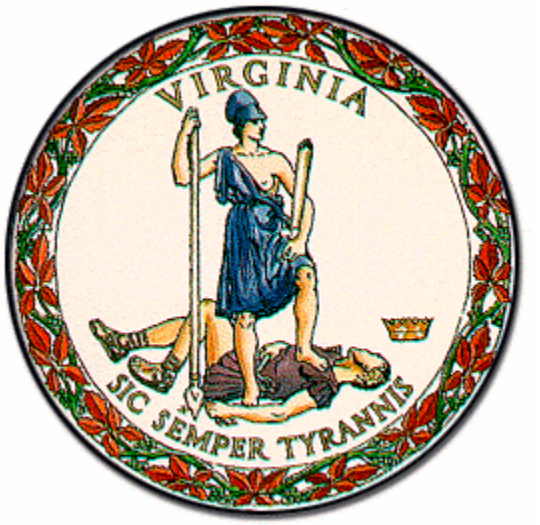
SUBSTANCE ABUSE SERVICES COUNCIL

ANNUAL REPORT AND PLAN

to the Governor

and the

General Assembly



COMMONWEALTH OF VIRGINIA

2011

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Substance Abuse Services Council

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Vice Chair

P. O. Box 1797
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December 15, 2011

To the Honorable Robert F. McDonnell, Governor of Virginia
and
Members, General Assembly of Virginia

In accordance with §2.2-2696 of the *Code of Virginia*, I am pleased to present the 2011 Annual Report of the Substance Abuse Services Council. The *Code* charges the Council "to recommend policies and goals" relating to substance abuse and dependence and also to coordinate efforts to control substance abuse and requires the Council to make an annual report.

The most recently appointed chairperson of the Council resigned due to illness in March 2010, and the Council has relied upon volunteers to convene and facilitate meetings since that time. In 2011, Charles Walsh served as Vice-Chair until his term on the Council expired. Currently, I have the honor of being selected by other Council members to serve as Vice-Chair.

As required, the Council met four times during 2011: April 26; June 21; September 16 and October 28. All meetings were conducted in the metropolitan Richmond area. Meeting notices and approved minutes are posted on the Council's website at www.dbhds.virginia.gov.SASC/default.htm.

As several key member agencies of the Council have developed strategic plans to increase their effectiveness, the Council agreed to spend this year learning about how these plans incorporated services to people with substance use disorders. The Council heard presentations from the Department of Corrections, the Department of Juvenile Justice and the Department of Health Professions Prescription Monitoring Program. In addition, the Department of Behavioral Health and Developmental Services was charged by the Governor with developing an interagency strategic plan to address the Commonwealth's issues with substance abuse and dependence. The plan incorporates input from eight other state agencies, including many who are Council members and is the focus of this report.

On behalf of the Council, I appreciate the opportunity to provide you with our annual report which we hope will contribute to improving the lives of the many Virginians affected by substance use disorders.

Sincerely,

William H. Williams, Jr.

pc: The Honorable William A. Hazel, Jr., M.D.
The Honorable Marla Graff Decker
The Honorable Laura W. Fornash
James W. Stewart, III
Harold W. Clarke
Patricia I. Wright

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EXECUTIVE SUMMARY

ANNUAL REPORT OF THE SUBSTANCE ABUSE SERVICES COUNCIL TO THE GOVERNOR AND THE GENERAL ASSEMBLY – 2011

The Substance Abuse Services Council spent the year learning about strategic plans that have been developed by several state agencies that involved the delivery of substance abuse treatment services. Among these agencies is the Department of Behavioral Health and Developmental Services (DBHDS), which was charged by the Governor with developing an interagency strategic plan to address the need for substance abuse treatment services. DBHDS was already involved in developing an overall agency strategic plan, *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*, and built on this initiative to develop a substance abuse service-specific plan that included input from public and private providers and eight other state agencies. The resulting report, *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development*, has been reviewed and approved by the secretaries of Public Safety and Health and Human Resources and accepted by the Governor's Office. It is posted on the DBHDS website (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf). After reviewing the interagency plan, the Council endorsed it and has highlighted those initiatives in this annual report.

The scope of the substance abuse problem in Virginia is significant and has been documented by several sources. The National Household Survey on Drug Use and Health (NSDUH) indicates that, in the year prior to the survey (2006, 2007, 2008), 22.9% of Virginians age 12 and older participated in an episode of binge drinking and that nearly 5% used pain relievers for a nonmedical use. More than 7% needed but did not receive treatment for alcohol use, and 2.45% needed but did not receive treatment for illicit drug use. Data from the Virginia Department of Health Office of the Chief Medical Examiner (OCME) indicate that the number of deaths caused by drugs increased 32% over the period 2003 to 2009, with more than 60% due to prescription drugs in 2009.

A variety of state agencies are involved in either directly providing treatment to people with substance use disorders, or providing supports and services to people who need treatment services.

- DBHDS funds 40 community services boards (CSBs) to support their role as the major provider of publicly-funded community-based substance abuse treatment. In 2009, CSBs provided treatment to 36,661 individuals.
- The Department of Corrections (DOC) estimates that 75% of the offenders under its supervision need treatment. Over 38,000 offenders are incarcerated in DOC institutions, and it provides active supervision to an additional 53,400 offenders in the community.
- The Department of Juvenile Justice (DJJ) screened 5,800 youths in 2010, the majority of whom were served in community settings. Of the 608 committed to custody, 85% received treatment while in DJJ facilities.

- The Department of Criminal Justice Services (DCJS) supports local community-based probation and pretrial services. It provides screening and assessment services for offenders as well as purchasing treatment services. In 2010, DCJS drug tested 11,364 individuals and placed 2,858 offenders in counseling.
- The Department of Rehabilitative Services (DRS) provides vocational rehabilitation counseling especially designed for people with substance use disorders to people receiving treatment in 18 CSBs with significantly positive results.
- The Department of Social Services (DSS) provides supports to those seeking recovery and helps to mitigate the impact of addiction on families. When the need for services is identified, the local DSS collaborates with CSBs to facilitate access.
- The Department of Health (VDH) provides health-related supports and makes referrals to CSBs for treatment services. VDH has also integrated screening into some services that target at-risk families.
- The Department of Medical Assistance Services (DMAS) administers Medicaid reimbursement for eligible treatment services provided to people who meet eligibility requirements.
- The Department of Health Professions (DHP) is home to the Prescription Monitoring Program that tracks all filled prescriptions of certain schedules of pharmaceuticals and provides a database that can be utilized by pharmacists and prescribers to prevent over-prescribing these medications.

DBHDS hosted numerous meetings and conference calls with public and private providers, and then hosted three meetings with these state agencies to develop this strategic interagency plan, which will involve multi-stage funding and implementation.

