2012 SUBSTANCE ABUSE SERVICES COUNCIL RESPONSE TO *CODE OF VIRGINIA* §2.2-2697

TO THE GOVERNOR AND THE GENERAL ASSEMBLY

OCTOBER 15, 2012

COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

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

October 15, 2012

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 *2012 Substance Abuse Services Council Response to Code of Virginia §2.2-2697.B. - Comprehensive Interagency State Plan*.

Sincerely,

William H. Williams, Jr.

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
The Honorable Marla Graff Decker, Secretary of Public Safety
James W. Stewart, III, Commissioner, Department of Behavioral Health and Developmental Services
Harold W. Clarke, Director, Department of Corrections
Mark Gooch, Director, Department of Juvenile Justice

Enc.

SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO *CODE OF VIRGINIA* 2.2-2697
2012

TABLE OF CONTENTS

Executive Summary i

I. Introduction 1
II. Program Reviews 2

A. Department of Behavioral Health and Developmental Services 2
B. Department of Corrections 6
C. Department of Juvenile Justice 8

III. Overview of Treatment Services Provided by State Agencies 9

A. Department of Behavioral Health and Developmental Services 9
B. Department of Corrections 10
C. Department of Juvenile Justice 12

Appendix

National Outcome Measures (NOMs) 14

SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO *CODE OF VIRGINIA* 2.2-2697
2012

EXECUTIVE SUMMARY

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."

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 report provides the statistical information for each agency for the state fiscal year that ended June 30, 2011 (the most recent year for which data are available) required by §2.2-2697.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DBHDS provides funding and oversight to 40 community services boards (CSBs) which provide publicly funded substance abuse treatment services to specific jurisdictions. The following information reflects these services.

- Treatment services expenditures totaled $145,680,168 for FY 2011.
  - This overall expenditure is an approximate sum of the following expenditure components:

Federal	$ 42,707,043
State	$ 46,679,700
Local	$ 37,550,461
Consumer fees or third party payers (e.g., insurance)	$ 13,849,259
Other	$ 4,893,705

- A total of 36,769 individuals received substance abuse treatment services supported by this funding.

Last year DBHDS, working with over 200 persons from state and local agencies, families, consumers, and advocates, completed a strategic plan for behavioral health and developmental services called "Creating Opportunities." The portion of the DBHDS plan dealing with substance abuse services was broadened and formalized as an interagency plan, in collaboration with the other state agencies listed in this report. (See *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* at http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf.) That report summarized the strengths and needs of Virginia's substance abuse treatment system, particularly that portion of it provided by community services boards (CSBs).

Based on this statewide assessment, additional investment of resources is needed in the following types of treatment:

- medication assisted treatment
- detoxification services
- uniform screening and assessment for substance abuse
- intensive outpatient services
- substance abuse case management
- community diversion services for young non-violent offenders
- 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
- Workforce development and training, especially to increase understanding and use of evidence-based assessment and treatment practices at all community and state-level agencies.

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 areas of field operations: Community Corrections and Institutions. DOC attempts to match the offender to appropriate treatment services based upon criminogenic factors and risk of recidivating.

Treatment services expenditures totaled $5,230,468 for FY 2011:

Community Corrections	$1,838,468
Institutions	$3,392,000

As of June 30, 2012, there were approximately 57,069 offenders under active supervision in the community and an active institution population of 29,729. Screenings conducted on all offenders entering DOC indicate that approximately 70% of the offender population may have a need for some level of substance abuse treatment.

DOC continues to face a number of issues related to substance abuse services:

- Limited resources for clinical supervision to ensure program fidelity, provide technical assistance, and enhance outcomes;
- Limited staff resources for programming as well as assessment and data collection activities;
- Limited availability of evidence-based treatment services in Community Corrections for offenders with substance abuse problems;
- Limited special resources for offenders with co-occurring mental disorders;
- Limited evaluation resources; and
- Sometimes a lack of optimal programming space in prisons.

An increase in resources would increase the number of offenders that could be provided with treatment as well as enhance the quality of the programs to provide better outcomes.

In general terms, successful outcomes of substance abuse treatment programs include a reduction in drug and alcohol use which can produce a decrease in criminal activities and, thereby, an increase in public safety. The Department-wide per capita cost of housing offenders was $24,380 in FY 2011. The cost avoidance and benefits to society that are achieved from offenders not returning or not coming into prison offsets treatment costs.

DEPARTMENT OF JUVENILE JUSTICE

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

JCC Programs:

Substance Abuse Services Expenditures:	$1,120,958
Total Division Expenditures:	$78,850,399

In FY 2011, 88% of the 569 residents admitted to JCCs had a mandatory or recommended substance abuse treatment need.

