SUBSTANCE ABUSE SERVICES COUNCIL

ANNUAL REPORT AND PLAN

to the Governor

and the

General Assembly

COMMONWEALTH OF VIRGINIA

December 31, 2009

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COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

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Chair

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December 31, 2009

To: The Honorable Timothy M. Kaine

and

Members, Virginia General Assembly

In accordance with § 2.2-2696 of the *Code of Virginia*, I am pleased to present the **2009 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.

Mindful of the serious fiscal situation of the nation and the commonwealth, the Council this year has focused on improving use of limited resources while setting goals for a future time when funding for expansion is available. To this end, the Council was pleased to see SJR 77 (2008) continued as SJR 318. Chaired by Senator Hanger, SJR 318, *The Study of Strategies and Models for the Treatment and Prevention of Substance Abuse in the Commonwealth,* continued the work of SJR 77 (2008) which, in turn, built on a report of the Joint Legislative Audit and Review Commission (JLARC), *Mitigating the Cost of Substance Abuse in the Commonwealth* (2008). Subcommittee members include representatives from DOC, DSS, DBHDS, as well as private providers, consumer/advocates, and legislators. Subcommittee members heard from a wide variety of speakers. This year, the research for the subcommittee was managed by three work groups, Prevention, Treatment and Recovery, and Prescription Drug Abuse, the membership of which consisted of a range of providers, advocates and representatives of state agencies involved in the provision of substance abuse services. I was pleased to be able to serve on the Treatment Work group, and several other Council members also participated on work groups. As I write this letter, the subcommittee is concluding its work, and so its final report is not yet available. However, the close working relationship of the Council with this commission leads me to have considerable confidence in the findings and recommendations of the commission. Therefore, the Council expresses its strong desire that the recommendations emanating from the commission be implemented as soon as is feasible. If the commission recommends extending its work for another year, the Council will support this action, as well.

The body of this report focuses on two issues. Following up on last year's report, the Department of Behavioral Health and Developmental Services (formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services) has provided detail about

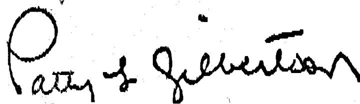
evidence-based treatment and prevention practices for older adults, and the Council has made recommendations about how this information should be used, as well as actions to further explore services to this increasing population.

The second issue addressed in this report focuses on how agencies providing substance abuse services evaluate their programs and services. This issue has been raised by the General Assembly in previous sessions, resulting in an amendment to the *Code* (§2.2-2697). A separate report responding to this *Code* section is published annually. However, when JLARC published its 2008 report, it suggested that the Substance Abuse Services Council work with its member agencies that provide substance abuse services to unify outcome information across agency systems, since there is considerable overlap in the individuals with whom they work.

To address this concern, I appointed a work group, skillfully led by Mr. Will Williams, Substance Abuse Director for the Fairfax-Falls Church Community Services Board (representing the Substance Abuse Council of the Virginia Association of Community Services Boards on the Council). The work group met multiple times and made considerable progress in identifying specific issues that need to be addressed to make the sharing of individual client/consumer outcome data across agency systems possible.

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 Virginias who are affected by substance use disorders.

Sincerely,



Patty L. Gilbertson

TABLE OF CONTENTS

EXECUTIVE SUMMARY………………………………………………………………………….. i

TREATMENT AND PREVENTION PROGRAMS FOR OLDER ADULTS ………………………………….……1

REPORT OF THE SERVICES OUTCOMES WORK GROUP…………………… ………… ..……………7

APPENDICES

A. Services Outcome Work Group Logic Model 16

B. Code of Virginia §2.2696 & 2697 17

C. Substance Abuse Services Council Membership Roster 20

EXECUTIVE SUMMARY
Substance Abuse Services Council Annual Report and Plan

Treatment and Prevention Programs for Older Adults

Following up on a report in last year's Council report, the Department of Behavioral Health and Developmental Services (DBHDS; formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services) identified evidence-based practices effective for treating and preventing substance abuse in older adults. This population is growing significantly: by 2030 it will constitute 20 percent of the U.S. population. This population is especially vulnerable to stigma that inhibits access to treatment, and continued substance abuse in older persons can also create barriers to receiving other needed supports and services.

Evidence-based programs and practices for this population include:

- Motivational Interviewing, which addresses ambivalent attitudes towards addressing substance abuse issues;
- Motivational Enhancement Therapy, which is an enhancement of Motivational Interviewing;
- Relapse Prevention Therapy, a behavioral control program that teaches individuals to anticipate challenging situations and practice proven successful responses before the challenges occur;
- Cognitive-Behavioral Therapy, which teaches the person to identify the chain of antecedent situations that trigger habitually occurring behaviors and likely consequences of those behaviors. Therapy focuses on changing the behaviors (substance using behaviors, in this case) so that more desirable outcomes will occur.
- Brief Interventions, an approach that uses a limited number of short counseling sessions to increase awareness about the deleterious effects of substance misuse and abuse.
- Screening, Brief Intervention, Referral and Treatment, an approach particularly endorsed by the federal Substance Abuse and Mental Health Services Administration, is being utilized in Florida as a targeted approach to working with older adults. Individuals who screen likely to be misusing or abusing are engaged in a brief intervention. If the brief intervention is not successful, the person is referred to specialty substance abuse treatment. SBIRT is an approach that may be offered by a variety of providers as it does not require extensive training and may be offered in a variety of settings.