A. PROPOSALS TO EXPAND CAPACITY NEEDED TO ASSURE TIMELY ACCESS TO SERVICES

Proposal 1: Enhance Substance Abuse Case Management Capacity. Two-thirds of CSBs report inadequate case management capacity, yet this is the service that can facilitate efficient and effective use of limited existing resources at the local level. Funds are needed to support case management services for people with substance use disorders.

Proposal 2: Develop Capacity to Serve Adolescents with Substance Use and Co-Occurring Mental Health Disorders. NSDUH data indicate that one in five adolescents regularly engage in binge drinking, but CSB utilization data indicate that fewer than 10% of admissions to substance abuse services are adolescents. CSBs often lack the appropriately trained workforce to provide treatment to adolescents, many of whom have a co-occurring mental health disorders that complicates their recovery. Funds are needed to support adolescent services and training in evidence-based treatment.

Proposal 3: Expand Project Link. Project Link is program of coordinated services designed to meet the needs of pregnant women who are abusing drugs or alcohol that is currently operating in 8 CSBs. Initially implemented in 1990, it has proven to be effective at improving pregnancy outcomes and reducing substance abuse among participating women. Funds are needed to expand this service so that it is available statewide.

Proposal 4: Expand Peer-run Support Services. Peer-run supports include emotional support (ex: peer-led groups), informational support (ex: life skills classes), instrumental support (ex: child care or transportation), and social supports (ex: sober social events). These types of supports provide another approach to improving access to needed services, however, only half the CSBs report using these types of services. DBHDS has funded five peer-run centers to provide these types of services, and another one is currently funded by a federal grant. Funds are needed to support expanding these types of services.

Proposal 5: Enhance Uniform Screening and Assessment of Mental Illness and Substance Use Disorders. Many CSBs are not using validated assessment instruments to determine the extent of an individual's problem with substance use, nor or they determining the extent to which mental illness may be present. Without an accurate clinical assessment, it is very difficult to develop a viable treatment plan. Funds are requested to support positions at CSBs and provide training in conducting accurate assessments.

Proposal 6: Implement a Structured Systems Improvement Practice Model such as the Network to Improve Addiction Treatment (NIATx). NIATx is a systems-engineering approach to quality improvement developed specifically for clinical substance abuse treatment programs. Its low-cost disciplined methods support an organizational culture of team-based problem solving that resolves issues efficiently. NIATx is free but does require dedicated focus. Funds are needed to support DBHDS staff to lead, coordinate and train CSBs in this statewide effort.

B. PROPOSALS NEEDED TO FILL GAPS IN THE SERVICES ARRAY

Proposal 1: Expand Access to Identification and Intervention for Offenders with Substance Use Disorders in Community Correctional Settings. Untreated substance abuse has been estimated to cost Virginia $613 million annually, mostly in criminal justice costs. As discussed, DOC, DJJ and DCJS estimate that significant numbers of individuals in the criminal justice system have a substance abuse issue of some degree. Funds for this initiative would be allocated to these agencies to purchase treatment services from any qualified provider, and services would be supervised locally to meet rigorous professional standards, including the use of evidence-based practices.

Proposal 2: Expand Intensive Outpatient Services. People receiving treatment for substance use disorders need to receive it at a level of intensity that is adequate to support change. Due to a lack of staff, only about one-third of CSBs are able to offer services at this level of intensity. Most offer only hourly outpatient services at a frequency of about one per week. Intensive outpatient services are offered multiple times per week for several hours each day. Funds would support additional CSB staff to adequately provide intensive outpatient services.

Proposal 3: Expand Capacity for Community-based Residential Medical Detoxification. Currently CSBs report only about 100 beds available for medical detoxification, a residential services lasting between three to seven days that provides medically supervised withdrawal from alcohol, sedatives, opiates and other dangerous drugs. Once discharged, the person is referred to the appropriate level of treatment for ongoing counseling and supports. Funding is needed to support expanded capacity for this service.

Proposal 4: Expand Capacity for Community-based Residential Medical Detoxification. Approximately half the CSBs lack access to medication assisted treatment, essential to the treatment of dependence on opioids which are increasing in use. As the previously cited data from the Office of the Chief Medical Examiner indicates, abuse of prescription opioid medications is an increasing cause of death in the Commonwealth. Currently there are 19 methadone clinics in Virginia, and while methadone is a highly effective approach to treating opioid dependence, it requires daily attendance at a clinic that may interfere with employment. Buprenorphine, a medication that can be prescribed by a specially trained physician and self administered, can provide excellent results when coupled with counseling and other supports. Funding is needed to support purchase of this medication, physician time and training for physicians.

Proposal 5: Develop Residential Treatment Capacity for Pregnant Women and Women with Dependent Children in Southwest Virginia. Currently there are only three publicly-funded residential treatment programs for women who are pregnant or who have dependent children. Research indicates that women are more likely to enter and stay in treatment if they can bring their children with them, and the results for the children are also better as part of the treatment focuses on improved knowledge and skills about parenting. Because abuse of prescription pain medication has reached epidemic proportions in this region and because it is geographically isolated from the rest of the state, women in this region lack access to this type of service. Funding is needed to establish and operate a residential program designed to meet the needs of these women.

Proposal 6: Re-establish Transitional Therapeutic Communities for DOC. Until 2009, when funds were eliminated due to budget cuts, DOC purchased intensive community-based residential services (transitional therapeutic communities) for 300 offenders returning to the community after being in special prisons that provided intensive substance abuse treatment services. Evaluation indicated a significantly lower rate of recidivism for offenders who completed both the institutional program and the community program as compared to those who completed on the institutional program. This proposal would fund the re-establishment of these transitional therapeutic communities.

C. PROPOSALS TO PROVIDE ADDITIONAL SERVICES AND SUPPORTS NEEDED TO SUSTAIN A RECOVERY ORIENTED SYSTEM

Proposal 1: Expand Department of Rehabilitative Services Substance Abuse (SA) Vocational Counselors Project. Stable employment is a key component of successful recovery from substance use disorders. Since 1988, DRS has provided specialized vocational counseling services to people in treatment for substance use disorders at CSBs. Evaluation indicates that clients who receive this specialty counseling cost less to serve, uses DRS resources for a shorter period of time, are more likely to achieve successful employment and have higher earnings that clients served by a general DRS vocational counselor. Currently, through a memorandum of agreement between DBHDS and DRS, 21 vocational counselors provide these services at 18 CSBs. This proposal would expand the number of vocational counselors so that every CSB would have access to a specialty vocational counselor.

Proposal 2: Expand Access to Housing Options Available to Adult Offenders in the Community. Stable housing, along with a sober and supportive environment is a critical need of offenders returning to the community. Returning offenders often lack financial resources to pay for housing when they first return. One option is to explore self-run households of four to six same gender individuals in recovery who rent a house and live under self-developed rules and agree to being sober. Individuals must make a minimum deposit and contribute financially to the operation of the house. Many recently returning offenders are not able to make this monetary contribution. DOC is already engaged in a pilot in which it pays the initial costs for individual offenders to start or join such a residence. Funds for this initiative would expand this pilot.