In order to maintain and improve effectiveness, 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.

SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO *CODE OF VIRGINIA* 2.2-2697
2012

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

As required, this 2012 report responds to Section B and includes a description of the substance use disorder (SUD) services provided by state agencies in Virginia. 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 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 for the state fiscal year that ended June 30, 2011 (the most recent year for which data are available) required by §2.2-2697.

II. PROGRAM REVIEWS

A. Department of Behavioral Health and Developmental Services

The Department of Behavioral Health and Developmental Services (DBHDS) provides funding and oversight to 40 community services boards (CSBs), entities of local government that provide publicly funded substance abuse treatment services (as well as mental health and developmental disability services) to specific jurisdictions. The following information reflects the substance abuse services provided by the CSBs.

(i) the amount of funding expended under the program for the prior fiscal year (FY 2011);

Treatment services expenditures totaled $145,680,168 for FY 2011. This overall expenditure is an approximate sum of the following expenditure components:

Federal	$ 42,707,043
State	$ 46,679,700
Local	$ 37,550,461
Consumer fees or third party payers (e.g., insurance)	$ 13,849,259
Other	$ 4,893,705

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

A total of 36,769 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 2007 General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to study the impact of substance abuse on the state and localities (House Joint Resolution 683/Senate Joint Resolution 395). In the resulting report, *Mitigating the Costs of Substance Abuse in Virginia* (June, 2008, pp. 65-66), JLARC staff concluded the following regarding evaluation and outcome measures:

> Based on a review of the research literature and interviews with staff at numerous State agencies, it appears that robust evaluations of substance abuse services must include participants' outcomes after they have completed treatment. Yet, obtaining this information can be very challenging because

> substance abuse has a variety of effects that are captured by numerous agencies whose information systems are not intended to perform an evaluation function. For example, the analysis presented . . . relies on data supplied by nine Virginia agencies, and some agencies have multiple internal information systems. In addition to the complexity of receiving and managing data supplied by multiple agencies, issues arise from attempting to transform existing data into information that can be used for evaluation purposes. Furthermore, because every agency uses a different approach to identifying their clients, it can be difficult to ensure that individuals are correctly matched across agencies.
>
> While the agencies that provide substance abuse treatment may place different priorities on the outcomes experienced by their clients, several measures of program effectiveness should be shared between them, such as employment and recidivism. Consequently, agencies that offer substance abuse treatment should undertake a coordinated effort to obtain needed data from other State agencies. Certain entities, such as DMHRSAS *(now Department of Behavioral Health and Developmental Services- DBHDS)* and the Supreme Court of Virginia have already begun collecting information from other agencies. According to DBHDS staff, it may take more than a year to design a process that will yield the information needed. Coordination should enable agencies to avoid duplication of efforts and to build upon the experience already gained by DBHDS and the Supreme Court of Virginia. To this end, agencies that provide publicly-funded substance abuse services could form a workgroup as part of 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.

The Substance Abuse Services Council established a work group and published its recommendations in its 2009 Annual Report to the Governor and the General Assembly (Report Document 110, http://www.dbhds.virginia.gov/SASC/documents/AnnualReport-SASC-2009.pdf). The Council made recommendations to an interim study (Senate Joint Resolution 318 – The Study of Models and Strategies for the Prevention and Treatment of Substance Abuse in the Commonwealth) that provided detailed information concerning the infrastructure which would be required to fully execute the common model developed by the Council, including strengthening the legal authority of DBHDS to require data from CSBs and provide funding to support implementation. The Council did not provide cost estimates of implementing these recommendations and the recommendations were not discussed by the General Assembly.

The federal Patient Protection and Affordable Care Act encourages the creation of "accountable care organizations" to promote better care coordination, quality and efficiency, requires electronic health records (EHRs), personal health records (PHRs), health information exchange (HIE) and "meaningful use," or using a certified HER in a meaningful manner, which includes the use of e-prescribing, electronic HIE, and submission of information on clinical quality measures. It is anticipated these provisions and the expansion of insurance

coverage of substance abuse treatment services should have a positive effect on the capacity to measure outcomes in the publically-funded behavioral health system.

A majority of CSBs have obtained information technology (IT) platforms capable of supporting an HER and a number of them have begun implementing HER functionalities. Last year, the Data Management Committee (DMC) of the Virginia Association of Community Services Boards (VACSB) 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 HER functionality to ultimately get all CSBs at the same baseline for HER data collection and sharing." The group estimates that, given the current status of HER implementation in Virginia, full implementation may take 4-5 years. (VACSB Data Management Committee, Report of Data Roadmap Work Group, 7/22/2011)

The Substance Abuse and Mental Health Services Administration (SAMHSA), 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 CSBs for several years to establish data collection and information management processes to collect this information, as discussed in *Mitigating the Cost of Substance Abuse in Virginia* (JLARC, 2008). A matrix of the outcome measures required for treatment is included as Appendix A of this report.