Recommendations:
In order to meet the needs of Virginia's older adults with substance use disorders, the Substance Abuse Services Council recommends the following:

1. The Office of Substance Abuse Services of the Department of Behavioral Health and Developmental Services (OSAS/DBHDS) shall:

(a) Continue research on issues related to the needs of Virginia's older adults with substance use disorders;
(b) Investigate additional evidence-based programs and practices demonstrated to be effective with an older adult population;
(c) Disseminate these findings to the statewide professional community; and
(d) Implement training in evidence-based practices and programs to ensure appropriate workforce development and training to meet the current and projected needs of Virginia's growing older adult population.

2. The Commonwealth's 40 community services boards (CSBs) shall be encouraged, but not mandated, to use the techniques described in this report to develop *evidence-based, age-specific model programs* that are similar to the effective and efficient examples recommended by SAMHSA and implemented successfully by other states. To maximize scarce resources, it is important that CSBs focus on the characteristics and needs of the populations they are serving. Those CSBs serving proportionately larger numbers of older adults—CSBs in rural areas, for example—should focus appropriate resources on identifying and meeting the needs of the older adult population in their service areas.

   Personnel costs (salary/benefits for program coordinators and counselors, and consultation fees for physicians and psychologists) would be the principal expense incurred by community services boards in implementing evidence-based model programs for older adults. Overhead costs (rent, utilities, insurance, etc.) would be included within each CSB's budget. Medicare, which covers all citizens over 65, is a major resource for reimbursement. It covers treatment for substance-related disorders in both inpatient and outpatient settings. To qualify for reimbursement, CSBs should take steps to become certified as Medicare providers.

3. The Substance Abuse Services Council shall collaborate with all responsible and interested parties (Federal government, State government, local government partners, advocacy groups, foundations and other not-for-profit organizations, etc.) to seek public support and sufficient funding to provide and expand critical services for Virginia's older adults.

Report of the Services Outcomes Work Group of the Substance Abuse Services Council

A report published by the Joint Legislative Audit and Review Commission (JLARC), *Mitigating the Cost of Substance Abuse in the Commonwealth* (2008) urged the Substance Abuse Services Council to:

> *(1) establish common measures capturing their clients' outcomes after treatment, (2) determine where to obtain outcomes information needed across agencies, and (3) design a process to collect the information from other agencies on an ongoing basis.* (p. 66)

In response, the Council chair appointed a work groupthat included Council member agencies that are engaged in the provision of treatment services or that collect data about the effects of treatment. These agencies include:

- Department of Behavioral Health and Developmental Services (DBHDS)
- Department of Corrections (DOC)
- Department of Criminal Justice Services (DCJS)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Commission on Virginia Alcohol Safety Action Program (VASAP)

The Governor's Office on Substance Abuse Prevention, also a Council agency, was also invited to provide some insight into the role of prevention in the continuum of services. However, the efforts of the work group were primarily focused on treatment services.

The work group decided to utilize the National Outcomes Measures (NOMs) as the basic framework for outcomes data. The NOMs were established by the Substance Abuse and Mental Health Services Administration (SAMHSA) as the dataset required for compliance with the federal Substance Abuse Prevention and Treatment Block Grant, the largest single source of nonstate funding for treatment and prevention in the Commonwealth. These funds are distributed to the forty community services boards (CSBs), and the CSBs provide the data on persons served. Each executive branch agency, however, has its own data set and data infrastructure. A major task of the work group was to identify and describe these for each agency. Each agency identified whether or not it was able to provide the outcome measures identified in the NOMs.

The work group also identified barriers to addressing the goals identified by JLARC. These included operational issues about how data is collected and stored, lack of a coordinating agency or authority, and lack of dedicated resources to support these efforts. Mindful that SJR 318 was very interested in program effectiveness, the Council agreed to endorse the recommendations of the work group to:

- Recommend that Senate Joint Resolution Study 318 (The Study of Models and Strategies for the Prevention and Treatment of Substance Abuse in the Commonwealth) support continuing the SASC Services Outcomes Work group to:

    - Develop NOMs, including agency ability to utilize and link existing systems that collect outcome data, even though each agency has already established its own system for creating the unique individual identifiers necessary to track individual outcomes.
    - Support the development of measures of program effectiveness that take into account the life-long, chronic nature of substance use disorders.
    - Recommend that DBHDS, DJJ and DOC prioritize development of a "data warehouse," infrastructure, in collaboration with the State Compensation Board (which collects information about jail inmates), that would store, manage and use commonly collected data about shared consumers/inmates/residents/ supervisees.

- Strengthen the legal authority of DBHDS to collect consumer data from CSBs.
- Explore ways to integrate prevention outcome data to provide another perspective on the impact of services on communities over time.
- Identify system gaps and barriers, and prioritize strategies to address them, including human resources, hardware and software necessary to build an information technology system that can support these goals, and provide cost estimates of implementing such a system.