Proposal 3: Establish Capacity for Supported Living Services. Lack of a safe, sober place to live is also a barrier for others in recovery. Supported living services can provide an option to placing a person in an expensive residential treatment program because they are homeless when such an intense placement is not clinically indicated. Supported living services would provide housing and additional supports such help with transportation to treatment and employment, case management and support groups and could be managed as a peer-run service. As they became employed, residents would contribute to the costs of living in the facility.

Proposal 4: Create a Multi-Agency Work Force Development Capacity Focusing on the Treatment of Substance Use Disorders. In the last 20 years, a substantial body of knowledge has evolved concerning effective treatment for substance use disorders, including the knowledge that specific populations (e.g., women, adolescents, criminal justice populations) respond better to some treatments than others. DOC and DJJ have trained their workforces to utilize appropriate evidence-based practices for the populations they serve, but when these offenders return to the community, providers are often not familiar with these clinical approaches. In addition, a variety of studies indicate that CSB staff lack access to appropriate clinical supervision that would help them utilize these or other evidence-based practices. Funds are needed to support

promotion, coordination and collaboration necessary to integrate these practices into publicly-funded community-based treatment settings.

Proposal 5: Develop an Ongoing Evaluation Process for Established Drug Treatment Courts. Drug treatment courts have evolved as a national model for adults and youths facing felony convictions for nonviolent crimes related to drug or alcohol abuse or dependence. They provide a closely supervised alternative to conviction and incarceration. Currently there are 27 drug treatment courts in Virginia. The process for establishing a drug treatment court involves making application to the Supreme Court of Virginia (SCV) and then, once approved, review and approval by the General Assembly. However, some members of the General Assembly are not confident that drug treatment courts are effective. In the 2011 Session of the General Assembly, six applications approved by the Supreme Court were presented to the General Assembly, but none were approved. This proposal would fund support for the development and implementation of a statewide evaluation of drug courts operating in the Commonwealth. In addition, pending the outcome, funds for existing drug treatment courts would be held harmless. ***Note:*** The Substance Abuse Services Council wishes to note that the National Center on State Courts is currently under contract to conduct a two-year cost-benefit analysis of the state drug treatment court system; the Council supports expansion of this evaluation and also supports the adoption of drug treatment courts that are approved by the Supreme Court of Virginia.

ANNUAL REPORT OF THE SUBSTANCE ABUSE SERVICES COUNCIL TO THE GOVERNOR AND THE GENERAL ASSEMBLY – 2011

INTRODUCTION

This year, the Council became aware that several state agencies had either recently developed or were in the process of developing strategic plans that, at least to some degree, included a focus on treatment for substance use disorders. The Council invited the Department of Corrections (DOC), the Department of Juvenile Justice (DJJ) and the Prescription Monitoring Program of the Department of Health Professions (DHP) to present information about activities, services and programs related to substance use disorders in their agencies. In addition, staff from the Department of Behavioral Health and Developmental Services (DBHDS) presented information about its strategic interagency plan for substance abuse treatment services in Commonwealth.

The Department of Behavioral Health and Developmental Services (DBHDS) was asked by the Governor and by Secretary William A. Hazel, Jr., M.D., to develop an interagency strategy plan to address the treatment needs of people with substance use disorders. The resulting report, *Creating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development*, utilized a two-stage planning effort that involved private and public providers as well as representatives of nine executive branch agencies from the Health and Human Resources and Public Safety secretariats, nearly all of which are also represented on the Council. The full report can be found on the DBHDS website (http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf). The recommendations presented here are summary statements of this interagency effort. The Council is requesting support from the Governor and the General Assembly for the initiatives as described.

SUMMARY OF CREATING OPPORTUNITIES FOR PEOPLE IN NEED OF SUBSTANCE ABUSE SERVICES: AN INTERAGENCY APPROACH TO STRATEGIC RESOURCE DEVELOPMENT

Scope of the Substance Abuse Problem in Virginia

Numerous documents, both national and Virginia-specific, have enumerated and described the substance abuse issues in Virginia, both epidemiologically and from the perspective of impact on the Commonwealth. Data from the National Survey on Drug Use and Health (NSDUH) conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that 1,551,487 (22.9%) Virginians age 12 and older have participated in an episode of binge drinking (consuming at least 5 drinks on one occasion). Among this same age group, 331,300 (4.89%) used pain relievers for a nonmedical use. Among Virginians age 12 years or older, 620,595 (9.16%) met clinical criteria for either dependence or abuse of illicit drugs or alcohol. Regarding unmet need for treatment, 489,836 (7.23%) Virginians age 12 years old or older needed but did not receive treatment for alcohol use, and 165,989 (2.45%) Virginians needed but did not receive treatment for illicit drug use in the past year.

The Virginia Department of Health Office of the Chief Medical Examiner's (OCME) Annual Report also provides information about mortality related to substance use, especially the misuse of prescription pain medication. **The number of deaths caused by drugs increased 32% over the period 2003 to 2009, from 563 in 2003 to 735 in 2009, with more than 60% due to prescription drugs in 2009.** In some Virginia communities, the very fabric of the community has been torn due to abuse of prescription pain medication.

The economic impact of substance abuse is also well documented. The Joint Legislative Audit and Review Commission (JLARC) concluded that untreated substance abuse cost the Commonwealth $613 million in 2006 dollars annually, mostly in costs to the criminal justice system (House Document 19, 2009).

The Department of Corrections estimates that as many as 75% of adults in jails and prisons have substance abuse problems.

Virginia's Substance Abuse Services System

Several state agencies are involved in either providing or financing treatment services for people with substance use disorders, or they provide other types of necessary supports to these individuals.

DBHDS funds the 39 community services boards and one behavioral health authority (referred to as CSBs) to support their role as the major provider of publicly funded community-based substance abuse treatment. CSBs provided substance abuse treatment to 38,661 individuals in 2010. Fewer than 10% were seventeen or younger. The criminal justice system constituted 42% of referrals.

The Department of Corrections provides treatment to even more people than the CSBs. Currently, over 38,000 offenders are incarcerated, and another 53,400 are under active supervision in the community. It is estimated by DOC that at least 75% of them need treatment for a substance use disorder. DOC has put forth considerable effort to provide services to these offenders, utilizing evidence-based treatment practices that are designed to address the needs of offenders.

The Department of Juvenile Justice also provides evidence-based treatment services to the youth under its supervision. In 2010, 5,800 youth were screened using standard risk assessment instruments. The majority of these youth are served in community settings. Of the youth who were committed to the custody of the Department (608 in FY 2010), 85% received evidence-based treatment while in juvenile justice facilities. DJJ has limited funds ($200,000 statewide) to purchase services for youth under supervision in the community.

