	1	Adult(felony)	20
Loudoun	100% Local	Loudoun County	2	Adult(felony)	20
Fairfax	100% Existing Agency Funds	Fairfax-Falls Church	2	Juvenile	12
Prince William	100% Federal	Prince William	2	Juvenile	12
Alexandria	100% Existing Agency Funds	Alexandria	2	Family	15
Roanoke City, Salem City & Roanoke Co.	100% State	Blue Ridge Behavioral Health Care	3	Adult(felony)	80
Lee, Scott, & Wise Counties	100% Local	Planning District 1	3	Juvenile	At least 20
Chesterfield	30% State, 60% Federal, 8% Local	Chesterfield	4	Adult(felony)	65
Chesterfield	40% State, 60% Local		4	Juvenile	25
Henrico County	65% State, 33% Local, 2% Participant fees	Henrico Area	4	Adult(felony)	No Maximum
Hopewell, Prince George & Surry	100 % Local	District 19	4	Adult(felony)	15-20
Richmond	70% State, 10% Federal, 20% Local	Richmond Behavioral Health Authority	4	Adult(felony)	75-100
Richmond	Closed June 2007		4	Family	
Richmond	42% State, 25% Federal, 25% Local, 8% Private Foundation		4	Juvenile	14

Hanover	65% Federal, 35% Local	Hanover County	4	Juvenile	15
Norfolk	66% State, 28% Local, 6% Participant fees	Norfolk	5	Adult(felony)	50
Portsmouth	100% State	Portsmouth Dept. of Behavioral Healthcare Services	5	Adult(felony)	75
Suffolk	75% Federal, 25% Local	Western Tidewater	5	Adult(felony)	40
Chesapeake	100% Federal	Chesapeake	5	Adult(felony)	5
Hampton	95% State, 4.5% Local, .5% Participant Fees	Hampton-Newport News	5	Adult(felony)	60
Newport News	73% State, 13% Federal, 13% Local, 1% Participant fees		5	Adult(felony)	55
Newport News	100% State		5	Juvenile	25
Newport News	100% Existing Agency Funds		5	Family	20
Planning Courts (pending approval from the General Assembly)					
Tazewell (SB 678)	100% Existing Agency Funds, FY 2008 Federal Grant $200,000	Cumberland Mountain	3	Adult(felony)	15
Franklin County (SB 775, HB 1156)	100% Existing Agency Funds	Piedmont	3	Juvenile	6-12 slots
Chesterfield (SB 391, HB 876)	Supported by participant fees	Chesterfield	4	DUI	

*Report on Evaluation of Virginia's Drug Treatment Courts Prepared for the Virginia General Assembly, December 2007 FY2008 Staunton, Loudoun County and Tazewell received Drug Court Discretionary Grant Program Awards

APPENDIX C

Established Dates-Virginia Drug Treatment Courts			
Year	**Locality**	**Court Model**	**Development Stage**
Sep-95	Roanoke	Adult (felony)	Operational
Jul-97	Charlottesville	Adult (felony)	Operational
Mar-98	Richmond City	Adult (felony)	Operational
Oct-98	Rappahannock Regional	Adult (felony)	Operational
Nov-98		Juvenile	Operational
Nov-98	Norfolk	Adult (felony)	Operational
Nov-98	Newport News	Adult (felony)	Operational
Mar-99	Richmond City	Juvenile	Operational
May-99	Rappahannock Regional	DUI	Operational
Sep-00	Chesterfield County	Adult (felony)	Operational
Jan-01	Portsmouth	Adult (felony)	Operational
Sep-01	Alexandria	Family	Operational
Mar-02	Newport News	Juvenile	Operational
Jul-02	Charlottesville	Family	Operational
Sep-02	Richmond City	Family	Operational -6/2008
Sep-02	Hopewell	Adult (misdemeanor)	Operational
Sep-02	Lee and Scott Co.	Juvenile	Operational
Jan-03	Henrico	Adult (felony)	Operational
Feb-03	Hampton	Adult (felony)	Operational
Apr-03	Fairfax County	Juvenile	Operational
May-03	Hanover County	Juvenile	Operational
May-03	Staunton	Adult (felony)	Operational
Jun-03	Colonial Heights	Juvenile	Operational
May-04	Suffolk	Adult (felony)	Operational
May-04	Prince William Co	Juvenile	Operational
May-04	Loudoun	Adult (felony)	Operational
2005	Tazewell County	Adult (felony)	Planning
	Franklin County	Juvenile	Planning
	Chesterfield County	DUI	Planning

