COMMONWEALTH of VIRGINIA

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

September 23, 2014

To: The Honorable Terry R. McAuliffe, 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 *2014 Substance Abuse Services Council Response to Code of Virginia §2.2-2697.B. - Comprehensive Interagency State Plan*.

Sincerely,

William H. Leighty

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
The Honorable Brian J. Moran, Secretary of Public Safety
Debrah Ferguson, Commissioner, Department of Behavioral Health and Developmental Services
Harold W. Clarke, Director, Department of Corrections
Andrew K. Block, Jr., Director, Department of Juvenile Justice

Enc.

2014 SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO
CODE OF VIRGINIA §2.2-2697

TO THE GOVERNOR
AND THE
GENERAL ASSEMBLY

COMMONWEALTH OF VIRGINIA
OCTOBER 1, 2014

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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.

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.

- Revenues supporting treatment services totaled $146,953,897 for FY 2013.

- This overall figure is an approximate sum of the following revenue components:

Federal	$ 42,709,125
State	$ 46,629,700
Local	$ 40,155,891
Consumer fees or third party payers	$ 14,437,296
Other	$ 3,021,885

- A total of 34,382 individuals received substance abuse treatment services supported by this funding.

Over the last decade, CSBs have experienced level funding from federal and state sources resulting in stagnant capacity while knowledge of evidence-based treatment for substance use

disorders has expanded. These services require more time and skill to successfully implement and often require the services of trained medical personnel as well as counseling staff trained in specific treatment models appropriate for the individual's issues. Increasing evidence indicates that many individuals with substance use disorders are also experiencing mental health issues that interfere with recovery.

Due to lack of adequate funding, CSBs are unable to provide the array of services needed to address these complex problems, with the consequence that individuals receive services that lack the intensity, duration or specific clinical approach needed to successfully address the substance use disorder, and they do not get the assistance they need to address barriers to treatment engagement. This results in less effective treatment services.

There are a number of factors that negatively impact the ability to report valid results on these metrics. House Joint Resolution 683 and Senate Joint Resolution 395 from 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. In the resulting report, *Mitigating the Costs of Substance Abuse in Virginia*, 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.

To support systems change, outcomes must be considered as part of an organized and committed quality improvement initiative at both the state and provider levels. DBHDS has developed a quality improvement process for CSBs and state facilities focused on intensity of engagement and retention in services.

DBHDS has developed a strategic plan (C*reating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* [1], http://www.dbhds.virginia.gov/library/document-library/omh-sa-interagencysareport.pdf) proposing 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.

DEPARTMENT OF JUVENILE JUSTICE

The Department of Juvenile Justice (DJJ) provides substance abuse treatment services to residents meeting the appropriate criteria at each of its juvenile correctional centers (JCCs)

[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.

with the exception of the Reception and Diagnostic Center (RDC). The following information reflects these services:

JCC Programs:

Substance Abuse Services Expenditures:	$1,104,531
Total Division Expenditures:	$80,054,196

In FY 2013, 86% of the 439 residents admitted to JCCs had a mandatory or recommended substance abuse treatment need.

DJJ institutions should continue to implement evidence-based programming: Cannabis Youth Treatment, individualized treatment plans for residents with co-occurring disorders, and VOICES, A Program of Self-discovery and Empowerment (gender-specific treatment programming for female residents). Re-entry systems and collaboration with community resources and families should continue to be strengthened to ensure smooth transition of residents to the community.

DEPARTMENT OF CORRECTIONS

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. VADOC is organized into two areas of field operations: community corrections and institutions. VADOC attempts to match the offender to appropriate treatment services based upon criminogenic factors and risk of recidivating.

Treatment services expenditures totaled $6,656,651 for FY 2013 with community corrections expending approximately $2,639,651and institutions expending approximately $4,017,000. As of June 2014, there were approximately 57,165 offenders under active supervision in the community and an active institution population of 30,086. Screenings conducted on all offenders entering VADOC indicate that approximately 70% of the offender population may have a need for some level of substance abuse treatment.

VADOC 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 (i.e., in particular for the Matrix Program) 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 and related security posts in prisons.

The availability of additional 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. In general, facilities must use existing limited staff resources to provide the program, and it has hindered the ability of VADOC to be able to provide the program to all offenders that may need it.

