2011 SUBSTANCE ABUSE SERVICES COUNCIL RESPONSE TO CODE OF VIRGINIA §2.2-2697.B. –

COMPREHENSIVE INTERAGENCY STATE PLAN

TO THE GOVERNOR AND THE GENERAL ASSEMBLY

DECEMBER 9, 2011

COMMONWEALTH of VIRGINIA

Substance Abuse Services Council
P. O. Box 1797
Richmond, Virginia 23218-1797

December 9, 2011

To: The Honorable Robert F. McDonnell, Governor

and

Members, Virginia General Assembly

The 2004 Session of the General Assembly amended §2.2-2697.B. of the *Code of Virginia*, to direct the Substance Abuse Services Council to collect information about the impact and cost of substance abuse treatment provided by public agencies in the Commonwealth. In accordance with that language, please find attached the *2011 Substance Abuse Services Council Response to Code of Virginia §2.2-2697.B. - Comprehensive Interagency State Plan.*

Sincerely,

William Williams

William Williams
Vice Chair

Enclosure

Cc: The Honorable William A. Hazel, Jr., M.D.
The Honorable Marla Graff Decker
James W. Stewart, III
Harold Clarke

SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO
CODE OF VIRGINIA 2.2-2697.B.
FOR 2011

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SUBSTANCE ABUSE SERVICES COUNCIL
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FOR 2011

EXECUTIVE SUMMARY

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department Behavioral Health and Developmental Services (DBHDS); the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior.

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)
DBHDS provides funding and oversight to 40 community services boards which provide publicly funded substance abuse treatment services to specific jurisdictions. The following information reflects these services.

- Treatment services expenditures totaled $147,915,747 for FY 2010.
    - This overall expenditure is an approximate sum of the following expenditure components:

Federal	$ 42,873,676
State	$ 46,678,876
Local	$ 38,310,365
Consumer fees or third party payers (e.g., insurance)	$ 14,105,100
Other	$ 5,947,730

    - A total of 38,661 individuals received substance abuse treatment services supported by this funding.

A variety of actions could be undertaken to improve program effectiveness. Because community services boards are limited in the array of services and capacity, consumers of

substance abuse treatment services may not have access to the intensity or duration of care that would be the most clinically appropriate, and may receive less intensive care (and thus, less effective). Evidence-based practices are not always available. Addressing these issues would require significant investments in workforce development of current and future professionals working in publicly-funded substance abuse treatment programs.

DEPARTMENT OF JUVENILE JUSTICE (DJJ)

DJJ institutions provide substance abuse treatment services at five of its six juvenile correctional centers (JCCs), excluding the Reception and Diagnostic Center (RDC), to residents meeting appropriate criteria. The following information reflects these services:

JCC Programs:

Substance Abuse Services Expenditures:	$1,039,012
Total Division Expenditures:	$76,455,205

In FY 2010, 88% of the 608 residents admitted to JCCs had a mandatory or recommended substance abuse treatment need.

DJJ institutions should continue to implement evidence-based programming: Cannabis Youth Treatment (MET/CBT 5 & 7), individualized treatment plans for residents with co-occurring disorders, and Residential Substance Abuse Treatment (RSAT) program (gender-specific treatment programming for female residents). Re-entry systems and collaboration with community resources and families should continue to be strengthened to ensure smooth transition of residents to the community.

DEPARTMENT OF CORRECTIONS (DOC)

DOC provides a tiered substance abuse services approach to address varying offender treatment needs based on the severity of the problem. DOC is organized into two (2) primary operating divisions: Community Corrections (DCC) and Operations (DO). DOC attempts to match the offender to the appropriate treatment services based upon criminogenic factors and risk to recidivate.

The Division of Community Corrections (DCC) encompasses adult probation and parole services, detention and diversion centers. There are approximately 58,000 offenders active under community supervision statewide. The Division of Operations (DOC-DO) has over 38,000 offenders in adult facilities and jails. Recent assessment results indicate that at least 70% of DOC's offender population may have a need for some level of substance abuse treatment.

DCC contracts for many of its treatment services with community service boards (CSBs) and private vendors. Most probation and parole districts (43), detention centers (3) and diversion centers (4) have a memorandum of agreement with their respective CSBs for substance abuse treatment services.

In 1998, Virginia's General Assembly passed House Bill 664 and Senate Bill 317 enacting the Drug Offender Screening, Assessment, and Treatment (DSAT) Initiative to reduce substance

abuse and criminal behavior among offenders. DSAT attempts to enhance the identification of substance-abusing offenders and their treatment needs and improve the delivery of substance abuse treatment services within the criminal justice system. However, cuts in funding since 2001 have hampered the implementation of DSAT. DOC is re-examining protocols and developing alternative strategies to maximize the use of remaining resources.