http://leg2.state.va.us/dls/h&sdocs.nsf/execsummaryreport/RD402005 (Courts identified through 2004)

§ 18.2-254.1. Drug Treatment Court Act.

A. This section shall be known and may be cited as the "Drug Treatment Court Act."

B. The General Assembly recognizes that there is a critical need in the Commonwealth for effective treatment programs that reduce the incidence of drug use, drug addiction, family separation due to parental substance abuse, and drug-related crimes. It is the intent of the General Assembly by this section to enhance public safety by facilitating the creation of drug treatment courts as means by which to accomplish this purpose.

C. The goals of drug treatment courts include: (i) reducing drug addiction and drug dependency among offenders; (ii) reducing recidivism; (iii) reducing drug-related court workloads; (iv) increasing personal, familial and societal accountability among offenders; and, (v) promoting effective planning and use of resources among the criminal justice system and community agencies.

D. Drug treatment courts are specialized court dockets within the existing structure of Virginia's court system offering judicial monitoring of intensive treatment and strict supervision of addicts in drug and drug-related cases. Local officials must complete a recognized planning process before establishing a drug treatment court program.

E. Administrative oversight for implementation of the Drug Treatment Court Act shall be conducted by the Supreme Court of Virginia. The Supreme Court of Virginia shall be responsible for (i) providing oversight for the distribution of funds for drug treatment courts; (ii) providing technical assistance to drug treatment courts; (iii) providing training for judges who preside over drug treatment courts; (iv) providing training to the providers of administrative, case management, and treatment services to drug treatment courts; and (v) monitoring the completion of evaluations of the effectiveness and efficiency of drug treatment courts in the Commonwealth.

F. A state drug treatment court advisory committee shall be established to (i) evaluate and recommend standards for the planning and implementation of drug treatment courts; (ii) assist in the evaluation of their effectiveness and efficiency; and (iii) encourage and enhance cooperation among agencies that participate in their planning and implementation. The committee shall be chaired by the Chief Justice of the Supreme Court of Virginia or his designee and shall include a member of the Judicial Conference of Virginia who presides over a drug treatment court; a district court judge; the Executive Secretary or his designee; the directors of the following executive branch agencies: Department of Corrections, Department of Criminal Justice Services, Department of Juvenile Justice, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Social Services; a representative of the following entities: a local community-based probation and pretrial services agency, the Commonwealth's Attorney's Association, the Virginia Indigent Defense Commission, the Circuit Court Clerk's Association, the Virginia Sheriff's Association, the Virginia Association of Chiefs of Police, the Commission on VASAP, and two representatives designated by the Virginia Drug Court Association.