The Department of Criminal Justice Services (DCJS), which supports local community-based adult probation and pretrial services, screens and assesses offenders routinely and is also another purchaser of treatment services. In 2010, DCJS drug tested 11,364 offenders and placed 2,858 into counseling.

The Department of Rehabilitative Services (DRS) has a contractual relationship with DBHDS to provide vocational rehabilitation (VR) services in 18 CSBs. Employment plays a key role in recovery from substance use disorders, and these specially trained VR counselors are able to help their clients achieve higher rates of success than those who receive conventional VR counseling.

The Department of Social Services (DSS) provides supports to people who are seeking recovery, and also absorbs the impact of untreated substance use disorders on families. When it identifies a family or individual in need of services, local departments of social services include treatment as a part of the services plan and seek collaboration with the local CSB.

The Department of Health (VDH) provides many health support services and is both a source of referral and a source of assistance for those with substance use disorders. Many health conditions are related to substance use disorders and some local health departments provide clinical treatment services for some health issues, such as sexually transmitted diseases and tuberculosis. VDH is also the base for the Home Visiting Consortium, which provides outreach to at-risk families and provides screening referral for substance use disorders.

The Department of Medical Assistance Services (DMAS) administers Medicaid, a federal program that provides matching reimbursement at about a 1:1 level for eligible substance abuse treatment services for people who meet income or disability eligibility criteria. In 2010, Medicaid paid about $1.3 million in reimbursement for substance abuse treatment.

The Department of Health Professions is home to the Prescription Monitoring Program (PMP), which tracks all filled prescriptions of a certain type, including pain medication, and provides a database that can be queried by prescribers and pharmacists to prevent prescription drug abuse or over-prescribing of certain medications. It also sponsors an online course for prescribers in pain management.

Private providers are a central part of the substance abuse treatment services network in many, if not most communities in Virginia. These organizations provide services across the entire spectrum of substance abuse services, from inpatient detoxification and residential treatment to peer support services. DOC and DJJ provide funding by contract to many of these private providers to support their role in the substance abuse service system. Private providers are an essential part of the system and were represented on the DBHDS *Creating Opportunities* planning committees.

Services Systems Gaps and Recommendations to Improve Access to Services

Several reports have identified significant gaps and limited capacity in Virginia's treatment system. Consistently, these documents point to a lack of timely access to treatment services, gaps in capacity in needed services that provide more intensive treatment, and lack of services that have been proven by research to be effective. The result is that **people with substance use disorders wait an average of nearly 19 days for services. Individuals don't always receive services that are intensive enough or that are proven to be effective – and many do not receive the services they need because those services do not exist at all.**

Because the state's capacity to provide substance abuse treatment services falls so far short of the needs that have been documented by this and other studies, a substantial and continuing commitment on the part of the Commonwealth will be necessary to address them adequately. Meeting these needs will require a multi-stage investment plan. Implementing this plan will be a budgetary challenge. Choices will have to be made and priorities assigned in order to make progress within the fiscal limits.

The interagency committees took these challenges into account in recommending the following suggested service improvement initiatives, which this document briefly describes. In making the necessary priority and budget-limiting choices, many of these proposals are pilot projects or gradual, staged expansions of capacity. In this step-by-step approach, an initial "down payment" would need to be followed by adding additional pilot sites, expanding coverage, etc. over the years in a sustained effort. More complete information about each proposal and how it might be phased in is in the body of the report.

A. Proposals to Expand Capacity Needed to Assure Timely Access to Services:

Proposal 1: Enhance Substance Abuse Case Management Capacity. According to a report from the Office of the Inspector General (OIG) published in 2006, two-thirds of CSBs report inadequate case management services[1] and utilization data from CSBs indicate that only one-quarter of persons receiving substance abuse treatment services receive any case management services at all.[2] This is particularly troubling as people with substance use disorders who present to CSBs and other public systems often have practical needs that complicate achieving the goal of recovery. Alienated from family and friends, they lack support systems that could help them and are in need of assistance with housing, employment, access to health care, and other supports which directly impact their capacity to engage in recovery. In addition, they frequently need treatment in varying levels of intensity in subsequent stages. A specialized case manager can monitor whether or not treatment intensity is appropriate, access health and other support needs, and then coordinate resources to address them. Persons returning to the community from incarceration or detention also need a person within the treatment system to communicate and plan with their probation officer.

Case management is an essential service for people debilitated by substance use disorders because it assists them in making these crucial connections. As the "glue" that helps the person assemble the community resources necessary to support recovery, case management utilizes the skills of an experienced professional knowledgeable about community and state resources. Quality case management can provide outreach, support ongoing engagement in treatment, and impart practical knowledge to assure that external barriers do not stand in the way of recovery. This initiative would fund case management positions dedicated to persons receiving substance abuse services at each community services board

[1] Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report #129-06, p. 17.
[2] DBHDS 2010 CSB Fourth Quarter Report.

Proposal 2: Develop Capacity to Serve Adolescents with Substance Use and Co-Occurring Mental Health Disorders. Data from NSDUH indicate that nearly one in five Virginia adolescents regularly engage in binge drinking (consuming at least five drinks on one occasion). CSB utilization data indicates that fewer than 10% of those receiving substance abuse treatment services are adolescents. The FY 2009 Comprehensive Services Gap Analysis reported that among all the services gaps in the state for children and adolescents, intensive substance abuse services ranked second, topped only by the need for crisis intervention and stabilization.[3] Information gathered by the Office of the Inspector General indicates that children/adolescents seeking services wait an average of 26 days to access any services. The same source reports that CSBs have inadequate capacity to serve children, rarely perform comprehensive assessments on which to base treatment plans, do not integrate findings about the child's substance use into the treatment plan, and have difficulty retaining staff that are knowledgeable about providing services to children and adolescents.[4] Information from a specialized federally grant-funded project that focused on the needs of adolescents indicated that CSB staff lack the specialized knowledge and skills to provide services to youth with substance use or co-occurring mental health disorders. The leading suggestion from CSBs about how services to children and adolescents could be improved was to provide training on evidence-based services to families and children.[5] As a result of their untreated problems, these youths fail to achieve their full potential as adults, and some end up involved with the criminal justice system. In addition, the juvenile justice system needs community treatment services for juveniles under community supervision.

Ongoing funds are needed to support one clinical staff person at each of the 40 CSBs who would be dedicated to providing treatment services to children with substance use and co-occurring mental health disorders. In addition, funds are needed to support, plan and implement ongoing training and coaching of these adolescent specialists to assure that the evidence-based practices being used are true to the model and represent the most current and effective practices. The Adolescent Specialist at each CSB would be knowledgeable and skilled in the use of evidence-based practices and programs that have been found to be effective in working with youth, including integrating the family into treatment services and developing community-based systems of care, such as working with the school and community health and social services professionals.