The DOC-DCC is engaged in the process of introducing and implementing evidence-based practices (EBPs) in each of the probation Districts and detention/diversion centers. EBPs have been shown to be effective in reducing recidivism through extensive research and meta-analysis. The process for integrating EBPs into a District or Center takes many months. A District and/or Detention/Diversion Center will undergo EBP training in the following areas: Introduction to EBPs, Deportment, Motivational Interviewing (MI), Risk/Needs Assessment, Case Planning, Treatment Referral, and EBP Fidelity. To date 17 P&P Districts, three Diversion Centers and one Detention Center have received the Introduction, Deportment, MI and Case Planning trainings.

As part of EBP integration, the DOC reviewed the Matrix Model (a registered evidence-based substance abuse program) and has chosen the model as its primary outpatient substance abuse intervention. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. A review is underway to determine the feasibility of offering the initial phase of treatment in the correctional centers followed by the relapse prevention and family component taking place in the community through probation & parole districts.

As the DOC-DO continues to review substance abuse program for EBP fidelity, there are currently five (5) programming tiers to DOC institution-based substance abuse related treatment and services: Orientation; Psycho-Education (to be eliminated); Substance Abuse Counseling: Support Programs, such as Alcohol Anonymous and Narcotics Anonymous; and the Cognitive Therapeutic Community (CTC) Programs. The CTC program is an evidence-based treatment model designed to address substance addiction, criminal thinking and anti-social behaviors. It is an evidence-based institutional substance abuse treatment program. There are approximately 1,450 CTC beds.

SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO CODE OF VIRGINIA 2.2-2697.B.
COMPREHENSIVE INTERAGENCY STATE PLAN FOR 2011

I. INTRODUCTION

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

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

In 2008, the Joint Legislative Audit and Review Commission (JLARC) published a study, *Mitigating the Cost of Substance Abuse in Virginia*, which included recommendations for the Council's role in establishing common outcome measures and designing a process that would utilize shared information across agencies. To address this recommendation, the Council established a workgroup which published its findings, including recommendations, in the Council's 2009 annual report. The Council's report included input from six member agencies that were all involved to some degree in the funding or provision of treatment or prevention services and identified barriers to utilizing a common set of outcome measures, as well as gaps in data collection. The report also made recommendations to the then active Senate Joint Resolution 318 (2009) (The Study of Models and Strategies for the Prevention and Treatment of Substance Abuse in the Commonwealth) concerning support for member agencies to

pursue integrated data among agencies. However, no financial support for this endeavor was made available.

The 2005 Substance Abuse Services Council report responded to Section A of the *Code* and included estimates of the large unmet need for treatment and recommendations to address this unmet need. As required, this 2011 report responds to Section B and includes a description of the substance abuse treatment services provided by state agencies in Virginia. As used in this document, treatment is defined narrowly as those services directed toward individuals with identified substance abuse and dependence disorders, and does not include prevention services for which other evaluation methodologies exist.

Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department Behavioral Health and Developmental Services (DBHDS); the Department of Juvenile Justice (DJJ); and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior. This section of the report provides the statistical information for each agency required by §2.2-2697.

II. PROGRAM REVIEWS

Department of Behavioral Health and Developmental Services

The Department of Behavioral Health and Developmental Services provides funding and oversight to 40 community services boards, entities of local government that provide publicly funded substance abuse treatment services to specific jurisdictions. The following information reflects these services.

(i) the amount of funding expended under the program for the prior fiscal year (FY 2009);

Treatment services expenditures totaled $147,915,747 for FY 2010.

This overall expenditure is an approximate sum of the following expenditure components:

Federal	$ 42,873,676
State	$ 46,678,876
Local	$ 38,310,365
Consumer fees or third party payers (e.g., insurance)	$ 14,105,100
Other	$ 5,947,730

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

A total of 38,661 individuals received substance abuse treatment services supported by this funding.

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

The Substance Abuse and Mental Health Services Administration, the federal agency responsible for administering the Substance Abuse Prevention and Treatment Block Grant (the bulk of federal funds used by states to support community-based substance abuse services), requires states to collect and report specific outcome measures. DBHDS has been working with community services boards for several years to establish data collection and information management processes to collect this information. The 40 CSBs utilize a variety of different IT platforms which has made standardization of data collection more difficult. One significant issue has been the lack of financial support for IT development in CSBs which has, in some cases, affected the quality of the data. In addition, CSBs vary considerably in the array of services that they offer, therefore, it is not always possible to provide the type or intensity of care needed. DBHDS 2011 strategic plan, *Creating Opportunities for People Who Need Substance Abuse Services*, provides a description of these service gaps and makes recommendations about how to address them.

A majority of CSBs have obtained IT platforms capable of supporting an EHR and a number of them have begun implementing EHR functionalities. Recently the Data Management Committee of the Virginia Association of Community Services Boards began work with DBHDS on a process to review the current data structure across systems and recommend improvements. This group prefaced an outline of its four-phase plan by observing, "A significant restraint in CSBs migrating to a cleaner data sharing model is the wide disparity of CSB MIS systems. The team did not envision unpacking the current system. It believes the best way forward is to leverage Federal meaningful use mandates around EHR functionality to ultimately get all CSBs at the same baseline for EHR data collection and sharing." The group estimates that, given the current status of EHR implementation in Virginia, full implementation may take 4-5 years. (VACSB Data Management Committee, Report of Data Roadmap Work Group, 7/22/2011.)