To support these requests, the SASC also requests that SJR 318 strengthen the mandate of DBHDS to collect data from CSBs and provide seed funding, when available, to address some of the gaps and barriers to developing a systemic approach to program evaluation across agencies.

TREATMENT AND PREVENTION PROGRAMS FOR OLDER ADULTS

Purpose

In its 2008 Annual Report and Plan, the Substance Abuse Services Council previously concluded that the prevention and treatment needs of Virginia's older adults with substance use disorders have not been adequately met. Recognizing that the substance abuse services needs of older adults will have a significant impact on the existing statewide service delivery system within the next decade, the Council recommended additional research into prevention programs and treatment services designed to meet the specialized needs of Virginia's older adult population.

Background

Since the 1970s there has been a growing national awareness that large numbers of older adults will be in need of substance abuse services as they enter into older age. Initially referred to as an "invisible epidemic," the phenomenon's epidemic nature is evidenced by both population statistics and societal trends. By 2030, it is projected that citizens over 65 will number 71 million, increasing to more than 20 percent of the country's population. Out of that 71 million, 16 percent (11 million people) will be in need of substance abuse services.

In Virginia, the community services boards (CSBs) are already beginning to experience effects of the "invisible epidemic." As consumers aged 50-80+ seek assistance from the state's community services boards, there will be a critical need for both expanded geriatric services and appropriately trained service providers. To be prepared to respond to this challenge, research must focus on targeted programs and specialized professional workforce training to meet the needs of older adults with substance use disorders.

Of particular importance in garnering public support, securing funding, enlightening program administrators, and training service providers is the need to confront the issue of stigma. Because older people suffering from substance use disorders are particularly stigmatized, many desiring help hesitate to discuss their problem, even with health care providers. Paradoxically, stigma against older individuals 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.

As resources become even more limited, it will be increasingly difficult to make a case for services dedicated to the needs of older adults unless those services can be shown to be evidence-based in their design and both efficient and effective in their implementation. An article on "Aging Policy and the States" in Generations, an American Society on Aging publication, notes the key role that state agencies play in Behavioral Health service delivery. Pointing out the scarcity of services for older adults—principally due to lack of funding—the authors state, "In an aging America, the resulting lack of critical services will lead to increased healthcare costs to Medicaid, Medicare, private insurance, and older adults and their families" (2008). 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 as well as on service delivery systems.

In response to the direction and recommendation of the Substance Abuse Services Council, the Office of Substance Abuse Services of DBHDS (OSAS/DBHDS) is continuing its research into evidence-based treatment and prevention practices and programs suggested to be especially effective with older adults. It is the Department's intention to disseminate this information to community services boards and other service providers throughout Virginia.

Evidence-based Programs for Older Adults with Substance Use Disorders

DBHDS is one of more than 20 public and private organizations representing health, mental health, and senior advocacy in Virginia that participates in the Alcohol and Aging Awareness Group (AAAG), which was formed by the Department of Alcoholic Beverage Control in 2007. Staff members participated in AAAG's initial service provider conference in 2008 and its follow-up conference in 2009, "The Hidden Epidemic, Alcohol, Medication and the Older Adult: Best Practices," which explored the best practices recommended for service providers to address the public health concern of alcohol and medication misuse in older adults.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) has recommended several effective programs and practices for service providers to use in working with older adults. The following are three pertinent examples:

Motivational Interviewing (MI), a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal.

Motivational Enhancement Therapy (MET), an adaptation of motivational interviewing (MI) that includes one or more client feedback sessions in which normative feedback is presented and discussed in an explicitly non-confrontational manner.

Relapse Prevention Therapy (RPT), a behavioral control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

An article in Drugs and Aging, "Relapse Prevention and Maintaining Abstinence in Older Adults with Alcohol-Use Disorders," notes that treatments such as cognitive behavioral therapy (CBT), group and family therapies, and self-help groups may be of particular benefit to older adults because of the emphasis on social support (2002).

Employing Cognitive Behavioral Therapy (CBT), a CBT/Self Management approach would include using the A-B-C's (Antecedents-Behaviors-Consequences) of behavioral analysis in a three-stage therapeutic model:

1. Begin with a substance use profile to identify the client's antecedents and consequences for substance use. Create an individualized "substance use behavior chain."
2. Teach the client how to identify the components of that chain so that s/he can understand the high-risk situations for alcohol or drug use.
3. Teach specific skills to address these high-risk situations to prevent relapse.

Two examples of successful use of CBT/Self Management are the Gerontology Alcohol Project (GAP) (Florida) and the GET SMART Program (California). The Florida GAP program targeted late-life alcohol abusers, using day treatment in a group format to teach CBT/Self Management strategies. Results over a 12-month follow-up period were that 75 percent of participants maintained their goals, no one returned to steady drinking, and there was a significant increase in participants' social support networks. The California GET SMART program targeted veterans aged 60+, recruited from hospitals, outpatient clinics and the community, who participated voluntarily. Using the A-B-C's described above, therapists helped clients analyze and modify their substance misuse behavior. The educational component of the program included sessions on "Social Pressure," "Depression," "Managing Anxiety, Tension, Anger, and Frustration," and "Preventing a Slip from Becoming a Relapse." Results after six months were that 40 of the 49 participants who completed the program remained abstinent or were abstinent after one slip.