(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;

Several factors currently impact program effectiveness of substance abuse services. CSBs and other providers vary in their approach to clinical assessment. By helping more providers – DOC, private, and CSBs - to adopt use of evidence-based, standardized assessments, the substance abuse services field will not only benefit from improved, more specific assessments and individualized treatment plans, there will also be a gain in efficiency and cost effectiveness across cooperating provider agencies. In addition, many people needing treatment often need more than one type of treatment to achieve stable recovery. For instance, a person with alcoholism may need to be detoxified in a medically-supervised setting for several days, followed by a stay of several months in a residential treatment program that provides supervised and structured therapeutic interventions to help the person learn how to function interpersonally without alcohol, provide opportunities to interact with family members and help them learn about alcoholism, and support a gradual transition into the community. This level of care would be followed by outpatient treatment, and all of the treatment episode would be overseen by a case manager.

In a strategic plan presented to Governor McDonnell in 2011, *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* [1], DBHDS 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 (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf).

Based on this statewide assessment, additional investment of resources is needed in the following types of treatment:

- medication assisted treatment
- detoxification services
- uniform screening and assessment for substance abuse
- intensive outpatient services
- substance abuse case management
- community diversion services for young non-violent offenders
- 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

This formal needs assessment and plan showed that communities differ in their ability to provide the necessary fundamental array of services, especially services that are evidence-based (proven by research to be effective with specific populations with particular clinical needs).

The services expansion described in *Creating Opportunities* and here will require additional resources, including support for a significant workforce development initiative so programs can adapt current resources to evidence-based practice models, when possible.

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

The adverse consequences of substance abuse in 2006 cost 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 un-served or underserved, focusing on offenders due to their high impact on State and local budgets as well as public safety. If the State decided to expand the availability of services, potential funding options that could be considered include

[1] Virginia Department of Behavioral Health and Developmental Services, et al. Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development. Report to Governor Robert F. McDonnell. 2011.

directing additional profits generated on the sale of alcoholic beverages, or designating a portion of the incremental revenues produced by the State's recent expansion in alcohol sales capacity (JLARC, 2008, p. 129).

B. Department of Corrections

The Department of Corrections (DOC) provides a tiered substance abuse services approach to address varying offender substance abuse (SA) treatment needs based on the severity of the problem. DOC has two areas of field operations: Community Corrections (community settings of probation/parole districts and detention/diversion centers) and Institutions (prison facilities).

The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk/needs assessment was implemented for use by Community Corrections staff statewide in October of 2010 and in Institutions as of April of 2011. The instrument contains a substance abuse scale that is used to assist with determining treatment program referrals. Screening results have indicated that at least 70% of the offender population may have a need for some level of substance abuse treatment.

In Community Corrections, DOC contracts for many of its treatment services with CSBs and private vendors. The Probation and Parole Districts and Community Corrections Facilities have either a Memorandum of Agreement (MOA) or contract services for substance abuse treatment. In addition to the services at the CSBs, DOC has access to thirty-two (32) contracted private SA outpatient vendors.

In Institutions, DOC provides substance abuse treatment programs and services. The Cognitive Therapeutic Community (CTC) program is an evidence-based, residential, treatment modality designed to address substance addiction, criminal thinking and anti-social behaviors. Some participants of the CTCs are Behavioral Correction Program (BCP) participants. This program, which is a sentencing option for judges presiding over circuit courts, was enacted by the General Assembly in 2009. Under this sentencing option, judges have the ability to place offenders directly into the CTCs.

In mid-2012, DOC began implementing The Matrix Model. The Matrix Model is an evidence-based, intensive outpatient, substance abuse treatment modality. Initial implementation is taking place at the Intensive Reentry Programs along with some Community Correction sites. DOC also has support services such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

(i) the amount of funding expended under the program for the prior fiscal year (FY2011);

Treatment services expenditures totaled for FY 2011: $5,230,468

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

Community Corrections	$1,838,468
Institutions	$3,392,000

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

As of June 30, 2012, approximately 57,069 offenders were under active supervision in the community. DOC's risk/needs assessment COMPAS substance abuse scale scores indicate that an estimated 70% of those under active supervision (which would equate to 39,948 probationers/parolees) have some history of substance abuse and may require treatment and/or support services. These services are mainly provided by CSBs and private vendors.