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

While data is available regarding the program costs, the unmet evaluation needs outlined above do not allow for analysis of program success in meeting objectives.

(v) how effectiveness could be improved;

DBHDS' strategic plan, *Creating Opportunities for People Who Need Substance Abuse Services,* proposes enhancing access to a consistent array of substance abuse services across Virginia by expanding statewide capacity and filling identified gaps in the array of substance abuse service modalities.

Based on a statewide assessment, additional investment of resources is needed in the following types of substance abuse treatment and support services:

medication assisted treatment
detoxification services

uniform screening and assessment for substance abuse
intensive outpatient services
substance abuse case management
peer support services
DRS employment counselors
intensive coordinated care for pregnant and postpartum women
supportive living capability
residential services for pregnant women and women with children

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

The adverse consequences of substance abuse in 2006 costs the state and localities between $359 million and $1.3 billion (JLARC, 2008, p. 39). Virginia investment in the substance abuse programs evaluated . . . appears to frequently reduce costs to the State and localities as well as improve public safety and economic benefits (JLARC, 2008, p. 129).

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

The JLARC report concludes, "The State could then consider expanding the availability of services to populations that are currently unserved or underserved, focusing on offenders due to their high impact on State and local budgets as well as public safety. (JLARC, 2008, p. 129).

Department of Juvenile Justice

The Department of Juvenile Justice provides substance abuse treatment services at five of its six juvenile correctional centers (JCCs), excluding the Reception and Diagnostic Center (RDC), for residents meeting appropriate criteria. The following information reflects these services.

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(i) the amount of funding expended under the program for the prior fiscal year (FY2010);

JCC Programs:

Substance Abuse Services Expenditures:	$1,039,012
Total Division Expenditures:	$76,455,205

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

In FY 2010, eighty-eight percent (88%) of the 608 residents admitted to JCC's had a mandatory (38%) or recommended (50%) substance abuse treatment need.

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

Data are not available regarding subsequent substance use by residents treated for substance abuse. However, rearrest and reconviction rates (for any offense; not limited to substance-related offenses) are available for these youth. In order to track reoffending for 12 months

after release, as well as the time necessary for court proceedings, the most recent rearrest rates are for JCC releases in FY 2009, and the most recent reconviction rates are for JCC releases in FY 2008.

The 12-month rearrest rate for females released from JCCs in FY 2009 who participated in the Residential Substance Abuse Treatment (RSAT) Program was 32.4%. For female participants released in FY 2008, the reconviction rate was 21.4%.

The 12-month rearrest rate for residents with a substance abuse treatment need released from JCCs in FY 2009 was 50.8%. For residents with a substance abuse treatment need released in FY 2008, the reconviction rate was 39.1%.

The Department anticipates providing additional information concerning program objectives in future reports.

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

Information to address this issue is not available.

(v) how effectiveness could be improved;

DJJ institutions should continue to implement evidence-based programming: Cannabis Youth Treatment (MET / CBT 5 & 7); individualized treatment plans for residents with co-occurring disorders, and RSAT (gender-specific treatment programming for female residents). Re-entry systems and collaboration with community resources and families should continue to be strengthened to ensure smooth transition of residents to the community.

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

Information to address this issue is not available.

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

Information to address this issue is not available.

Department of Corrections

The Department of Corrections (DOC) provides a tiered substance abuse services approach to address varying offender treatment needs based on the severity of the problem. DOC is organized into two (2) primary operating divisions: Community Corrections (DCC) and Operations (DO). The Division of Community Corrections (DOC-DCC) encompasses adult probation and parole services, detention and diversion centers. There are approximately 58,000 offenders active under community supervision statewide. The Division of Operations (DOC-DO) has over 38,000 offenders in adult facilities and jails. Recent assessment results indicate that at least 70% of DOC's offender population may have a need for some level of substance abuse treatment.

Current Screening and Assessment Status

In 1998, Virginia's General Assembly passed House Bill 664 and Senate Bill 317 enacting the Drug Offender Screening, Assessment, and Treatment (DSAT) Initiative to reduce substance abuse and criminal behavior among offenders. DSAT attempts to enhance the identification of substance-abusing offenders and their treatment needs and improve the delivery of substance abuse treatment services within the criminal justice system. However, cuts in funding since 2001 have hampered the implementation of DSAT. DOC is re-examining protocols and developing alternative strategies to maximize the use of remaining resources.

The Division of Community Corrections staff use the Simple Screening Instrument (SSI) to identify offenders having substance abuse issues. Most recently the DOC has incorporated the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) in districts and institutions to screen offenders to ascertain the severity of substance use and risk to relapse. COMPAS is a seamless, integrated and web-based software system for offender screening, assessment, classification and case management. It is a state-of-the-art assessment system designed to identify the risk and needs of offenders. Through the identification of certain criminogenic factors, one being substance abuse, DOC staff are able to develop a more accurate case supervision plan that meets the treatment needs of the offender. Of the 30,963 assessments done during FY 2010, 70% have scores that indicate a possible substance abuse treatment need. COMPAS has now been interfaced with CORIS, our new offender management system.

