COMMONWEALTH of VIRGINIA

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

October 1, 2015

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 *2015 Substance Abuse Services Council Response to Code of Virginia §2.2-2697.B. - Comprehensive Interagency State Plan*.

Sincerely,

William H. Leighton, Jr.

Cc: The Honorable William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
The Honorable Brian J. Moran, Secretary of Public Safety
Jack Barber, Interim 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.

SUBSTANCE ABUSE SERVICES COUNCIL
REPORT ON CODE OF VIRGINIA § 2.2-2697
FOR 2014

TO THE GOVERNOR
AND THE
GENERAL ASSEMBLY

OCTOBER 1, 2015

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I. INTRODUCTION

The 2004 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 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." As used in this document, treatment means those services directed toward individuals with identified substance abuse or dependence disorders, and does not include prevention services for which other evaluation methodologies exist. Publicly funded substance abuse treatment services in the Commonwealth of Virginia are provided by the following state agencies: the Department Behavioral Health and Developmental Services (DBHDS), the Department of Juvenile Justice (DJJ), and the Department of Corrections (DOC). Common goals of these programs include abstinence or reduction in alcohol or other drug usage and reduction in criminal behavior.

II. PROGRAM REVIEWS

Department of Behavioral Health and Developmental Services (DBHDS)

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.

(i) the amount of funding expended under the program for the prior fiscal year (FY 2014)

Expenditures for treatment services totaled $141,462,860 in FY 2014.

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

A total of 33,035 unduplicated individuals received substance abuse treatment services supported by this funding in FY 2014.

(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. [1]

Federal confidentiality regulations for substance abuse treatment programs (42 CFR Part 2) are 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. 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 are 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

[1] 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, pp 66-67). House Document No. 19, 2008.

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 Virginia makes it difficult to match individuals to the appropriate level of care. This last point is discussed further in the following section.

(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 and counseling staff trained in specific treatment models appropriate for the individual's issues, such as trauma history or co-occurring mental health disorders. Many individuals seeking services for their substance use 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 individuals receiving services each year. Anecdotal reports indicate considerable wait-times for treatment. Lacking funding, CSBs are unable to expand the array of services offered and are unable to 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. Currently, DBHDS uses the following two measures for substance abuse services:

1. Intensity of engagement – Percent of adults admitted to the substance abuse services program area during the previous 12 months who received 45 minutes of outpatient treatment services after admission (denominator) who received at least an additional 1.5 hours of outpatient services within 30 days of admission (numerator).

2. Retention in community substance abuse services – Percent of all individuals admitted to the substance abuse services program area during the previous 12 months who received at least one valid substance abuse or mental health service of any type, except residential detoxification services or those services provided in jails or juvenile detention centers, in the month following admission (denominator) who received at least one valid mental health or substance abuse service of any type, except residential detoxification services or services provided in jails or juvenile detention centers, every month for at least the following two months (numerator). This is measured again for the five months following admission.

(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 Virginia and its localities between $359 million and $1.3 billion[2] and states that "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."[3]

(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 CSB 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 Plan for Medical Assistance.

DBHDS Commissioner Debra Ferguson has initiated a transformation process to comprehensively review the state behavioral health and developmental services system. This effort focuses on access, quality, and accountability. This transformation process is grounded in the principles of recovery, resiliency, self-determination, and wellness for everyone served in the DBHDS system. The ultimate goal is to become a model services system and to achieve the DBHDS vision of "A life of possibility for all Virginians."

The transformation teams are in the process of analyzing the behavioral health and developmental services system and developing strategic proposals for services, delivery, and infrastructure. The transformation team for adult behavioral health is taking the lead on addressing substance use disorders.

The first round of recommendations was received in the Spring of 2015. Opportunities for public comment on these recommendations have included four statewide town-hall style meetings and a feedback mechanism posted on the website. This provides the public with opportunity to review the proposals developed by the teams and provide feedback. These recommendations are being reviewed to determine which can be implemented administratively, legislatively or with budget action. The second round of the transformation process is currently underway.

Department of Juvenile Justice (DJJ)

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.

[2] JLARC p. 39.
[3] JLARC p. 129.

(i) the amount of funding expended under the program for the prior fiscal year (FY2014)

JCC Programs:

Substance Abuse Services Expenditures:	$ 1,025,645
Total Division Expenditures*:	$70,653,599

* Total division expenditures exclude closed facilities (Natural Bridge and Barrett) as well as the Virginia Public Safety Training Center.