G. Each jurisdiction or combination of jurisdictions that intend to establish a drug treatment court or continue the operation of an existing one shall establish a local drug treatment court advisory committee. Jurisdictions that establish separate adult and juvenile drug treatment courts may establish an advisory committee for each such court. Each advisory committee shall ensure quality, efficiency, and fairness in the planning, implementation, and operation of the drug treatment court or courts that serve the jurisdiction or combination of jurisdictions. Advisory committee membership shall include, but shall not be limited to the following people or their designees: (i) the drug treatment court judge; (ii) the attorney for the Commonwealth, or, where applicable, the city or county attorney who has responsibility for the prosecution of misdemeanor offenses; (iii) the public defender or a member of the local criminal defense bar in jurisdictions in which there is no public defender; (iv) the clerk of the court in which the drug treatment court is located; (v) a representative of the Virginia Department of Corrections, or the Department of Juvenile Justice, or both, from the local office which serves the jurisdiction or combination of jurisdictions; (vi) a representative of a local community-based probation and pretrial services agency; (vii) a local law-enforcement officer; (viii) a representative of the Department of Mental Health, Mental Retardation, and Substance Abuse Services or a representative of local drug treatment providers; (ix) the drug court administrator; (x) a representative of the Department of Social Services; (xi) county administrator or city manager; and (xii) any other people selected by the drug treatment court advisory committee.

H. Each local drug treatment court advisory committee shall establish criteria for the eligibility and participation of offenders who have been determined to be addicted to or dependent upon drugs. Subject to the provisions of this section, neither the establishment of a drug treatment court nor anything herein shall be construed as limiting the discretion of the attorney for the Commonwealth to prosecute any criminal case arising therein which he deems advisable to prosecute, except to the extent the participating attorney for the Commonwealth agrees to do so. As defined in § 17.1-805 or 19.2-297.1, adult offenders who have been convicted of a violent criminal offense within the preceding 10 years, or juvenile offenders who previously have been adjudicated not innocent of any such offense within the preceding 10 years, shall not be eligible for participation in any drug treatment court established or continued in operation pursuant to this section.

I. Each drug treatment court advisory committee shall establish policies and procedures for the operation of the court to attain the following goals: (i) effective integration of drug and alcohol treatment services with criminal justice system case processing; (ii) enhanced public safety through intensive offender supervision and drug treatment; (iii) prompt identification and placement of eligible participants; (iv) efficient access to a continuum of alcohol, drug, and related treatment and rehabilitation services; (v) verified participant abstinence through frequent alcohol and other drug testing; (vi) prompt response to participants' noncompliance with program requirements through a coordinated strategy; (vii) ongoing judicial interaction with each drug court participant; (viii) ongoing monitoring and evaluation of program effectiveness and efficiency; (ix) ongoing interdisciplinary education and training in support of program effectiveness and efficiency; and (x) ongoing collaboration among drug treatment courts, public agencies, and community-based organizations to enhance program effectiveness and efficiency.

J. Participation by an offender in a drug treatment court shall be voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court.

K. Nothing in this section shall preclude the establishment of substance abuse treatment programs and services pursuant to the deferred judgment provisions of § 18.2-251.

L. Each offender shall contribute to the cost of the substance abuse treatment he receives while participating in a drug treatment court pursuant to guidelines developed by the drug treatment court advisory committee.

M. Nothing contained in this section shall confer a right or an expectation of a right to treatment for an offender or be construed as requiring a local drug treatment court advisory committee to accept for participation every offender.

N. The Office of the Executive Secretary shall, with the assistance of the state drug treatment court advisory committee, develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local drug treatment courts. A report of these evaluations shall be submitted to the General Assembly by December 1 of each year. Each local drug treatment court advisory committee shall submit evaluative reports to the Office of the Executive Secretary as requested.

O. Notwithstanding any other provision of this section, no drug treatment court shall be established subsequent to March 1, 2004, unless the jurisdiction or jurisdictions intending or proposing to establish such court have been specifically granted permission under the Code of Virginia to establish such court. The provisions of this subsection shall not apply to any drug treatment court established on or before March 1, 2004, and operational as of July 1, 2004.

P. Subject to the requirements and conditions established by the state Drug Treatment Court Advisory Committee there shall be established a drug treatment court in the following jurisdictions: the City of Chesapeake and the City of Newport News.

(2004, c. 1004; 2005, cc. 519, 602; 2006, cc. 175, 341; 2007, c. 133.)

APPENDIX E

§ 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.)

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§ 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, § 37.1-207.1; 2005, c. 716.)

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