Offenders whose scores reflect a high probability of substance abuse are referred for further assessment and referral to services. In addition, the COMPAS suite contains a more comprehensive assessment instrument, the Texas Christian University (TCU) Drug Screen. A score of 3 or higher is indicative of a severe drug related problem requiring substance abuse intervention.

In some instances an assessment using the Addiction Severity Index (ASI) is also being completed. Those individuals deemed to have a serious substance abuse problem are referred to the appropriate treatment. The chart below represents the many types of alcohol and drug treatment modalities in to which an offender under supervision can be referred.

The DOC-DCC is engaged in the process of introducing and implementing evidence-based practices (EBPs) in each of the probation Districts and detention/diversion centers. EBPs have been shown to be effective in reducing recidivism through extensive research and meta-

analysis. The process for integrating EBPs into a District or Center takes many months. A District and/or Detention/Diversion Center will undergo EBP training in the following areas: Introduction to EBPs, Deportment, Motivational Interviewing (MI), Risk/Needs Assessment, Case Planning, Treatment Referral, and EBP Fidelity. To date 17 P&P Districts, three Diversion Centers and one Detention Center have received the Introduction, Deportment, MI and Case Planning trainings.

As part of EBP integration, the DOC reviewed the Matrix Model (a registered evidence-based substance abuse program) and has chosen the model as its primary outpatient substance abuse intervention. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. A review is underway to determine the feasibility of offering the initial phase of treatment in the correctional centers followed by the relapse prevention and family component taking place in the community through probation & parole districts.

As the DOC-DO continues to review substance abuse program for EBP fidelity, there are currently five (5) programming tiers to DOC institution-based substance abuse related treatment and services: Orientation; Psycho-Education (to be eliminated); Substance Abuse Counseling: Support Programs, such as Alcohol Anonymous and Narcotics Anonymous; and the Cognitive Therapeutic Community (CTC) Programs. The CTC program is an evidence-based treatment model designed to address substance addiction, criminal thinking and anti-social behaviors. It is an evidence-based institutional substance abuse treatment program. There are approximately 1,450 CTC beds.

Currently the referral process has just begun to take the results of COMPAS assessment along with other file information into consideration when referring inmates to the Therapeutic Communities (TCs) for treatment. Once the individual arrives at the TC program a more thorough clinical assessment using the ASI and Texas Christian University (TCU) instruments is performed and a final determination is made regarding the need for substance abuse treatment. Data on TC participants is entered into CADMUS, an online electronic data collection system that was implemented in 2008. This system has proven to be very beneficial for tracking participants' progress and completion information.

At this time, both the DOC-Division of Operations (DO) and DCC have begun entering comprehensive electronic data into a new Offender Management System, Virginia CORIS. This system, once fully implemented, will enable the DOC to generate numerous custom reports and to capture valuable data to provide accurate outcome measures.

<u>Current Outcomes Tracking Capabilities</u>

As CORIS and COMPAS continue to be integrated and implemented at DOC, a comprehensive data collection system will enable DOC to monitor offenders from the initial screening process through the completion of treatment. In addition, the tracking of post-release outcomes will improve as CORIS and COMPAS become fully operational in all institutions and districts.

DOC's capability to track the National Outcomes Measures (NOMS) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA is summarized below:

1. *DOMAIN:* Abstinence
   OUTCOME: Decreased use of alcohol and other drugs (AOD)
   TREATMENT MEASURE: Percentage of program completers who remain alcohol and drug free as measured with results of random drug testing.
   HOW MEASURED/BARRIERS: Drug testing is done for Community Corrections offenders and prison inmates. For the probation and parole offenders random testing is performed at intake and randomly thereafter, but the results are not kept in electronic format. For prison inmates, 5% of the inmates are periodically subjected to random drug tests at each facility. In the TCs the participants are randomly tested at a higher percentage. Drug test results are not currently entered into CADMUS and, therefore, data is not available at the participant level. Post release testing occurs at random (see note above for Community Corrections offenders) for as long as the individual remains under supervision.
   POST CORIS IMPLEMENTATION: As accurate drug screening data becomes available, DOC will measure abstinence through the results of random drug screens and breathalyzers. Furthermore, percentages of those actually completing treatment should be more readily available as data is entered. As of May 2009, drug screening information began being entered into CORIS for DOC-DCC. As of 9/1/2010, Community Corrections has conducted 105,995 drug screens, with 85,910 testing negative (81.05 %) and 20,085 testing positive (18.95 %).

2. *DOMAIN:* Employment/Education
   OUTCOMES: (A) Retain employment; (B) Increase employment; and (C) Obtain at least a GED.
   TREATMENT MEASURES: (A) Percentage of program completers employed as of status check date using data from the Virginia Employment Commission (VEC); (B) Percentage of program completers that have increased employment as measured by quarterly or semi-annual follow-ups with VEC wage data; (C) Percentage of program participants who increased their educational level to GED or above while in the treatment program or within 12 months post completion of the treatment program.
   HOW MEASURED/BARRIERS: Currently, DOC is developing a plan to incorporate data from the Department of Correctional Education (DCE) into the offender management system.
   POST CORIS IMPLEMENTATION: Education history and employment history information fields have begun to be entered into CORIS. Employment data from VEC can be obtained if an accurate social security number is available.