Another evidence-based therapy model, Brief Intervention, is frequently successful with older adults who have scant awareness of the deleterious effects of misuse of alcohol, drugs and medications. In a limited number of sessions—three is the average—therapists use age-appropriate screening techniques to target specific health behaviors, employ motivation enhancement strategies, and offer advice and education. The goals of Brief Intervention therapy are to motivate individuals to change dangerous behaviors, to eliminate/reduce alcohol or substance use, and to use medications appropriately. Examples of elder-specific Brief Intervention projects include:

- *Project GOAL (Guiding Older Adult Lifestyles)* (Wisconsin), which showed reduced consumption rates after six months;
- *Health Profile Project* (Michigan), which used in-home motivational enhancement sessions and showed reduced at-risk drinking at a 12-month follow-up; and
- *Staying Healthy Project* (California), which showed a 40 percent reduction of alcohol use in 4,300 individuals screened upon admission to the program.

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS) (2002) provides useful data on the kinds of facilities reporting programs and services targeted to the older adult population. The survey reported that elder-specific services were:

- Typically offered in facilities owned or operated by hospitals and psychiatric hospitals;
- More common in programs operated for profit and those subsidized by federal and tribal governments;
- Less often in state and private/not-for-profit facilities;

- Less often in substance abuse specific facilities; and
- More often in programs offering specialized programs for other groups (dually diagnosed, adolescents, HIV/AIDS, pregnant women, etc.).

The BRITE Project: An Innovative Federally-Funded, State-Implemented Approach

Due to age-specific needs, innovative methods are necessary to identify and treat older adults with substance use disorders. Two staff members of the Department of Behavioral Health and Developmental Services serve on an advisory committee of the Center for Excellence in Aging and Geriatric Health (CEAGH), a Williamsburg-based not-for-profit research organization that is investigating best practices in dealing with multiple issues confronting the older adult population, including of misuse of alcohol, drugs and medications.

Through CEAGH, DBHDS staff learned of an especially promising program that has been implemented by the Florida Department of Children and Families/Substance Abuse Program (DCF/SAPO) through a grant from SAMHSA's Center for Substance Abuse Treatment (CSAT). It is an innovative approach that combines federal funding and state implementation to provide services to the state's older adult population.

Florida's BRITE Project—Brief Intervention and Treatment for Elders—implements the Screening, Brief Intervention, and Referral to Treatment (SBIRT*)* initiative of SAMHSA/CSAT. The BRITE Project is an evidence-based approach to identifying older adults with substance abuse and related problems. It recognizes that older adults with such problems are rarely served by traditional systems of services.

The mission of the BRITE project is to help individuals 55 years and older to identify non-dependent substance use or prescription medication issues and to provide effective service strategies prior to their need for more extensive or specialized substance abuse treatment. The Florida BRITE Project is the first federally funded SBIRT project that focuses on meeting the needs of older adults.

Clients may be offered screening, brief intervention, and brief treatment by generalist providers or they may be offered more intensive care by a substance abuse specialist provider agency. Provider agencies offer in-home screening and services for elders with problems related to alcohol, illicit substances, and prescription and over-the-counter medications. SBIRT programs typically are located in medical settings such as emergency departments and primary care practices. In some states, all admissions to the medical setting are screened for substance abuse and then given a brief intervention if there are signs of problems that are related to substance use. Duration for a typical session in an E.R. might be no more than 20 minutes, but research suggests a substantial reduction in harmful behaviors with a brief intervention that is implemented by a suitably trained clinician.

With the CSAT grant, Florida's BRITE Project focuses on providing services within primary and emergency health care settings, public health clinics, elder homes, and at sites coordinated by aging services. In addition to the usual medical settings, BRITE screens and

provides brief interventions in retirement communities and senior housing and at health fairs. The growing population of older adults is a high priority age-group in Florida, given that Florida has the highest median age population among all states in the United States. Since the SBIRT grant was received, nearly 18,000 people have been screened across all BRITE sites.

It should be noted that—due to the efforts of the statewide Florida Coalition for Optimal Mental Health and Aging, and other state taskforces—recent changes in legislation in Florida have prompted two significant changes in treatment services:

- The Florida Department of Children and Families is now mandated to serve older adults as a separate target population for mental health and substance abuse services; and
- The Florida Department of Elder Affairs is now mandated to screen older adults for mental health problems and substance abuse.

Recommendations

In order to meet the needs of Virginia's older adults with substance use disorders, the Substance Abuse Services Council recommends the following:

1. The Office of Substance Abuse Services of the Department of Behavioral Health and Developmental Services (OSAS/DBHDS) shall:

   (a) Continue research on issues related to the needs of Virginia's older adults with substance use disorders;
   (b) Investigate additional evidence-based programs and practices demonstrated to be effective with an older adult population;
   (c) Disseminate these findings to the statewide professional community; and
   (d) Implement training in evidence-based practices and programs to ensure appropriate workforce development and training to meet the current and projected needs of Virginia's growing older adult population.