In Institutions, there are approximately 1,450 CTC participants. The Matrix Model program is being implemented in the Intensive Reentry Programs, so there are no participant figures for FY 2011. The number of offenders participating in support services such as NA and AA varies. The support services are generally provided by volunteers.

Special Note: The implementation of CORIS (Corrections Information System), the offender management system, will facilitate providing program participant data. DOC is in the process of modifying the programs module in CORIS and performing quality control checks so that accurate and timely program participation data can be more easily captured. Once these modifications are in place, participation figures should be more readily available.

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

In September of 2005, the Department submitted the *Report on Substance Abuse Treatment Programs* which contained research information on the effectiveness of the Therapeutic Communities and contractual residential SA treatment programs. The findings from these studies suggest that DOC's SA treatment programs – when properly funded and implemented – are able to reduce recidivism for the substance abusing offender population. Due to a lack of evaluation resources, more up-to-date formal studies are not available. However, a one-year recommitment status check is performed annually for the CTC participants. The latest one that was done for the calendar year 2010 cohort indicated that the recommitment rate was 7%. Of course, since this status check is not a formal outcome evaluation, caution should be exercised in the interpretation of the data.

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

Although DOC specific information is not available at this time, a recent report from the Washington State Institute for Public Policy indicated that drug treatment in prison as well as the community has a positive monetary benefit. Of course, in order for evidence-based treatment programs to be cost effective and achieve positive outcomes, they must be implemented as designed, a concept referred to as fidelity. DOC has placed an emphasis on implementation fidelity and created program fidelity reviews for this purpose. This is an important first step that is necessary prior to performing any cost effectiveness studies.

(v) how effectiveness could be improved;

DOC continues to face a number of issues related to substance abuse services:

- Limited resources for clinical supervision to ensure program fidelity, provide technical assistance, and enhance outcomes;

- Limited staff resources for programming as well as assessment and data collection activities;
- Limited availability of evidence-based treatment services in Community Corrections for offenders with substance abuse problems;
- Limited special resources for offenders with co-occurring mental disorders.
- Limited evaluation resources; and
- Sometimes a lack of optimal programming space in prisons.

An increase in resources would increase the number of offenders who could be provided with treatment as well as enhance the quality of the programs to provide better outcomes.

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

In general terms, successful outcomes of substance abuse treatment programs include a reduction in drug and alcohol use which can produce a decrease in criminal activities and, thereby, an increase in public safety. The Department-wide per capita cost of housing offenders was $24,380 in FY 2011. The cost avoidance and benefits to society that are achieved from offenders not returning or not coming into prison offsets treatment costs.

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

Assessment results for the offender population have established the need for substance abuse treatment programs and services. DOC has implemented evidence-based substance abuse treatment programs such as the Cognitive Therapeutic Communities and the Matrix Model. A fidelity review process has been established that can be used by Community Corrections to assess and monitor the quality of contracted programs and services. The implementation of CORIS, the offender management system, has improved the collection of data that can be used in future outcome and cost effectiveness studies. By continuing to fund the existing programs and securing additional resources, when possible, to address the aforementioned issues, DOC will be able to address the treatment needs of the substance abusing offender population.

C. Department of Juvenile Justice

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

(i) the amount of funding expended under the program for the prior fiscal year FY2011);

JCC Programs:

Substance Abuse Services Expenditures:	$1,120,958
Total Division Expenditures:	$78,850,399

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

In FY 2011, eighty-eight percent (88%) of the 569 residents admitted to JCC's had a mandatory (33.7%) or recommended (54.5%) 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, re-arrest 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 re-arrest rates are for JCC releases in FY 2010, and the most recent reconviction rates are for JCC releases in FY 2009.

The 12-month re-arrest rate for females released from JCCs in FY 2010 who participated in the Residential Substance Abuse Treatment (RSAT) Program was 25.0%. For female participants released in FY 2009, the reconviction rate was 13.5%.

The 12-month re-arrest rate for residents with a substance abuse treatment need released from JCCs in FY 2010 was 47.1%. For residents with a substance abuse treatment need released in FY 2009, the reconviction rate was 36.7%.

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.

III. Overviews of Treatment Services Provided by State Agencies

A. 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.

B. 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 areas of field operations: Community Corrections and Institutions.

Community Corrections contracts for many of its substance abuse treatment services with CSBs and private vendors. These services include: detoxification, intensive residential, outpatient, relapse prevention and peer support groups. (The descriptions of these services are provided in a prior section of this report by the Department of Behavioral Health and Developmental Services.) Beginning in 2012 some of the Community Corrections sites will be providing the Matrix Model which is an intensive, outpatient substance abuse treatment program. Support services such as NA and AA are also offered in the Districts.