3. *DOMAIN:* Crime/Criminal Justice
   OUTCOMES: Decreased criminal justice involvement
   TREATMENT MEASURES: Percentage of program participants who are recidivists within one year of successful program completion.

HOW MEASURED/BARRIERS: The term recidivism can have different meanings: re-arrest, reconviction, or recommitment. While re-arrest data can be obtained from the Virginia State Police System (VCIN) and re-arrest and reconviction data can be obtained from the Virginia Courts Automated Information System (CAIS) or the jails' Local Inmate Data System (LIDS), these systems currently do not exchange recidivists' information electronically with DOC's systems. DOC does track the program completion information on TC participants in CADMUS, and is able to do recidivism status checks by merging of several different data files to obtain a one-year recommitment rate. There were 682 program participants released from a VA DOC TCs during 2008. The one-year recommitment rate for these participants as of the status check date in early 2010 was 7.33% overall (2.2% for females and 9.16% for males.)
POST CORIS IMPLEMENTATION: Program completion information will be available electronically through CORIS as data continues to be entered, facilitating the determination of recidivism rates, In order to facilitate obtaining re-arrest and reconviction data, it will be necessary to exchange data electronically with other agencies

4. *DOMAIN:* Stability in Housing
OUTCOMES: Increased stability in housing
TREATMENT MEASURES: Percentage of program participants who maintain stable housing while in the program and one-year post release.
HOW MEASURED/BARRIERS: Housing information for past and current program participants in Community Corrections is being incorporated into.
POST CORIS IMPLEMENTATION: Program completion information will be available electronically as well as address information. CORIS also has a 'homeless' field that could be used to determine how many of the program participants have that housing status. In addition, DOC is looking to expand its Community Residential Placements (CRP) in order to increase the availability of stable housing.

5. *DOMAIN:* Capacity and Access
OUTCOMES: Increase access to services and maintain capacity
TREATMENT MEASURES: (A) Percentage of Community Corrections offenders who are determined to need treatment services that actually receive access to services; (B) Percentage of prison inmates who are determined to need treatment services who actually participate in the TC; and (C) Percentage of DOC allotted treatment beds that are filled based on average daily population figures.
HOW MEASURED/BARRIERS: Implementation of the COMPAS screening and assessment instrument will enhance DOC's ability to identify those individuals needing substance abuse treatment. CADMUS contains data that will allow the determination of bed utilization rates data is not currently available to track the number of offenders needing TC placement who were given a chance to participate. As of August 2010 the bed utilization rate at the TCs was 103%.
POST CORIS IMPLEMENTATION: DOC is in the process of joining assessment information with program participation data at the offender level and planning for a

collaborative data collection effort with third party treatment providers to obtain the information for this measure.

6. *DOMAIN:* Retention
OUTCOMES: Increased percentage of program participants who successfully complete the treatment programs
TREATMENT MEASURES: Percentage of substance abuse treatment program participants who successfully complete the program.
HOW MEASURED/BARRIERS: Past analyses have indicated that approximately 80% of offenders who begin the TC program complete it. This figure has been promising because the TC treatment modality is one that is known to have lower retention rates.
POST CORIS IMPLEMENTATION: DOC is entering program completion fields CORIS. CADMUS will eventually be integrated into CORIS will provide data on this measure.

7. *DOMAIN:* Social Connectedness
OUTCOMES: Increased social supports/social connectedness
TREATMENT MEASURES: Percentage of program completers who participate in recovery support activities and self help organizations.
HOW MEASURED/BARRIERS: Data on this measure is not currently available
POST CORIS IMPLEMENTATION: At that point consideration could be given to measuring social supports.

8. *DOMAIN:* Perception of Care
OUTCOMES: Positive Perception of Care
TREATMENT MEASURES: Percentage of program completers reporting a positive perception of care.
HOW MEASURED/BARRIERS: Data on this measure is currently collected by some programs. Community Corrections has begun to conduct substance abuse treatment provider fidelity reviews, including feedback from the client on program perception.
POST CORIS IMPLEMENTATION: DOC could consider the introduction of a policy requiring all substance abuse treatment programs to survey participants in order to provide information on this domain.