2. The Commonwealth's 40 community services boards (CSBs) shall be encouraged, but not mandated, to use the techniques described in this report to develop *evidence-based, age-specific model programs* that are similar to the effective and efficient examples recommended by SAMHSA and implemented successfully by other states. To maximize scarce resources, it is important that CSBs focus on the characteristics and needs of the populations they are serving. Those CSBs serving proportionately larger numbers of older adults—CSBs in rural areas, for example—should focus appropriate resources on identifying and meeting the needs of the older adult population in their service areas.

   Personnel costs (salary/benefits for program coordinators and counselors, and consultation fees for physicians and psychologists) would be the principal expense incurred by community services boards in implementing evidence-based model programs for older adults. Overhead costs (rent, utilities, insurance, etc.) would be included within

each CSB's budget. Medicare, which covers all citizens over 65, is a major resource for reimbursement. It covers treatment for substance-related disorders in both inpatient and outpatient settings. To qualify for reimbursement, CSBs should take steps to become certified as Medicare providers.

3. The Substance Abuse Services Council shall collaborate with all responsible and interested parties (Federal government, State government, local government partners, advocacy groups, foundations and other not-for-profit organizations, etc.) to seek public support and sufficient funding to provide and expand critical services for Virginia's older adults.

REPORT OF THE SERVICES OUTCOMES WORK GROUP OF THE SUBSTANCE ABUSE SERVICES COUNCIL

Purpose

In its report, *Mitigating the Costs of Substance Abuse in Virginia* (June, 2008), the Joint Legislative Audit and Review Commission (JLARC) recommended that the Substance Abuse Services Council:

> *(1) establish common measures capturing their clients' outcomes after treatment, (2) determine where to obtain outcomes information needed across agencies, and (3) design a process to collect the information from other agencies on an ongoing basis.* (p. 66)

The context of this recommendation was that outcomes evaluation is a critical component of measuring the effectiveness of substance abuse treatment; that the various agencies involved in delivering substance abuse treatment services employed different methods of tracking consumers of services; and that some agencies do not have data systems dedicated to evaluation. Further, the report noted that, although various agencies might have different priorities for programs, some measures, such as employment and recidivism, were shared across agency systems. JLARC reasoned that coordination among agencies involved in the delivery of substance abuse services could avoid duplication of effort and build upon the experience that the Department of Behavioral Health and Developmental Services (then the Department of Mental Health, Mental Retardation and Substance Abuse Services) gained in implementing federal National Outcome Measures required by the Substance Abuse Prevention and Treatment Block Grant.

To this end, at its July 7, 2008 meeting, the Substance Abuse Services Council voted to establish the Services Outcomes Work Group. Council Chair Patty Gilbertson appointed Will Williams, Director of Alcohol and Drug Services at Fairfax/Falls Church Community Services Board and representative of the Virginia Association of Community Services Boards on the Council, to convene the Services Outcomes Work Group. The following Council member agencies were invited to participate:

- Department of Behavioral Health and Developmental Services (DBHDS)
- Department of Corrections (DOC)
- Department of Criminal Justice Services (DCJS)
- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Commission on Virginia Alcohol Safety Action Program (VASAP)

The Governor's Office on Substance Abuse Prevention, also a Council agency, was also invited to provide some insight into the role of prevention in the continuum of services. GOSAP has recently received a federal grant to support collection of community-based prevention data (e.g., measures of community health related to substance use and abuse) that

support local prevention planning activities. Because the JLARC recommendation specifically focused on *treatment* outcomes related to measures of change for individuals receiving services, the work group, while acknowledging the significance of prevention in the continuum of services, focused its efforts on treatment services.

The work group met face-to-face on six occasions between September 2008 and August 2009. Its efforts were supplemented through reviews and correspondence by email.

Developing the Methodology

The Substance Abuse and Mental Health Services Administration (SAMHSA) requires recipients (all states and U.S. territories) of the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) to utilize National Outcome Measures (NOMs) to measure the effects of treatment and prevention activities supported by the Block Grant. The Department of Behavioral Health and Developmental Services (DBHDS) is the recipient of the SAPT-BG in Virginia, and allocates the funds to the forty community services boards (CSBs), which provide services to residents of designated jurisdictions.

The treatment outcome measures reflected in eight of the ten identified NOMs domains are collected from data gathered at a participant's admission and at discharge from treatment services, requiring the use of a unique client identifier. The work groupreviewed the NOMs and respective domains and collectively agreed to use these as the basis for outcome measurement for this project, as well as a blueprint for the work of the represented agencies.

Current NOMS domains are: *Reduced Morbidity; Employment/Education; Crime and Criminal Justice; Stability in Housing; Social Connectedness; Access/Capacity; Retention; Perception of Care; Cost Effectiveness;* and *Use of Evidence-Based Practices.* Measures for *Social Connectedness* and *Use of Evidence-Based Practices* are under development; measures for the other eight NOMs were previously developed. A matrix of these domains, their outcomes and measures is included at the end of this section.