Proposal 3: Expand Project Link. Pregnant women who are using alcohol or other drugs during their pregnancy present a special challenge to treatment providers because of complex psychiatric, medical and social needs. These women often have co-occurring mental health issues and usually are severely addicted. However, because of the risk of losing custody of current children or the unborn baby, they may be afraid to seek help. In addition, infants born to mothers who are addicted to alcohol are at risk for Fetal Alcohol Syndrome, a type of intellectual disability that is associated with severe learning disabilities and physical abnormalities. Children born to mothers addicted to other types of drugs may experience neurological abnormalities and may suffer from learning disabilities. Untreated, these infants will require treatment in Newborn Intensive Care Units, costing hundreds of thousands of

[3] Office of Comprehensive Services (2009). FY09 CSA Critical Service Gaps. January 29, 2010.
[4] Office of the Inspector General, (2008) Review of Community Services Board Child and Adolescent Services. Report #149-08. p. 19.
[5] Office of the Inspector General, (2008) Review of Community Services Board Child and Adolescent Services. Report #149-08. p. 19.

dollars, and requiring extensive educational and social supports, including potential removal to foster care.

Project Link, initially implemented by DBHDS in 1990 with federal funds, provides intensive case management to pregnant women who are either using substances or who are at risk of using substances that harm their unborn children. It utilizes a local interagency team consisting minimally of the local department of social services, the local health department, and the community services board to engage pregnant women who present for services at any of these agencies by providing prenatal care, social services supports, substance abuse treatment and intensive case management. The result is that a healthy infant is born to a mother who is fully engaged in recovery. If the woman has other dependent children, these agencies can also provide services for them. Special needs can be attended to in early childhood when intervention is likely to have the greatest affect, the family can receive services and supports from local health and social services agencies, and the mother can receive treatment and recovery support through the local community services board.

Currently DBHDS funds eight Project Link sites that have been highly successful in helping these mothers deliver healthy babies (birth weights and head circumference), treat their addiction, improve their understanding of effective parenting, and provide "wrap-around" services to address the health and social needs of the family. Sites would be staffed by a Link Coordinator who will establish and maintain focused interagency relationships with the local departments of social services and health, at a minimum.

Proposal 4: Expand Peer-run Support Services. Peer-run support services provide another approach to improving timely access to services, as well as providing supports to persons in need of services. Although peer-run support services can often provide effective and low-cost supplemental supports to treatment, and can tide people over until treatment is available, only half the CSBs report using these services. People with substance use disorders need many different types of support, and some types of assistance are more appropriate and more effective when provided by people who are in recovery themselves. These types of support can include emotional support (peer-led support groups); informational support (life skills classes such as financial management, nutrition and wellness, time management, relapse prevention, career planning, leadership development); instrumental support (child care, transportation, housing, clothing, food banks); and social supports (pro-social recreational events, drop-in centers).

Currently DBHDS is funding five peer-support centers, and one center is funded by a federal grant. These centers provide a variety of supports that complement treatment or support people who are either not ready to seek treatment, not able to access treatment, or who are in long-term recovery and seeking additional supports, such as recovery-oriented social events. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that DBHDS and CSBs partner with peer-run recovery organizations in the provision of substance abuse services.[6]

[6] Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

DBHDS would use a competitive request for proposal process to award five to seven additional projects in the first year based on the organization's ability to address program requirements, quality standards, accountability, and other criteria. Participants in peer-run support services would have improved access to supports that would increase the likelihood of long-term recovery from substance use disorders. Programs would be tailored to address local gaps and needs as demonstrated in its proposal response and would be monitored by DBHDS. In subsequent years additional programs in other communities would be added through competitive grants.

Proposal 5: Enhance Uniform Screening and Assessment of Mental Illness and Substance Use Disorders. Effective treatment begins with a thorough assessment of the issues and problems of the person seeking services. Although three out of four CSBs use a standard instrument to assess the clinical needs of people seeking services, the instruments are not scientifically validated (e.g., they have not been proven to be accurate), and fewer than that are using industry standard criteria for deciding what clinical services are needed to address the clinical substance use disorder problems that are identified in the assessment. Thus, decisions about what services are to be provided are often subjective.

Complicating this lack of a common approach to basic assessment is the fact that many people seeking services for either mental illness or a substance use disorder actually have both disorders, yet often only one disorder is identified. Mental health needs of adults seeking services for substance use disorders from CSBs are under-assessed and under-treated. This is significant because the research literature indicates that a significant proportion of people with substance use disorders also suffer from anxiety and mood disorders, such as depression or bipolar disorder. The risk of intentional suicide among people with substance use disorders is high, and these undiagnosed and untreated mental health disorders are a contributing factor. Apart from the suicide risk, these untreated mental health disorders compound the treatment of the substance use disorder, making it difficult for the person seeking services to maintain the necessary motivation to fully engage in treatment, and undermining the chances that the person will be able to maintain sobriety.

Since the basis of treatment planning and delivery for any disorder is a comprehensive assessment, the lack of thorough assessment and diagnosis severely hampers the effectiveness of treatment. The lack of a uniform scientific approach to an assessment undermines the treatment planning process so that it is difficult to determine if consumers are receiving the appropriate intensity or duration of treatment that will be effective in addressing their addiction. It also impedes communication between collaborating agencies such as those in the criminal justice system. Many of these instruments are in the public domain (e.g., available at no cost), however training is required to learn how to administer the instruments and use the information they provide to develop effective treatment plans.

Funds are requested to support positions at CSBs dedicated to conducting assessment using validated instruments and training on administering the instrument.

Proposal 6: Implement a Structured Systems Improvement Practice Model such as the Network to Improve Addiction Treatment (NIATx). A national systems-engineering approach to this issue, originally sponsored by the Robert Wood Johnson Foundation and developed by the University of Wisconsin, resulted in NIATx. This low-cost disciplined approach to continuous quality improvement develops an organizational culture that supports team-based problem-solving for service system problems such as long waiting times for treatment. It provides the organization with a concrete framework for identifying needed changes, such as *eliminating wait times by providing same day intakes*. Organizations learn to measure the impact of small, simple changes to how treatment is made available. Each organization develops a change team that must involve the leadership of the organization as well as practitioners and other key players. They "walk-through" their organization with a volunteer consumer to identify barriers to effective treatment. This exercise enables them to "see" their services system through the eyes of the consumer and identify barriers to services that they would not otherwise have noticed. It helps them to identify a process for removing those barriers in small, simple steps, measuring before and after implementation to test the success of their solution.

Participation in NIATx is free, but does require dedicated focus. Funds are needed to support staff at DBHDS to coordinate NIATx efforts across the state, coach CSB leadership and staff in implementing the process, and facilitate learning cooperatives so that CSBs could benefit from each others' experience. Funds also would support travel around the state to conduct meetings and purchase technology needed to facilitate electronic communication among participating CSBs.