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

In FY 2014, 33 percent of the 367 residents admitted to JCC had a mandatory need for substance abuse treatment and 52 percent were recommended for substance abuse, for a total of 85 percent. A mandatory treatment need indicates that the resident must participate in and complete treatment before his or her release or remain until the statutory release date. A recommended treatment need indicates that a resident may be kept until his or her late release date if he or she does not complete treatment.

(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 or recommended substance abuse treatment need. Rates are calculated based on a re-arrest for any offense. The re-arrest rates for juveniles released with a mandatory or recommended treatment need are compared to re-arrest rates for all juveniles released from DJJ. It should be noted that the juveniles with mandatory or recommended treatment needs are included in the comparison group of all juveniles released from DJJ.

Re-arrest rates are slightly lower for all juveniles than for those with a mandatory or recommended treatment need. In FY 2012, 51.8 percent of residents with a mandatory or recommended treatment need were rearrested within 12 months of release, as compared to 48.1 percent of all residents. Of the residents with a mandatory or recommended treatment need served in FY 2013, 46.8 percent were rearrested during FY 2014, as compared to 46.3 percent of all residents.

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.

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 gender-specific treatment program 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 program evaluation.

(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 separate distinct costs for substance abuse treatment.

Department of Corrections (DOC)

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

The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) Risk and Needs Assessment was implemented for use by community corrections staff statewide in October 2010 and in institutions as of April 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 percent of the offender population may have a need for some level of

substance abuse treatment.

In community corrections, DOC contracts for many of its treatment services with CSBs and private vendors. The probation and parole districts and community corrections facilities provide services primarily through a memorandum of agreement or local contract services for substance abuse treatment, although some DOC staff also provides services.

In institutions, DOC provides substance abuse treatment programs and services. The Cognitive Therapeutic Community (CTC) program is an evidence-based, residential treatment modality designed to address substance addiction, criminal thinking, and anti-social behaviors. 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) sentenced participants. This program, which is a sentencing option for judges presiding over circuit courts, was enacted by the General Assembly in 2009 through the Appropriation Act. Under this sentencing option, judges have the ability to place offenders directly into the CTCs and to allow early release based on successful treatment participation.

DOC 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.

(i) the amount of funding expended under the program for the prior fiscal year (FY 2014)

Treatment services expenditures totaled $6,727,135 for FY 2014 with community corrections expending $2,886,638 and institutions expending $3,840,497.

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

As of June 2014, there were approximately 58,558 offenders under the active supervision in the community and an active institution population of 30,034. DOC's risk/needs assessment COMPAS substance abuse scale scores indicate that an estimated 70 percent of those under active supervision (over 40,000 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 12 participants. Approximately 1,500 offenders complete the Matrix program each year. The number of offenders participating in support services such as Narcotics Anonymous and Alcoholics Anonymous 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 2005, DOC submitted the *Report on Substance Abuse Treatment Programs* that contained research information on the effectiveness of the Therapeutic Communities and contractual residential substance abuse treatment programs. The findings from these studies suggest that DOC's substance abuse treatment programs – when properly funded and implemented – are able to reduce recidivism for the substance abusing offender population. 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 2012 cohort indicated that the recommitment rate was eight percent. However, since this status check is not a formal outcome evaluation, this data must be interpreted with caution.

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

Although DOC specific information is not available at this time, a report from the Washington State Institute for Public Policy indicated that drug treatment in prison and in the community has a positive monetary benefit. However, in order for evidence-based treatment programs to be cost effective and achieve positive outcomes, they must be implemented as designed, a concept referred to as fidelity. DOC has placed an emphasis on implementation fidelity and has created program fidelity reviews for this purpose. This is an important first step that is necessary prior to performing any cost effectiveness studies. The DOC plans to conduct a more thorough evaluation of substance abuse programs during 2015.

(v) how effectiveness could be improved

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

- Limited resources for clinical supervision to ensure program fidelity, provide technical assistance, and enhance outcomes;
- Limited staff to review fidelity of contract substance abuse treatment in community corrections;
- 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.

Fully funding DOC's treatment based on the needs listed above 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. Department-wide, the DOC per capita cost of housing offenders was $27,462 in FY 2014. The cost avoidance and benefits are achieved from offenders not returning to prison. In addition, effective treatment benefits communities as former offenders can become productive citizens by being employed, paying taxes, supporting families, and when former offenders can interrupt the generational cycle of crime by becoming effective parents and role models.

(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. DOC 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 the offender management system (CORIS), has improved the collection of data that can be used in future outcome and cost effectiveness studies. By continuing to fund the existing programs and securing additional resources, when possible, to address the aforementioned issues, DOC will be able to address the treatment needs of the substance abusing offender population.