The work group realistically identified that not every represented agency expects to collect data or outcomes in all the domains identified by the NOMs. In addition, given that substance use disorders are usually life-long, chronic and often relapsing, use of outcome measures is a somewhat limiting approach to measuring a program's effect on an individual. However, the federal Substance Abuse and Mental Health Services Administration has chosen to develop this approach and has integrated it into both the Substance Abuse Prevention and Treatment Block Grant and all of its discretionary grant activities to addressing federal Government Performance and Reporting Act (GPRA) requirements. The narrative below provides information about the capacity of the following participating agencies' data systems to collect and manage outcome data. A graphic illustration of the logic model developed by the work group is included as Appendix A of this report.

The Department of Behavioral Health and Developmental Services (DBHDS), in partnership with the community services boards, submits data through the Community Consumer Submission (CCS3), developed by DBHDS in conjunction with the CSBs, to

comply with federal and state reporting requirements. The CCS3 provides a mechanism to collect data for comparisons and trends on the numbers and characteristics of individuals receiving substance abuse services from CSBs. Data are collected and extracted into the CCS3 system by CSBs at admission and discharge. In addition, DBHDS also collects arrest data from the Virginia State Police, and wage and employment data from the Virginia Employment Commission (VEC). This assortment of data supports reporting in the required NOMs domains.

The Department of Corrections (DOC) is organized into two primary operating divisions: *Community Corrections* and *Operations.* In the past, DOC had a separate information management system for each division. Currently, however, DOC is in the process of implementing one comprehensive information management system, VirginiaCORIS. The Division of Community Corrections has already begun using the new system. Implementation for the Division of Operations will begin during the first quarter of 2010. Once VirginiaCORIS is fully executed, data collection fields for most of the outcome measures will be available. At this time, however, all substance abuse services data are not readily available for past years since they are stored mainly in paper files or in legacy systems.

The Division of Community Corrections substance abuse services are largely provided by CSBs. The Division of Operations substance abuse services are provided through facility-based therapeutic communities. These services are tracked through CADMUS, an online electronic data collection system established to collect information on participants receiving substance abuse services. CADMUS has proved beneficial for tracking inmate progress and program completion information. The system also collects some assessment information but screening information is not available.

In addition, DOC utilizes COMPAS (Correctional Offender Management Profiling for Alternative Sanctions) a computerized risk and needs assessment software suite at some sites. Eventually COMPAS will interface with VirginiaCORIS, which will provide data infrastructure to support collecting screening and assessment information, as well as tracking outcomes for inmates and supervisees who participate in substance abuse treatment.

The Department of Criminal Justice Services (DCJS) collaborates with the State Compensation Board (SCB), which collects data for the Local Inmate Data System (LIDS). DCJS utilizes the data to forecast and plan facilities for the jail population, as a part of its offender population forecast.

Department of Juvenile Justice (DJJ) utilizes the Juvenile Tracking System (JTS), which contains information on juvenile intakes, detention placements, and commitments to juvenile correctional centers (JCCs) or other incarceration alternatives, as well as probation placements for all localities within Virginia.

Currently DJJ is able to track juveniles who have been committed to a JCC and who are identified as needing substance abuse treatment. The parole officer, through the discharge evaluation, reports data on abstinence from drug and alcohol use based on self-report of the

juvenile offender, employment/education status, and housing stability during the participant's parole period.

DJJ also provides an annual recidivism analysis on re-arrest, re-conviction, and re-incarceration. DJJ collects all instances of petitioned delinquent intakes and adult arrests from criminal activity (for which a juvenile has been adjudicated guilty) that occur after a juvenile is released from a JCC. The information for juveniles who have been identified as needing treatment for substance abuse while at a JCC can be extracted from data on the population as a whole. DJJ has established a collaborative relationship with the Virginia State Police, Virginia Sentencing Commission, Department of Corrections, and the State Compensation Board, which provides adult and arrest conviction data for juveniles who had an identified substance abuse treatment issue while incarcerated at a JCC. The data that is collected allows for the examination of juvenile re-offending patterns in a standardized manner.

Currently service capacity data is collected via the active service lists maintained at each JCC. Data on the number of current active treatment slots at each JCC, as well as a count of juveniles on the waiting list, is available.

Outcome Measures

As a process to accomplish the goals recommended by the JLARC report, the work group utilized a strategy of mapping implementation planning and developing a logic model to provide a graphic presentation. Its work was facilitated by staff from the Fairfax County Department of Systems Management for Human Services. Each participating agency identified domains in which their agency is currently able to measure and collect outcome data. The following table, based on the NOMs domains, indicates which agencies are able to report data for each domain.