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 $25,498 in FY 2012. The cost avoidance and benefits to society that are achieved from offenders not returning or not coming into prison offsets treatment costs.

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SUBSTANCE ABUSE SERVICES COUNCIL
RESPONSE TO
***CODE OF VIRGINIA* 2.2-2697**
FOR 2014

I. INTRODUCTION

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

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

The 2005 Substance Abuse Services Council report responded to Section A of the *Code* and included estimates of the large unmet need for treatment and recommendations to address this unmet need. As required, this report on services provided in FY 2013 responds to Section B and includes a description of the substance use disorder (SUD) services provided by state agencies in Virginia. As used in this document, treatment is defined narrowly as those services directed toward individuals with identified substance abuse and dependence disorders, and does not include prevention services for which other evaluation methodologies exist.

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

II. PROGRAM REVIEWS

Department of Behavioral Health and Developmental Services

The Department of Behavioral Health and Developmental Services (DBHDS) provides funding and oversight to 40 community services boards (CSBs), entities of local government that provide publicly funded substance abuse treatment services to their specific jurisdictions. Summary information regarding these services is presented below.

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(i) the amount of funding expended under the program for the prior fiscal year (FY 2013);

- Revenues supporting treatment services totaled $146,953,897 for FY 2013.

- This overall figure is an approximate sum of the following revenue components:

Federal	$ 42,709,125
State	$ 46,629,700
Local	$ 40,155,891
Consumer fees or third party payers	$ 14,437,296
Other	$ 3,021,885

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

A total of 34,382 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;

There are a number of factors that negatively impact the ability to report valid results on these metrics. House Joint Resolution 683 and Senate Joint Resolution 395 from 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. In the resulting report, *Mitigating the Costs of Substance Abuse in Virginia*, 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. [2]

In addition, federal confidentiality regulations for substance abuse treatment programs (42 CFR Part 2) are proving to be a significant barrier to the exchange of information cited above that is essential to the measurement of outcomes and the establishment of electronic health records. This federal regulation protects information about individuals who have participated in substance abuse treatment that is federally funded (e.g., the Substance Abuse Prevention and Treatment Block Grant or Medicaid). For instance, CSBs cannot share with DBHDS identifying information about a specific person who has participated in treatment that would allow DBHDS to track this person's engagement in other services or retrieve information such as income that would support outcome measures.

Going forward, the Patient Protection and Affordable Care Act (ACA) encourages the creation of "accountable care organizations" to promote better care coordination, quality and efficiency, the use of information technology, including clinical quality and outcome measures, in a meaningful manner to improve patient care. These provisions and the expansion of insurance coverage for substance abuse treatment services is expected to have a positive effect on the capacity to measure outcomes in the publically-funded behavioral health system. However, it is unclear at this time what the implementation impact of the ACA will be on publicly-funded substance abuse treatment services.

(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 challenges outlined above make it difficult to provide a meaningful analysis of program success in meeting objectives. An increasing appreciation of addiction as a chronic, relapsing disorder, much like diabetes or heart disease, calls for a different model for assessing outcomes, one that tracks client status beyond a single treatment episode. In addition, the lack of a consistently available continuum of services of various levels of intensity across the Commonwealth makes it difficult to match individuals to the appropriate level of care. This last point is discussed further in the following section.

[2] Report of the Joint Legislative Audit and Review Commission to the Governor and the General Assembly of Virginia. Mitigating the Cost of Substance Abuse in Virginia, pp66-67). House Document No. 19, 2008.

(v) how effectiveness could be improved;

A lack of access to the appropriate clinical level of care results in less effective care. Over the last decade, CSBs have experienced level funding from federal and state sources resulting in stagnant capacity while knowledge of evidence-based treatment for substance use disorders has expanded. These services require more time and skill to successfully implement and often require the services of trained medical personnel as well as counseling staff trained in specific treatment models appropriate for the individual's issues, such as trauma history or co-occurring mental health issues. Many individuals seeking services for their substance abuse disorder also have other life issues that present barriers to successful recovery such as lack of transportation to treatment, lack of childcare while participating in treatment, unsafe housing, or serious health or mental health issues. Successful treatment programs require personnel and resources to help the individual address these problems.