III. Overviews of Treatment Services Provided by State Agencies

Department of Behavioral Health and Developmental Services

Descriptions of substance abuse treatment services provided by CSBs are as follows:

- ***Emergency Services*** – These services are unscheduled services available 24 hours per day, seven days per week, to provide crisis intervention, stabilization and referral assistance either over the telephone or face-to-face. They may include jail interventions and pre-admission screenings.
- ***Inpatient Services*** – These services provide short-term, intensive psychiatric treatment or substance abuse treatment, except for detoxification, in local hospitals or d*etoxification Services* using medication under the supervision of medical personnel in local hospitals or other 24-hour-per-day-care facilities to systemically eliminate or reduce effects of alcohol or other drugs in the body.
- ***Outpatient and Case Management Services*** - These services are generally provided to an individual, group or family on an hourly basis in a clinic or similar facility. They may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and medication services. Intensive substance abuse outpatient services are included in this category, are generally provided over a four to 12 week period, and include multiple group therapy sessions plus individual and family therapy, consumer monitoring and case management.
- ***Methadone Detoxification Services and Opioid Replacement Therapy Services –*** These services combine outpatient treatment with the administering or dispensing of synthetic narcotics approved by the federal Food and Drug Administration for the purpose of replacing use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.
- ***Day Support Services –*** These services provide structured programs of treatment in clusters of two or more continuous hours per day to groups or individuals in a non-residential setting.
- ***Highly Intensive Residential Services –*** These services provide up to seven days of detoxification in nonmedical settings that systematically reduces or eliminates the effects of alcohol or other drugs in the body, returning the person to a drug-free state. Physician services are available.
- ***Intensive Residential Services*** -These services provide substance abuse rehabilitation services up to 90 days and include stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.
- ***Jail-Based Habilitation Services*** –This substance abuse psychosocial therapeutic community provides intensive daily group counseling, individual therapy, psycho-education services, self-help meetings, discharge planning, pre-employment and community preparation services in a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Normally the inmates served by this program are housed separately within the jail. The expected length of stay is 90 days.

Department of Juvenile Justice
DJJ institutions provide substance abuse treatment services at five of its six juvenile correctional centers, excluding the Reception and Diagnostic Center (RDC), to residents meeting appropriate criteria. When residents arrive at RDC they receive a series of evaluations, psychological tests, and substance abuse screening. Subsequent to testing, a treatment and evaluation team meets and makes initial treatment recommendations and assigns an appropriate substance abuse treatment need (mandatory, recommended, or applicable) prior to residents being transferred to a correctional center.

Substance abuse treatment services at the five correctional centers (Beaumont, Bon Air, Culpeper, Hanover, and Oak Ridge) are administered through the Cannabis Youth Treatment Program (also known as MET / CBT 5 & 7). This program is evidence-based with emphasis on motivation to change, goal setting, drug and alcohol refusal skills, relapse prevention, problem solving, anger awareness and control, effective communication, addiction/craving coping skills, depression management, and managing thoughts about drug use. Individualized treatment planning also allows the Behavioral Services Unit (BSU) to administer therapies for residents with co-occurring disorders and/or other debilitating clinical issues via individual, group, or family therapy. Treatment course for residents in this program generally ranges from three to four months.

Generally, residents assigned to substance abuse treatment programs are housed in self-contained units where they receive individual and group therapy with other residents requiring the same program. Currently, Beaumont, Bon Air, and Hanover JCC residents housed in these units also receive aggression replacement training parallel to substance abuse treatment services. While Culpeper residents may also receive aggression replacement training, services are provided in a different format, and not according to their housing unit.

<u>Beaumont JCC</u>
Beaumont has two and a half BSU positions and one BSU clinical supervisor assigned to substance abuse treatment services. The majority of residents with a substance abuse treatment need receive services in a self-contained unit (24 bed maximum capacity) or an eight bed unit, both located within the medium security building. Residents who are unable to enter the medium security building or who are housed in specialized units due to a variety of safety/security and/or other mental health related reasons, are offered substance abuse treatment services either in the general population or within the specialized housing unit when deemed appropriate. Beaumont houses males approximately 17-20 years of age.

<u>Bon Air JCC</u>
Bon Air houses both males and females and has two BSU positions with two BSU clinical supervisors assigned to substance abuse treatment services. The foundation of treatment services for Bon Air's male population is the same as those administered at Beaumont. Females housed at Bon Air receive substance abuse treatment services in a residential program addressing individual, group, and family therapies with emphasis on relapse prevention; psycho-education; emotional, physical, and sexual trauma; grief and loss; co-occurring disorders; and gender-specific issues. Treatment course is generally six months. Bon Air houses males approximately 16 to 17.5 years of age and females of all ages up to 21.

Culpeper JCC
Culpeper has one BSU staff member and one BSU clinical supervisor assigned to substance abuse treatment services. Substance abuse treatment services are provided several times a week with residents culled from the general population. Satellite substance abuse services are provided within specialized housing units as needed. Culpeper houses males aged 18.5-21 years of age.

Hanover JCC
Hanover has one BSU clinical supervisor assigned to provide substance abuse treatment services. Treatment is provided within a self-contained unit. Satellite substance abuse services are provided within specialized housing units as needed. Hanover houses males of all ages up to 21.

Oak Ridge JCC
Oak Ridge serves 40 males of all ages up to 21 with developmental disabilities. Residents who require substance abuse services receive a modified version of MET / CBT 5 & 7 and individualized treatment planning as appropriate. Services are provided by one assigned BSU staff member.

Department of Corrections
DOC provides a tiered substance abuse services approach to address varying offender treatment needs based on the severity of the problem. DOC is organized into two (2) primary operating divisions: Community Corrections (DCC) and Operations (DO).