B. Proposals Needed to Fill Gaps in the Services Array:

Proposal 1: Expand Access to Identification and Intervention for Offenders with Substance Use Disorders in Community Correctional Settings. A study conducted by the Joint Legislative Audit and Review Commission (JLARC) found that Virginia expended $613 million dollars in 2006 due to untreated substance abuse, with much of the expense occurring in the criminal justice system.[7] DOC and DJJ provide significant substance abuse treatment services to people who are either in or emerging from institutional care. In addition, many adults supervised by local probation and pre-trial agencies funded by DCJS also have substance abuse problems. As the JLARC report indicates, it is costly to incarcerate these individuals. Further, incarceration has a lifetime impact on people as they seek to re-establish themselves in the community.

This initiative is targeted at providing services to offenders whose criminal offenses are related to substance use. The Report on the Status and Effectiveness of Offender Drug Screening, Assessment and Treatment to the General Assembly of Virginia (Report Document No. 374, 2010) indicates that similar efforts in the past were very effective when they were funded. The 2008 OIG report acknowledges that state Probation and Parole offices across the state report long wait times for services from CSBs and that the array of services needed by these individuals was often not available. Funds for this project would be

[7] Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008) Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19.

allocated to DOC, DJJ and DCJS to purchase services from any qualified provider of the services needed by the individual. Provision of these services would be supervised by local offices of these agencies or, in the case of DCJS, local community corrections. These funds would insure that these individuals received needed services.

Potentially eligible offenders would be screened by staff at DOC, DJJ and local community corrections agencies, just as they are now under the current arrangement described in the Report on the Status and Effectiveness of Offender Drug Screening, Assessment and Treatment to the General Assembly of Virginia (Report Document No. 374, 2010). Funds would be used to purchase clinically appropriate services, including additional psychological assessments, case management, and treatment services of the proposer clinical intensity and duration, based on the clinical assessment. Community treatment providers would be contractually required to meet rigorous professional standards, including the use of evidence-based practices and achievement of outcomes, including employment or educational gains.

Proposal 2: Expand Intensive Outpatient Services (IOP). Persons seeking substance abuse treatment need to receive evidence-based services at a level that is intense enough to support substantial change in thought processes and behavior. Many people seeking treatment have significant involvement with the criminal justice system, and may be re-entering the community after a period of incarceration or detention. They require an initial period of strong clinical support that could be provided by IOP services. Providing treatment services in an IOP modality will be a more efficient use of resources because individuals will be receiving services that are more likely to be at an effective intensity.

IOP services include intensive individual and group experiences (more than an hour, or more than twice per week) facilitated by professionals, utilizing positive peer supports as well as evidence-based counseling practices that are appropriate for the individual. By providing services at a more intensive level, individuals are able to engage in the recovery process more quickly and be more productive in the treatment process. Currently, CSBs do not have the capacity (work force) to provide IOP services. Only about one-third of CSBs report that they provide services at the level of intensity offered by IOP services. Services provided by the remaining CSBs are at a frequency of once per week or less, which does not provide the intensity required to support or sustain recovery.

Funds would support necessary positions at CSBs to provide IOP services that are age appropriate and gender specific. Individual and family counseling would also be available and services would be offered at staggered hours so as not to interfere with employment or school. Services would be provided by qualified professionals.

Proposal 3: Expand Capacity for Community-based Residential Medical Detoxification. Detoxification is often the necessary first step for a person who is physically dependent on alcohol or other drugs. Detoxification from alcohol and certain other drugs can be life threatening, and can be complicated by psychiatric and other health issues, such as heart conditions, seizure disorders or diabetes. For detoxification to be safely conducted, the person should be in a safe, clean, medically supervised residential setting that has access to an on-call physician 24 hours a day, and where care is supervised by a registered nurse and

provided by qualified health professionals. The physician can order medications to assist in safe withdrawal, and the health professionals provide constant monitoring of the patients progress. Detoxification usually lasts from three to seven days, and the patient is ideally discharged to another level of care so that actual substance abuse treatment can continue. Currently, half the CSBs lack local social detoxification services, and a quarter lack local medical detoxification services.[8] There are only about 100 beds for this purpose in the state. The DBHDS *Creating Opportunities* survey of CSBs indicated that CSBs ranked the need for additional detoxification capacity as the second highest needed service in the next five years. Funds would support expansion of detoxification capacity. The bed capacity for this service would be integrated into existing services, such as Crisis Stabilization Units, whenever possible, and would be geographically distributed to improve access around the state.

Proposal 4: Expand Access to Medication Assisted Treatment (Buprenorphine). The 2006 OIG report indicates that half of CSBs lack any access to opiate maintenance treatment, yet opiates are frequently seen in 65% of communities and they lead the list of all drugs considered by CSB staff to be increasing in use.[9] The survey conducted for this report indicated no significant change in this capacity. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that "Funding should be made available to allow community services boards to provide medication assisted treatment and required wrap-around and support services to all persons for whom such treatment is appropriate." [10]

Data from the VDH Office of the Chief Medical Examiner indicated significant increases in abuse of narcotic prescription pain medication. Although this problem began in rural far Southwest Virginia, data indicate that the problem is spreading across the state. In addition, anecdotal reports from treatment providers indicate increasing numbers of young people abusing heroin. Until recently, people addicted to opiates had two treatment choices. They could either withdraw without the use of any medication, which results in extreme flu-like symptoms and does not address the accompanying anxiety and physiological craving, or they could be treated with methadone, a medication that can only be administered in clinics regulated by the federal and state governments. Although methadone treatment is very effective, treatment with methadone requires that the patient report to the clinic on a daily basis which requires daily transportation and can interfere with employment and other productive pursuits. Currently, there are 19 methadone clinic sites in Virginia (only four are operated by CSBs). The private clinic in Lebanon (Tazewell County) is the largest in the state, dosing over 1,000 patients daily, and many people in need of services live more than one hour away.

This project will expand the capacity of CSBs to provide evidence-based treatment for people addicted to opiates, including pain medication, and reduce the number of deaths from

[8] Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report: #129-06, p 17.
[9] Office of the Inspector General. (2006) Review of Community Services Board Substance Abuse Outpatient Services for Adults, Report #129-06, p. 17.
[10] Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

drugs. Buprenorphine is a medication that can be initiated under the supervision of a specially-trained physician in the physician's office or other outpatient setting.

Buprenorphine cancels the craving of the addicted person for opiates and prevents the person from feeling the euphoria of the narcotic. Once the physician determines the correct dosage for the patient, the person receives a prescription and manages his or own medication under supervision while continuing to participate in counseling. When combined with counseling and other supports, it has proven to be an extremely effective component of treatment. Many people are able to taper off the medication over time and live independently of any additional medication, while others find it helpful to continue the medication.