NATIONAL OUTCOME MEASURES (NOMS)

DOMAIN	OUTCOME	MEASURES	AGENCY
Reduce Morbidity	Increase abstinence from drug and alcohol use	Reduction in/no change in frequency of use at date of last service (contact) compared to date of initial service (contact)	DBHDS, DOC, DJJ, VASAP
Employment/Education	Maintain or enhance employment /education	Increase in/no change in number of employed or in school at date of last service compared to initial service	DBHDS, DOC, DJJ, VASAP
Crime and Criminal Justice	Decrease Criminal Justice involvement	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last services	DBHDS, DOC, DJJ,, VASAP
Stability in Housing	Decrease incidence of homelessness	Increase in/no change in number of participants in stable housing situation from date of first service to date of last service; same residence 75% of the time being supervised (DJJ)	DBHDS, DOC, DJJ
Access/Capacity	Increase access to appropriate services	Unduplicated count of participants served at appropriate level of care; numbers served as compared to those in need	DBHDS, DOC, VASAP
Retention	Increase retention in appropriate levels of care	Length of stay and transition in appropriate levels of care	DBHDS, DOC , VASAP
Social Supports	Increase social supports	Increase in number of Recovery Centers, peer-to-peer mentoring services, appropriate social/entertainment venues	DBHDS, DOC
Perception of Care	Ensure satisfaction with services	Unduplicated count of participants that indicate satisfaction or increased satisfaction with services during treatment	DBHDS, DOC

Identified Barriers and Gaps in Data Collection and Outcomes

Barriers:

1. Inability to share information across state, local, and privately operated agencies.
2. Lack of a centralized agency or entity to collect data sets and follow through with evaluations.
3. Lack of common or unique identifiers for consumers across agencies.
4. Resource limitations (no directed allocations for data collection and evaluation).
5. Integrated system to identify services provided to consumers receiving services across agencies.
6. Lack of consistent baseline data about prevalence of student risk behavior.

Staff participating in the work group provided input regarding outcome measures that they considered feasible for their agencies to report. The unique context in which each agency provides services requires data to be collected through a variety of methods. Agencies vary in the extent to which they can calculate the NOMs based on individual client data rather than comparisons in the aggregate.

It is clear that many individuals receive services from more than one agency providing treatment services. The ability to track individuals across the various information systems would enhance efforts to gauge the overall effectiveness of services and would improve treatment planning, continuity of care, and planning for systemic development for treatment of substance use disorders. Before this can be accomplished, however, significant challenges must be overcome related to communicating across multiple IT platforms and constructing unique client identifiers that can link individual records. These tasks are complicated by federal laws protecting the confidentiality of individuals receiving substance abuse treatment services.

Additionally, prevention activities funded by the SAPT-BG also have an established set of NOMs. By statute, SAPT-BG funds can only support prevention activities targeting individuals who are not yet in need of substance abuse treatment. While the project—as defined by the SASC mission to address the concerns of the JLARC study—focuses on treatment outcomes, prevention data sets do not fit effectively into the language of treatment outcomes, although prevention is recognized as an important part of the continuum of care. The consideration of prevention data, which focuses on community-level comparisons, in conjunction with treatment outcome data, will provide a more complete picture of the impact of services. However, there is a lack of consistent data about youth risk behavior, as school systems may elect not to participate in "statewide" surveys. This lack of consistent data collected at regular intervals makes measuring progress or developing problems among youth difficult.

Summary

The Services Outcomes Work Group of the Substance Abuse Services Council is in agreement to:

- Refine implementation of outcome measurement and review its status annually, and work to identify and develop other approaches to measuring treatment effectiveness that acknowledge the life-long, chronic nature of substance use disorders.

- Use the federal National Outcomes Measures (NOMs) to provide basic data structure (domains and specific measures) for community-based treatment. The NOMs definitions can be adjusted for specific contexts (e.g., incarcerated populations).

- Recognize that substance use disorders are chronic, relapsing, and characterized by multiple cycles of treatment-relapse-treatment through which an individual can reach and maintain a state of recovery. In this context, the effective measurement of outcomes requires a long view that can track individuals across episodes of treatment and involvement with various agencies and services providers. Tracking across episodes provides a more accurate assessment of the benefits versus the costs of interventions. By identifying utilization patterns, tracking can improve cost-effectiveness.

- Recommend that Senate Joint Resolution Study 318 (The Study of Models and Strategies for the Prevention and Treatment of Substance Abuse in the Commonwealth) support continuing the SASC Services Outcomes Work groupto

    - Develop NOMs, including agency ability to utilize and link existing systems that collect outcome data, even though each agency has already established its own system for creating the unique individual identifiers necessary to track individual outcomes.
    - Support the development of measures of program effectiveness that take into account the life-long, chronic nature of substance use disorders.
    - Recommend that DBHDS, DJJ and DOC prioritize development of a "data warehouse," infrastructure, in collaboration with the State Compensation Board (which collects information about jail inmates), that would store, manage and use commonly collected data about shared consumers/inmates/residents/ supervisees.
    - Strengthen the legal authority of DBHDS to collect consumer data from CSBs.
    - Explore ways to integrate prevention outcome data to provide another perspective on the impact of services on communities over time.
    - Identify system gaps and barriers, and prioritize strategies to address them, including human resources, hardware and software necessary to build an information technology system that can support these goals, and provide cost estimates of implementing such a system.

To support these requests, the SASC also requests that SJR 318 strengthen the mandate of DBHDS to collect data from CSBs and provide seed funding, when available, to address some of the gaps and barriers to developing a systemic approach to program evaluation across agencies.