These added demands have increased costs, resulting in a gradual decline in the number of clients served each year and average waiting time for individuals to enter treatment of almost three weeks. Lacking funding, CSBs are unable to expand the array of services offered and provide necessary supports for successful engagement, limiting access to appropriate types and intensity of service for many individuals. These factors all negatively impact treatment outcomes and could be addressed with additional funding.

To support systems change, outcomes must be considered as part of an organized and committed quality improvement initiative at both the state and provider levels. DBHDS has developed a quality improvement process for CSB and state facilities. While focused on process measures rather than outcomes, there is a substantial body of literature that supports the relationship between these measures and improved client outcomes. The two substance service measures are:

1. Intensity of engagement
The engagement measure is defined the percent of adults admitted to substance abuse services during the previous 12 months who received one hour of outpatient services after admission and two additional hours within 30 days of admission.

2. Retention in community substance abuse services
The retention measure is define as the percent of all individuals admitted to substance abuse services in the previous 12 months who received one valid substance abuse or mental health service in the month following admission and one valid service every month for the following five months (excluding services provide in jails and juvenile detention centers).

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

The JLARC study previously cited indicates that the adverse consequences of substance abuse in 2006 cost the State and localities between $359 million and $1.3 billion[3] , and also states that

[3] JLARC 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."[4]

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

Numerous reports, including the JLARC reported previously cited, have called for additional funding to support expansion and improved quality of care for the community services board system. Additional state general fund appropriations for substance abuse services are needed to support this expansion, as well as inclusion of an adequate array of substance abuse services for adults and adolescents in the Essential Benefits Plan of the State Medicaid Plan.

Three years ago, DBHDS developed a strategic plan (C*reating Opportunities for People in Need of Substance Abuse Services: An Interagency Approach to Strategic Resource Development* [5] , http://www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf) proposing enhancing access to a consistent array of substance abuse services across Virginia by expanding statewide capacity and filling identified gaps in the array of substance abuse service modalities.

Based on this statewide assessment, an additional investment of resources is needed in:

- 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; and,
- residential services for pregnant women and women with children .

[4] JLARC p. 129.

[5] 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.

Department of Juvenile Justice

The Department of Juvenile Justice (DJJ) provides substance abuse treatment services to residents meeting the appropriate criteria at each of the juvenile correctional centers (JCCs) with the exception of the Reception and Diagnostic Center (RDC). The following information reflects these services.

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(i) the amount of funding expended under the program for the prior fiscal year (FY2012);

JCC Programs:

Substance Abuse Services Expenditures:	$1,104,531
Total Division Expenditures:	$80,054,196

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

In FY 2013, eighty-six percent (86%) of the 439 residents admitted to JCC's had a mandatory (42%) or recommended (44%) substance abuse treatment need.

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

DJJ calculates 12-month re-arrest rates for residents who had a mandatory substance abuse treatment need. Rates are calculated based on a re-arrest for any offense, and an additional analysis examines re-arrest for only substance offenses. A mandatory treatment need indicates that the resident had to participate in and complete treatment before his or her release (or remain until the statutory release date). Re-arrest rates of residents with mandatory treatment needs are compared to the re-arrest rates of those without mandatory treatment needs. However, residents with a recommended treatment need are included with the group of residents without a mandatory treatment need even though they may have completed treatment. Residents with a recommended need are not included with the mandatory needs group because data are not available on whether a juvenile with a recommended need participated in or completed treatment.

Re-arrest rates for any offense are lower for juveniles without a mandatory substance abuse treatment need than for those with the mandatory treatment need. In FY 2011, 51.6% of residents with a mandatory treatment need were rearrested for any offense within 12 months of release, as compared to 44.3% of residents without a mandatory treatment need. In FY 2012, 52.2% of residents with a mandatory treatment need were rearrested for any offense within 12 months of release, as compared to 45.7% of residents without a mandatory treatment need.

Re-arrest rates for substance offenses are also lower for juveniles without a mandatory substance abuse treatment need than for those with the mandatory treatment need. In FY 2011, 12.2% of juveniles with a mandatory treatment need were rearrested for a substance offense as their first re-offense within 12 months of release, as compared to 10.3% of juveniles without a mandatory treatment need. In FY 2012, 13.5% of juveniles with a mandatory treatment need were rearrested for a substance offense as their first re-offense within 12 months of release, as compared to 8.1% of juveniles without a mandatory treatment need.