Funding is needed to purchase this medication and to support physician time necessary to examine patients and manage the care of patients using this medication. This funding would also support six two-day physician training events throughout the state about addiction and the use of buprenorphine and other medications.

Proposal 5: Develop Residential Treatment Capacity for Pregnant Women and Women with Dependent Children in Southwest Virginia. Currently there are only three publicly-funded residential treatment programs designed to meet the needs of women with dependent children in Virginia. These are located in Hampton, Richmond and Roanoke. Experience and research clearly indicate that women are more successful in treatment that is segregated by gender, and that allows them to bring dependent children with them into treatment. Such programs provide services and supports that help the woman recover and bond with her children, thereby strengthening the family unit and reducing the need for foster care.

The abuse of prescription narcotic pain medication in Southwest Virginia has reached epidemic proportions with devastating effects on the health and social fabric of many communities that are already suffering from very high rates of unemployment, poor rates of school completion and poor access to routine medical care. Because this area is so remote, women needing this level of treatment are resistant to seeking services in another part of the state. This project would prevent deaths of women, keep families united and reduce the need for costly foster care for children removed from the custody of their families due to abuse or neglect. DSS reports that the rate of foster care entries for the Western region is significantly higher (1.6 per 1,000 children) than any other part of the state (0.9 per thousand was the next highest rate), and that 32% of these entries had parental drug abuse, a rate nearly twice as high as the next highest region.[11]

Ongoing funding would support development and operation of this therapeutic program to house up to 16 individuals (mothers and children up to age 12) and would provide intensive therapy for women who are dependent on drugs. It would include access to medical services for the women and their children, psychiatric and psychological services, daily counseling, classes in parenting skills, coaching in independent living, and intensive case management for the children to address the problems caused by the mother's addiction. Services would be delivered by CSB staff. Women would be transitioned into the community with extensive case management and a plan of ongoing treatment and other supports.

[11] VDSS Research Brief: Parent Substance Abuse and Foster Care Entry by Region in Virginia. October 15, 2010.

Proposal 6: Re-establish Transitional Therapeutic Communities for DOC. DOC currently operates three therapeutic communities (TCs) for offenders with severe substance use disorders, one for men at Indian Creek, and one for women at the Women's Correctional Center, and at Lawrenceville, a privately operated facility. Together, these institutions have a capacity of 1,432 beds. These programs are quite intensive, involving the incarcerated offender in treatment programming virtually every waking hour. Prior to 2009, approximately 300 of these offenders each year re-entered society by entering a transitional therapeutic community (TTC), a service which was purchased from existing community providers. Funds for this service were eliminated in 2008. DOC outcome data indicate that men who completed both the institutional program and the TTC had a recommitment rate of only 13.6%, whereas offenders who completed only the institutional TC had a recommitment rate of 20%.[12] The results were similar for women, with those who completed both the TC and the TTC having a recommitment rate of 8.8% compared to 19.3% among those who completed only the TC.[13]

The TTCs would provide room and board and intensive treatment for approximately 300 offenders with substance use disorders per year in a closely supervised residential treatment setting licensed by DBHDS. The TTC program would include individual, group and family therapy using evidence-based treatment models and services approved by DOC. Residents would also be responsible for many tasks involving the operation of the residence, such as cooking, cleaning and basic clerical work, thereby learning basic life skills under the supervision of staff. The TTC program would also include assistance with moving back into the community independently, such as finding employment and housing. TTCs would be staffed by persons who are licensed or certified by the DHP in behavioral health and substance abuse specialties. By providing this additional post-release support, these individuals would be much less likely to re-offend. Residents would stay for approximately six months.

C. Proposals to Provide Additional Services and Supports Needed to Sustain a Recovery Oriented System

Proposal 1: Expand Department of Rehabilitative Services SA Vocational Counselors Project. Stable employment is a key component of successful recovery from substance use disorders. Often people in substance abuse treatment have lost their jobs due to their disorder, and may have never developed essential job-seeking and job-keeping skills. In 1988, DBHDS entered into a memorandum of agreement (MOA) with DRS to provide specialty vocational rehabilitation (VR) counseling services to persons receiving substance abuse treatment at CSBs. Currently there are 21 VR counselors working with 18 CSBs. DRS's annual evaluation of this project indicates the following:

- Case service costs for clients with substance use disorders receiving specialized VR services from dedicated VR counselors is 39% lower than the case service costs for clients with substance use disorders served by generalist VR counselors ($1,042 versus $1,700, on average, over the "life" of the case).

[12] Department of Corrections (DOC) (2005) Evaluation Update: Therapeutic Community Program (2001 Males).
[13] Department of Corrections (DOC) (2005) Evaluation Update: Therapeutic Community (2002 Females).

- The typical "life" of a VR case for clients with substance use disorders served by the dedicated counselors is somewhat shorter which reduces the per-client cost of in-house services.
- VR clients with substance use disorders served by the dedicated counselors are more likely to achieve successful employment outcomes (56% with SA specialty counselors) as opposed to these individuals being served by general caseload counselors (45%).
- VR clients with substance use disorders served by dedicated VR counselors have significantly higher hourly earnings when their VR cases are closed ($9.98 versus $9.19, on average) than other clients with substance use disorders served by general caseload counselors.

This initiative would provide funds to DBHDS to expand the MOA with DRS to additional DRS positions dedicated to providing VR counseling services to people receiving substance abuse treatment through CSBs.

Proposal 2: Expand Access to Housing Options Available to Adult Offenders in the Community. The first 30 to 60 days of an offender's return to the community are critical to successful re-entry. Unfortunately, this period of time also represents a time frame in which return to substance use and criminal behavior are likely unless basic needs are met. Returning offenders often lack the financial resources to pay for their own housing, such as security deposits for apartments and utilities, and initial rent. Lack of safe, sober housing can present a major barrier to recovery, employment and establishing relationships with others who support a sober, law-abiding life. Family relationships may be too strained to move home, and former friends are likely to have criminal ties or to be using illegal drugs or abusing alcohol. Yet without housing and social supports, the returning offender may recidivate.

One option that could be explored would be to utilize a model already in use in Virginia, self-run households of four to six same gender individuals in recovery who rent a house and live under self-developed rules and agree to being sober. The adults provide mutual support for living without alcohol or other drugs. They live in rented houses under self-developed rules and additional structure, along with the requirement that all must stay sober. In order to participate in the program, the individual must make a minimum deposit and contribute financially to the operation of the home. Most recently returning offenders are unable to make this monetary contribution.

DOC is already engaged in a pilot in which it pays the initial entry costs to cover approximately six weeks in order to give the returning offender time to locate employment and then assume responsibility for the cost of remaining at the residence. The current pilot is focused on the 22 homes in Fredericksburg, Lynchburg and Hampton. Additional funds would permit DOC to provide assistance to returning offenders in other areas of the state.