APPENDIX A

SERVICES OUTCOME WORK GROUP LOGIC MODEL

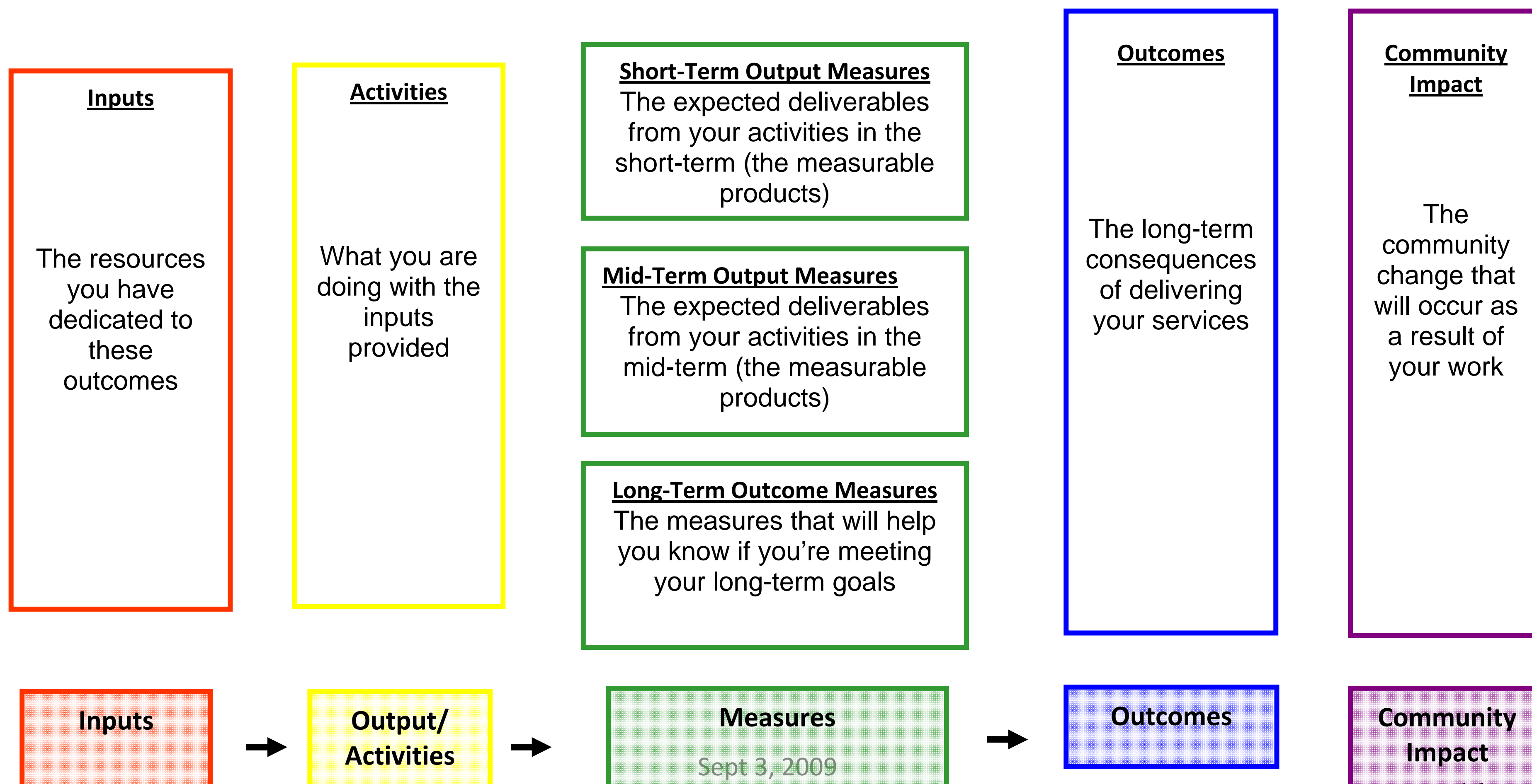
Substance Abuse Services Council Work group Logic Model

SASC Work group Goals

Establish common measures capturing participants outcomes after treatment * DOE provides intervention and prevention services-no treatment

Determine where to obtain outcome information needed across agencies

Design a process to collect the information from agencies on an ongoing basis



§ 2.2-2696 Substance Abuse Services Council

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

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

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

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

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

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

F. The duties of the Council shall be:

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

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

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

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

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

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

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

2.2-2697 Review of state agency substance abuse treatment programs

A. On or before December 1, 2005, the Council shall forward to the Governor and the General Assembly a Comprehensive Interagency State Plan identifying for each agency in state government (i) the substance abuse treatment program the agency administers; (ii) the program's objectives, including outcome measures for each program objective; (iii) program actions to achieve the objectives; (iv) the costs necessary to implement the program actions; and (v) an estimate of the extent these programs have met demand for substance abuse treatment services in the Commonwealth. The Council shall develop specific criteria for outcome data collection for all affected agencies, including a comparison of the extent to which the existing outcome measures address applicable federally mandated outcome measures and an identification of common outcome measures across agencies and programs. The plan shall also include an assessment of each agency's capacity to collect, analyze, and report the information required by subsection B.

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

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

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

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