The Division of Community Corrections (DCC) encompasses adult probation and parole services, detention and diversion centers. There are approximately 58,000 offenders active under community supervision statewide. The Division of Operations has over 38,000 offenders in adult facilities and jails.

DCC contracts for many of its treatment services with Community Service Boards (CSBs) and private vendors. Most Probation and Parole Districts (43), Detention Centers (3) and Diversion Centers (4) have a memorandum of agreement with their respective CSBs for substance abuse treatment services. There are four (4) private contractual vendors providing inpatient substance abuse services, and 21 private non-residential service providers, as well as 41 Memoranda of Agreement with CSBs for outpatient substance abuse treatment services. (*Special note:* The DCC previously funded the Residential Transitional Therapeutic Community (TTC) program that was the final phase of DOC's Therapeutic Community (TC) substance abuse treatment model. Due to budget constraints, the TTCs were eliminated during the latter part of 2008.)

The DCC is in the process of introducing and implementing evidence-based practices (EBP) in each of the probation districts and detention/diversion centers. EBP is a term that is defined as programs that are shown to be effective in reducing recidivism through research and empirical studies.

The process for integrating EBPs into a district or center takes many months. Moreover, each district and center incorporates substance abuse treatment services that adhere to fidelity standards for each EBP. Substance abuse treatment services are monitored for quality assurance through fidelity reviews and audits. The EBP implementation plan is designed to have EBPs in all 43 Districts and Detention and Diversion Centers by 2015

The Division of Operations (DO) had 49 institutions as of the end of FY2008. These institutions included thirty-two (32) major facilities, ten (10) field units, five (5) work centers and one (1) private prison. The types of facilities ranged from maximum security, housing the most serious offenders, to minimum security and work centers housing less violent offenders. The average daily population for FY 2008 was 33,538 offenders. Almost 13,000 offenders were released to the community in FY 2008.

There are five (5) programming tiers to DOC institution-based substance abuse related treatment and services: Orientation; Psycho-Education; Substance Abuse Counseling: Support Programs, such as Alcohol Anonymous and Narcotics Anonymous; and the Therapeutic Community (TC) Programs. The TC program is an evidence-based treatment model designed to address substance addiction, criminal thinking and anti-social behaviors. It is the only evidence-based institutional substance abuse treatment program. There are approximately 1,800 TC beds. While not a substance abuse specific intervention, DOC is currently providing the "Thinking for a Change" cognitive curriculum at the male and female Therapeutic Community programs. The Department is currently training staff at all major institutions to deliver this curriculum to all incoming offenders after they leave their reception center and are transferred to a major institution. This curriculum will assist offenders with substance abuse issues to more realistically view the consequences of their drug/alcohol use and consequently be more amenable to treatment interventions.

In September of 2005, the Department of Corrections submitted the ***Report on Substance Abuse Treatment Programs*** which contained research information on the effectiveness of the Therapeutic Communities and DCC's contractual residential substance abuse treatment programs. The findings from these studies suggest that DOC's substance abuse treatment programs – when properly funded and implemented – are able to reduce recidivism for the substance abusing offender population. A recommitment status check in early 2010 revealed that the return rate for the CY 2008 TC participants was 7.33%.

Alcohol and Other Drug Services Continuum

SERVICES	PROGRAM COMPONENTS	OUTPUTS (OBJECTIVES)	OUTCOMES (GOALS)
Orientation – Introduction to group process and AOD services available.	**Available services in the Department, Program, Facility or Community and service delivery procedures.**	**To recognize the need for treatment. To become aware of substance abuse issues, the services available and how to access these services.**	**Willingness to participate in cognitive interventions and/or treatment.**
Motivational Enhancement groups regarding the stages of change, the development of substance abuse/addiction and the process of cognitive restructuring, abstinence, and recovery. Note: A minimum of 8 to a maximum of 15 participants, more or less must be approved by Unit Head.	1. **Introduction to the Stages of Change and Cognitive Behavioral Interventions** 2. **The Disease Model of Addiction** 3. **The Effects of Addiction and AOD Abuse** 4. **The Effects of AOD Abuse and Addiction on Others** 5. **SA/Addiction and the relationship to criminal behavior and criminal thinking** 6. **Distorted thinking patterns, identifying beliefs, attitudes, feelings, and reframing to make positive behavioral change** 7. **Denial and Defense Mechanisms** 8. **Twelve Step/Peer Support Programs** 9. **Maintaining Abstinence/Recovery tools** 10. **STD/HIV/AIDS Prevention** 11. **Relapse Prevention** 12. **Role Play, Thinking Reports, Journaling** 13. **Discharge/Action/Referral Plan**	**To improve the participant's level of functioning, replace previously held myths and reduce the level of denial. To motivate the individual towards making positive behavioral change by incorporating Motivational Interviewing.**	**Participation to successfully achieve established goals in the required time frame identified in the individualized treatment plan. Initiate abstinence and/or recovery and/or participate in continued treatment. Utilization of learned cognitive behavioral skills to model pro-social behavior and eliminate criminal/AOD use behaviors.**
Outpatient Group Counseling - Managing the abstinence/recovery process. Indeterminate length based on meeting treatment plan goals. Generally one session/week for 16 weeks. Maximum 15 participants.	**Offender subjected to drug testing on a random basis. Group counseling based upon using a validated risk/needs assessment to develop an individualized treatment plan. Participation in an acceptable cognitive behavioral model. Utilization of graduated incentives and sanctions as appropriate.**	**Participation in the treatment planning process. Progress toward achieving the individualized objectives of the treatment plan.**	**Achievement of established goals in the required time frame identified in the individualized treatment plan. Demonstration of the ability to use cognitive restructuring, adaptive coping skills, and problem solving skills through thinking reports and role plays. Maintenance of abstinence and agree to follow discharge plan.**