Proposal 3: Establish Capacity for Supported Living Services. Lack of a safe place to live that supports sobriety is a frequent barrier to successful recovery. People seeking recovery have often alienated family and friends and lack income to rent safe secure housing. This might include persons leaving correctional institutions, people being discharged from

detoxification or residential treatment, or people who are simply without a safe, supportive environment while they actively seek recovery through some level of outpatient service. Supported living services can provide an option to placing a person in an expensive residential treatment program whose clinical needs do not really warrant that level of treatment services. In the DBHDS *Creating Opportunities* survey, CSBs indicated that the lack of safe, sober housing is a significant barrier to recovery, but one-third indicate that they have no access to this type of resource.

This proposal for ongoing funding would provide support to CSBs to operate supported housing services that provide a limited amount of structure and support for people who are actively engaged in treatment. The projects would be geographically distributed throughout the state. Many of the activities and supports, such as transportation, recreation, basic case management, and support groups, could be provided by peer-counselors supervised by a professional at the CSB or through a peer-run support service. As they are able, residents would be employed, would purchase and prepare their own food, and would pay a monthly fee to supplement the costs of living in the facility.

Proposal 4: Create a Multi-Agency Work Force Development Capacity Focusing on the Treatment of Substance Use Disorders. In the last 20 years, a substantial body of knowledge has evolved concerning effective treatment for substance use disorders. It has also become clear that certain practices and programs are more effective for some populations or specific clinical issues than others. For instance, there are particular models that are effective for addressing clinical issues that are common among women. The developmental needs of adolescents call for specific evidence-based practices and programs, and with the help of a grant procured by DBHDS, DJJ has been able to convert its institutional service system into one that is evidence-based. Research indicates that people with criminal histories benefit from specific approaches, and DOC is implementing these practices system-wide. However, when the individuals served by DJJ or DOC re-enter the community, they need to be able to continue to receive treatment using the same practices that worked for them in the institution. In its 2008 report, JLARC noted that although three-quarters of the CSBs had incorporated some EBPs in their array of services, their inclusion needed to be more widespread. In addition, fewer than half of CSBs have the appropriate supervisory framework to assure that they are properly implemented, which can undermine effectiveness.[14] Generally, this knowledge is not conveyed in college or graduate level courses where health or behavioral health professionals are trained. In addition, improved collaboration concerning work force development could promote system-efficiencies in developing training events and ongoing coaching and supervision opportunities.

Ongoing funds would support promotion and coordination of implementation of evidence-based practices for treatment of substance use disorders and co-occurring mental illness that are appropriate to the populations served in the community, and to collaborate with DJJ and DOC, and other agencies when appropriate, in the dissemination of knowledge, skills and abilities throughout the work force. This activity needs to be ongoing because:

- The rate of staff turnover indicates that training needs to be repeated;

[14] Virginia General Assembly, Joint Legislative Audit and Review Commission. (2008)Mitigating the Cost of Substance Abuse in Virginia, House Document No. 19, pp.81-85.

- Evidence-based practices are constantly evolving;
- Existing staff need to periodically refresh their skills and knowledge; and
- Implementing evidence-based practices often involves making changes to the organizational culture that must occur overtime.[15]

Proposal 5: Develop an Ongoing Evaluation Process for Established Drug Treatment Courts. Many adults, youths and families end up in court facing felony convictions for nonviolent crimes related to drug or alcohol abuse or dependence which are costly to the person, his family and the Commonwealth. Drug treatment courts, which provide intensive supervision, treatment and case management under the supervision of a judge, have proven to be an effective alternative to conviction and incarceration. Currently there are 27 drug treatment courts in Virginia. The Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention recommended that "Drug courts should be established in all localities throughout the Commonwealth, and should be funded by the General Assembly."[16]

The process for establishing a drug treatment court in Virginia is rigorous, and requires that a court present a consensus of significant community stakeholders and make application to the Supreme Court of Virginia (SCV). The application is reviewed by the State Drug Treatment Court Advisory Committee, whose membership consists of judges, sheriffs, representatives of state agencies and advocacy organizations. Once an application is reviewed and approved, it is forwarded to the General Assembly where it is reviewed by the appropriate legislative committees. However, failure to gain an affirmative vote prevents the establishment of the drug treatment court in the locality requesting it and denies its residents of the benefits of such a court, even if no funds are being requested to support the operation of the court. In the 2011 Session of the General Assembly, six applications were presented for approval; however, none of the applications were approved. It appears that a number of legislators are not convinced drug treatment courts are cost-effective.

A one-time appropriation would fund a position, equipment (hardware/software) and travel necessary to develop a statewide evaluation model to conduct an ongoing assessment of every drug treatment court in the state. The evaluation would include outcome measures, including recidivism. In addition, pending the outcome of this analysis, it is requested that existing funding for drug treatment courts be held harmless from reduction or elimination.

Note: The Substance Abuse Services Council wishes to note that the National Center on State Courts is currently under contract to conduct a two-year cost-benefit analysis of the state drug treatment court system; the Council supports expansion of this evaluation and also supports the adoption of drug treatment courts that are approved by the Supreme Court of Virginia.

[15] See Fixsen, Dean L., et.al. Implementation Research: A Synthesis of the Literature (2005). University of South Florida.
[16] Senate Document 5 (2010). Executive Summary of the Joint Subcommittee to Study Strategies and Models of Substance Abuse Treatment and Prevention (SJR 318, 2009).

APPENDICES

§ 2.2-2696. Substance Abuse Services Council.

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

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

C. Appointments of legislative members and heads of agencies or representatives of organizations shall be for terms consistent with their terms of office. Beginning July 1, 2011, the Governor's appointments of the seven nonlegislative citizen members shall be staggered as follows: two members for a term of one year, three members for a term of two years, and two members for a term of three years. Thereafter, appointments of nonlegislative members shall be for terms of three years, except an appointment to fill a vacancy, which shall be for the unexpired term. The Governor shall appoint a chairman from among the members for a two-year term. No member shall be eligible to serve more than two consecutive terms as chairman.

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

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

E. Members of the Council shall receive no compensation for their services but shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties

as provided in §§ 2.2-2813 and 2.2-2825. Funding for the cost of expenses shall be provided by the Department of Behavioral Health and Developmental Services.

F. The duties of the Council shall be:

1. To recommend policies and goals to the Governor, the General Assembly, and the State Board of Behavioral Health and Developmental Services;

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

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

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

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

G. Staff assistance shall be provided to the Council by the Office of Substance Abuse Services of the Department of Behavioral Health and Developmental Services.

(1976, c. 767, § 37.1-207; 1977, c. 18; 1978, c. 171; 1979, c. 678; 1980, c. 582; 1984, c. 589; 1990, cc. 1, 288, 317; 1998, c. 724; 1999, c. 614; 2005, cc. 713, 716; 2009, cc. 424, 554, 813, 840; 2011, cc. 691, 714.)

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