While recidivism rates provide some insight to the effectiveness of programs, the rates presented here cannot be interpreted as a sound program evaluation due to a number of limitations. DJJ does not currently have treatment completion data to determine if a juvenile actually completed treatment. Additionally, residents are assigned treatment needs based on their offenses, so they may have a predisposition to certain types of reoffending which cannot be measured. Also, because juveniles are assigned treatment needs based on certain characteristics that distinguish them from the rest of the population, there is no control group for treatment need. Finally, determining the type of re-offense is not always possible, so the rates for substance-related rearrests may be slightly underestimated.

DJJ is currently in the process of reviewing treatment program completion data. Once this process is complete, available data from previous years will be collected, and staff will be trained to ensure current program completion information is up-to-date in the database. DJJ will then analyze institutional behavior before, during, and after the program as well as long-term recidivism rates of program completers.

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

Per person costs cannot be determined because a large amount of the money allotted to substance abuse programming goes toward the salaries of staff who act as counselors and facilitators of the program. These staff also administer aggression management and sex offender treatment and perform other tasks within the behavioral services unit (BSU) at each facility. Each staff member performs a different set of duties based on his or her background and current abilities. Staff do not devote a clear-cut percentage of their time to each duty, but rather adjust these percentages as needed; therefore, there is no way to calculate how much of a staff member's pay goes directly toward substance abuse programming, and per person cost cannot be determined.

(v) how effectiveness could be improved;

DJJ institutions should continue to implement evidence-based programming: Cannabis Youth Treatment; individualized treatment plans for residents with co-occurring disorders, and VOICES, A Program of Self-discovery and empowerment (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. Currently, DJJ's electronic data system tracks community-based urine screens on residents released from JCCs who were assigned substance abuse programming. Data culled from this set will hopefully prove useful to further programming outlooks.

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

Information to address this issue is not available due to the inability to calculate per person costs.

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

Information to address this issue is not available due to the inability to calculate per person costs.

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. VADOC 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, VADOC contracts for many of its treatment services with Community Service Boards (CSB) and private vendors. The Probation and Parole Districts and community corrections facilities provide services primarily through a Memorandum of Agreement (MOA) or contract services for substance abuse treatment, although some VADOC staff also provide services.

In institutions, VADOC 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. The CTC program is designed for offenders who are assessed as having high need for treatment. 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.

VADOC continues to operate the Matrix Model for offenders assessed as having moderate to lower range substance abuse treatment needs. The Matrix Model is an evidence-based, intensive outpatient, substance abuse treatment modality. The program is operated at all Intensive Re-entry Programs along with a few other institutions and community correction sites. VADOC also has support services such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

§ 2.2-2697 B.

(i) the amount of funding expended under the program for the prior fiscal year (FY 2013);

Treatment services expenditures totaled for FY 2013: $6,656,651. This overall expenditure is an approximate sum of the following expenditure components:

Community corrections	$2,639,651
Institutions	$4,017,000

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

As of June 30, 2013, there were approximately 57,165 offenders under active supervision in the community. VADOC's risk/needs assessment COMPAS substance abuse scale scores indicate that an estimated 70% of those under active supervision, which would equate to 40,016 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 has been implemented in the Intensive Re-entry Programs. There are four components to the program, and group sizes are usually kept to twelve (12) participants. The number of offenders participating in support services such as NA and AA varies. The support services are generally provided by volunteers.

(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 VADOC'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 2011 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 VADOC specific information is not available at this time, a 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. VADOC 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;

VADOC 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 and related security posts 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 $25,498 in FY 2012. The cost avoidance and benefits to society that are achieved from offenders not returning or not coming into prison offsets treatment costs.

(vii) 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. VADOC has implemented evidence-based substance abuse treatment programs including the Cognitive Therapeutic Communities for offenders assessed with higher treatment needs and the Matrix Model for those with moderate treatment needs. 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, although the reviews are restricted by limited staff resources. 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, VADOC will be able to address the treatment needs of the substance abusing offender population.