SERVICES	PROGRAM COMPONENTS	OUTPUTS (OBJECTIVES)	OUTCOMES (GOALS)
Intensive Outpatient Counseling - process groups and/or one on one counseling. Referrals made for individuals requiring more intensive intervention than outpatient counseling. Generally 3-4 sessions/week for a minimum of 20 weeks. Maximum 15 participants.	**Typically (9) hours of service per week to include process groups and one individual counseling session if necessary for a minimum of six (6) weeks.**	**Participation in the treatment planning process. Progress toward achieving the individualized objectives of the treatment plan.**	**Achievement of established goals in the required time frame identified in the individualized treatment plan. Demonstration of the ability to use cognitive restructuring, adaptive coping skills, and problem solving skills through thinking reports and role plays. Maintain abstinence and agree to follow discharge plan.**
Social – Detoxification	**24-hour staff monitored social setting detoxification, initial AOD Motivational Enhancement Education, Group Therapy, Referral, Case Management and Medical intervention if required.**	**3-7 days of safe withdrawal through ongoing triage, evaluation; referral to further treatment and support.**	**Stabilization and detoxification**
Medical – Detoxification	**24-hour -monitored by medical/mental health care professionals. Meds to ease withdrawal**	**3-7 days of withdrawal through ongoing triage, evaluation; referral to treatment and support.**	**Stabilize - agree to follow discharge plan. pursue further treatment and recovery referrals**
Residential Treatment – On Site Primary Care.	**24-hour supervised treatment, group and individual counseling, vocational services, transition services,**	**A minimum of 28 days up to 180 days contingent upon severity of AOD**	**Successfully achieve established goals - commit to discharge/aftercare and recovery plan.**
Recovery/Transitional/Half way House Placement..	**24-hour monitoring, group therapy and individual counseling, 12-step, vocational, occupational educational services and peer recovery support.**	**2-9 months of stabilization and rehabilitation focused on continuing abstinence and long term recovery, obtaining employment and employment retention.**	**Successfully achieve established goals - commit to continuing care and recovery plan.**
Peer Support Groups	**Groups and Centers led by persons in recovery. Includes personal sharing, problem solving, group planning, social support to motivate ongoing behavioral change**	**Support re-entry from the therapeutic community into society utilizing therapeutic community (CTC) tools.**	**Incorporate pro-social behavior and long term recovery while living independently.**
Relapse Prevention/ Aftercare Minimum one (1) session per week; minimum 1 ½ hours per session for a total of 14 - 24 sessions.	**Typically an open group for persons who have completed an AOD treatment program or have relapsed. Identify personal cues and relapse triggers.**	**Remain abstinent, maintain positive peer associations, and develop an individual relapse prevention plan which integrates adaptive coping strategies and problem solving skills.**	**Reinforce to the participant skills necessary to maintain abstinence from AOD, model pro-social behaviors and establish long term recovery.**
Drug/Alcohol Testing	**Unannounced, random sampling throughout Continuum.**	**Identify substance and/or drug of choice, deter use, encourage abstinence from AOD.**	**Maintain abstinence from AOD.**

SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION
NATIONAL OUTCOME MEASURES (NOMS) FOR
SUBSTANCE ABUSE TREATMENT

DOMAIN	OUTCOME	MEASURES
Reduced Morbidity	Abstinence from Drug/Alcohol Use	Reduction in/no change in frequency of use at date of last service compared to date of first service
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Increase in/no change in number of employed or in school at date of last service compared to first service
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Reduction in/no changes in number of arrests in past 30 days from date of first service to date of last service.
Stability in Housing	Increased Stability in Housing	Increase in/no change in number of clients in stable housing situation from data of first service to date of last service
Social Connectedness	Increased Social Supports/Social Connectedness	Under development
Access/Capacity	Increased Access to Services (Service Capacity)	Unduplicated count of persons served; penetration rate-numbers served compared to those in need
Retention	Increased Retention in Treatment	Length of stay from date of first service o date of last service
		Unduplicated count of persons served
Perception of Care	Client Perception of Care	Under development
Cost Effectiveness	Cost Effectiveness (Average Cost)	Number of States providing substance abuse treatment services within approved cost-per-person bands by the type of treatment
Use of Evidence-Based Practices	Use of Evidence-Based Practices	Under development