Currently in several institutions, DOC has cognitive therapeutic communities (CTC) which are intensive, residential, substance abuse treatment programs. There are approximately 1,450 CTC treatment beds. CEC (Community Educational Centers) is a private treatment vendor that provides the program for males at Indian Creek Correctional Center. The private prison in Lawrenceville also has a program for males. The two CTC programs for female offenders are at Virginia Correctional Center for Women and Central Virginia Correctional Unit.

In mid-2012 DOC began implementing the Matrix Model program at the Intensive Reentry Sites. Support groups such as NA and AA are also provided in the institutions. In the past, a psycho-educational substance abuse program was provided by DOC staff in many of the institutions. However, since it was not an evidence-based treatment program, it has been discontinued.

DOC also receives grant funding from the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) program. The DOC program is entitled STAND (Start Today a New Direction). This program has a capacity of 50 offenders. This program is in partnership with Rubicon, a private treatment provider in Richmond. Client advocates (CAs) assist substance abusing offenders with their reentry into the community.

While not a substance abuse specific intervention, DOC is currently providing the evidence-based "Thinking for a Change" program at all institutions and some districts. This cognitive behavioral treatment program assists offenders, with substance abuse issues, to more realistically view the consequences of their drug/alcohol use and consequently be more amenable to treatment interventions.

Descriptions of substance abuse treatment programs and related services provided by DOC are as follow:

- ***The Matrix Model*** – This program is an evidence-based intensive outpatient treatment modality. Treatment professionals at The Matrix Institute drew from numerous treatment approaches, incorporating into their model methods that were empirically tested and practical. The treatment model consists of four components: early recovery, relapse prevention, family education and support groups.

- ***Cognitive Therapeutic Communities*** (CTCs) – The CTC program is an intensive residential treatment model designed to address substance addiction, criminal thinking and anti-social behaviors. The CTC model utilizes social learning theory and affords offenders an opportunity to use the skills they are taught through programming. Programming focuses on cognitive behavioral therapy targeting the thought process and substance abuse along with other criminogenic needs. The CTC Model provides the laboratory for offenders to practice new cognitive behavioral patterns in a supportive environment.

- ***Thinking for a Change (T4C)*** – The *Thinking for a Change* curriculum uses, as its core, a problem solving program integrating both cognitive restructuring and social skills interventions. While each of the concepts is presented systemically, the participant ideally learns that cognitive restructuring requires cognitive skills methods. This closed group program consists of 25 lessons and includes role-plays, presentations, homework assignments, discussion, and group participation.

- ***HIDTA/STAND*** – This program is a sentencing alternative for drug abusing offenders and technical violators under supervision. Offenders from Henrico, Chesterfield, Richmond and Petersburg comprise the STAND population. Client advocates provide participants with intensive case management services and multi-level modalities of substance abuse treatment.

- ***Behavioral Correction Program*** – These program participants are a subset of the CTC program. This program is a sentencing option for offenders with substance abuse needs. Judges are able to place offenders directly into the CTC. Probation and parole officers assist with the referral process to determine that the offender meets the criteria. Judges imposes full sentence with a minimum of three years to serve. Offenders are processed into the CTC program for a minimum of 24 months.

- ***Peer Support Groups*** – In both institutions and Community Corrections, peer support groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) are provided by volunteers. These self help groups provide support to enhance relapse prevention efforts.

C. Department of Juvenile Justice

DJJ institutions provide substance abuse treatment services at all five of its juvenile correctional centers (JCCs) as well as 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, Hanover, and RDC 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 one of three self-contained unit: 24 bed capacity unit; eight bed unit (both located within the medium security building); and a 12 bed capacity unit (maximum security

building). Residents who are unable to enter SA specific units, 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 16 to 20 years of age with classification levels 3 and 4.

Bon Air JCC

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 13 to 18 years of age with classification levels 3 and 4 as well as females of all ages up to 21 and all classification levels.

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 approximately 18 to 21 years of age with classification levels 3 and 4.

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 with classification levels 1 and 2.

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. Residents who receive substance abuse treatment also receive aggression management services, concurrently. Services are provided by one assigned BSU staff member.

Reception and Diagnostic Center (RDC)

RDC began a pilot substance abuse and aggression management treatment program in FY2013. The program consists of a 12 bed unit currently serving residents culled from the Beaumont JCC population approximately 16-20 years of age with classification levels 3 and 4. The treatment program components are the same as the other facilities.

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