III. Overviews of Treatment Services Provided by State Agencies

Department of Behavioral Health and Developmental Services

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

- ***Emergency Services*** – These services are unscheduled services available 24 hours per day, seven days per week, to provide crisis intervention, stabilization and referral assistance either over the telephone or face-to-face. They may include jail interventions and pre-admission screenings.
- ***Inpatient Services*** – These services provide short-term, intensive psychiatric treatment or substance abuse treatment, except for detoxification, in local hospitals or detoxification services using medication in a general hospital setting 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.
- ***Medication Assisted Treatment 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. Services are supervised by a physician who is available 24 hours per day and onsite services are supervised by a nurse and are provided by other trained medical personnel.
- ***Intensive Residential Services*** -These services provide long-term substance abuse rehabilitation services and include stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.
- ***Other Residential Services*** include supervised services which provide onsite supervision in a setting that provides overnight care, and Supportive Services which provide services to a person who lives in a more independent setting, such as a personal apartment.

Department of Juvenile Justice

DJJ institutions provide substance abuse treatment services at each of the JCCs, with the exception of 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.

Please note that two JCCs (Oak Ridge and Hanover) that previously provided substance abuse treatment services closed during the last fiscal year. The Oak Ridge program was moved to the Beaumont campus; therefore, substance abuse programming referred to as "The Oak Ridge Program" should be considered a program within Beaumont's physical structure.

Substance abuse treatment services at the three correctional centers (Beaumont, Bon Air, and Culpeper) utilize the Cannabis Youth Treatment Program, also known as Motivational Enhancement Therapy/Cognitive Behavioral Therapy 5&7 (MET / CBT 5 & 7). MET / CBT 5 & 7 is evidence-based with an 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 BSU to administer therapies for residents with co-occurring disorders and/or other debilitating clinical issues via individual, group, or family therapy. The course of treatment 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 participating in the same program. Currently, Beaumont and Bon Air JCC residents housed in these units also receive aggression replacement training in conjunction with 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.

Beaumont JCC

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 two self-contained units (24 bed capacity each – total of 48 beds). Residents who are unable to enter these 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 other specialized housing units when deemed appropriate. Beaumont houses males approximately 17-20 years of age.

Bon Air JCC

Bon Air houses both males and females and has two and half 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 an 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 17.5 years of age and females of all ages up to 21.

Culpeper JCC

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

Oak Ridge Program at Beaumont

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

Department of Corrections

The Department of Corrections (VADOC) provides a tiered substance abuse services approach to address varying offender treatment needs based on the severity of the problem. VADOC 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 as described under DBHDS heading on page 11. Beginning in 2012 some of the community corrections sites started providing the Matrix Model which is an intensive, outpatient substance abuse treatment program. Support services such as NA and AA are also offered through the Districts.

In several institutions, VADOC provides 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 2013 the VADOC fully implemented the Matrix Model program at the prison Intensive Re-entry Program 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 VADOC staff in many of the institutions. However, since it was not an evidence-based treatment program, it has been discontinued.

VADOC also receives grant funding from the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) program. The VADOC program is entitled STAND (Start Today a New Direction). This program has a capacity of 50 offenders. This program utilizes two Client Advocates (CAs) positions to assist substance abusing offenders with their reentry into the community and referrals to treatment. The Client Advocate model is considered effective but is resource intensive since each CA carries a caseload of typically 15 but no more than 25 offenders.

While not a substance abuse specific intervention, VADOC is currently providing the evidence-based "Thinking for a Change" program at all institutions and a follow up peer support group is provided at all 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 VADOC 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 that integrates 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. 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 impose full sentences 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.

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

Abstinence from Drug/Alcohol Use measured by reduction in/no change in frequency of use at date of last service compared to date of first service.

Increased/Retained Employment or Return to/Stay in School measured by increase in/no change in number of employed or in school at date of last service compared to first service.

Decreased Criminal Justice Involvement measured by reduction in/no changes in number of arrests in past 30 days from date of first service to date of last service.

Increased Stability in Housing measured by increase in/no change in number of clients in stable housing situation from data of first service to date of last service.

Increased Social Supports/Social Connectedness measured by an increase in how often in the past 30 days an individual has participated in a non-professional, peer-operated organization that is devoted to helping individuals reach or maintain recovery.

Increased Access to Services measured by the unduplicated count of persons served or the penetration rate (numbers served compared to those in need).

Increased Retention in Treatment measured by length of stay from date of first service to date of last service.