COMMONWEALTH of VIRGINIA

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

December 1, 2017

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 *Substance Abuse Services Council Report on Treatment Programs for FY 2016.*

Sincerely,

Sandra O'Dell

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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 TREATMENT PROGRAMS FOR FY 2016 (Code of Virginia § 2.2-2697)

to the Governor and

the

General Assembly

COMMONWEALTH OF VIRGINIA

December 1, 2017

Preface

Section 2.2-2697.B of the Code of Virginia directs the Substance Abuse Services Council to report by December 1 to the Governor and the General Assembly information about the impact and cost of substance abuse treatment provided by each agency in state government. The specific requirements of this section are below:

§ 2.2-2697. Review of state agency substance abuse treatment programs.

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.*

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ON TREATMENT PROGRAMS FOR FY 2016

Introduction

This report summarizes information from the three executive branch agencies that provide substance abuse treatment services: the Department of Behavioral Health and Developmental Services (DBHDS), the Department of Juvenile Justice (DJJ), and the Department of Corrections (DOC). These agencies share the common goals of increasing abstinence from alcohol and other drug use and reducing criminal behavior. All of the agencies are invested in providing treatment that is evidence-based, and each agency has specific constraints on its ability to provide the most effective treatment services to its population. In this report, the following information is detailed concerning each of these three agencies' substance abuse treatment programs:

1. Amount of funding spent for the program in FY 2016;
2. Unduplicated number of individuals who received services in FY 2016;
3. Extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures;
4. Identifying the most effective substance abuse treatment;
5. How effectiveness could be improved;
6. An estimate of the cost effectiveness of these programs; and
7. Funding recommendations 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. This report provides information for Fiscal Year 2016, which covers the period from July 1, 2015 through June 30, 2016.

Department of Behavioral Health and Developmental Services (DBHDS)

The publicly funded behavioral health and developmental services system provides services to individuals with mental illnesses or substance use disorders, developmental disabilities, or co-occurring disorders through state hospitals and training centers operated by DBHDS, and 40 community services boards (CSBs). CSBs were established by Virginia's 133 cities or counties pursuant to Chapters 5 or 6 of Title 37.2 of the Code of Virginia. CSBs provide services directly and through contracts with private providers, which are vital partners in delivering services. Summary information regarding these services is presented below.

1. Amount of Funding Spent for the Program in FY 2016 – Expenditures for substance abuse treatment services totaled $137,069,635, including state and federal funds, local funds, fees and funds from other sources.

2. Unduplicated Number of Individuals Who Received Services in FY 2016 – A total of 30,180 unduplicated individuals received substance abuse treatment services supported by this funding in FY 2016.

3. Extent Program Objectives Have Been Accomplished as Reflected by an Evaluation of Outcome Measures – Currently, DBHDS uses the following substance abuse services quality measures for each CSB:

- **Intensity of Engagement in Substance Abuse Outpatient Services**: Intensity of engagement is measured by calculating a percentage. The denominator is the number 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. The numerator is the number of these individuals who received at least an additional 1.5 hours of outpatient services within 90 days of admission. The 2016 percentage was 70 percent, surpassing the target of 63 percent.

- **Retention in Community Substance Abuse Services:** Retention is measured by calculating a percentage at two points in time: three months and six months following admission. The denominator is the number of all individuals admitted to the substance abuse services program area during the 12 months who received at least one valid substance abuse or mental health service of any type in the month following admission. The numerator for retention at three months is the number of these individuals who received at least one valid mental health or substance abuse service of any type every month for at least the following two months. The numerator for retention at six months is the number of these individuals who received at least one valid mental health or substance abuse service of any type every month for at least the following five months. The 2016 three month percentage for this measure was 61 percent which surpassed the 60 percent target. The five month percentage for this measure was 31 percent, which surpassed the 26 percent target. In calculating this measure, valid substance abuse services do not include residential detoxification services or those services provided in jails or juvenile detention centers.

4. Identifying the Most Effective Substance Abuse Treatment – Identifying the most effective substance abuse treatment based on a combination of per person costs and success in meeting program objectives is difficult because the chronic relapsing nature of the condition often results in a non-linear path to recovery. Also, evidence-based treatment for substance use disorders consists of an array of modalities and interventions that are tailored to the specific needs of each individual seeking treatment, depending on severity and need for clinical services and supports. The lack of a consistently available array of services across Virginia makes it difficult to match individuals to the appropriate level of care. Comparisons of cost per person would result in comparing a relatively meaningless average of the treatment costs across many different individuals receiving very different combinations of services.

The deadly opioid overdose epidemic, that began in the mid-2000s and resulted in 809 deaths in calendar year 2015[1], has made access to appropriate treatment an urgent need. DBHDS strongly encouraged CSBs to help individuals access medication assisted treatment (MAT), the evidence-based standard of care for opioid addiction. However, MAT, which requires qualified health care professionals, infrastructure and clinical treatment and support, is costly to provide.

[1] Virginia Department of Health Office of the Chief Medical Examiner: http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Quarterly-Drug-Death-Report-FINAL_10.2016.pdf

5. How Effectiveness Could be Improved – Without access to the appropriate clinical level of care, the overall results of healthcare outcomes are diminished. Over the course of the last decade, CSBs have experienced level funding from federal and state sources. This has resulted in stagnant or reduced capacity while knowledge of evidence-based treatment for substance use disorders has expanded. These services require more time and skill to implement successfully and often require the services of medical and counseling staff trained in specific treatment models appropriate for the individual's issues, such as trauma-informed care or co-occurring mental health disorders. Many individuals seeking services for their substance use disorder 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 and, combined with level state and federal funding, have resulted in a gradual decline in the number of individuals receiving services each year. Anecdotal reports indicate considerable wait-times for treatment. Lacking additional 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 intensities of services for many individuals.

To support systems change, outcomes must be considered as part of an organized and committed quality improvement initiative at state and provider levels. DBHDS has developed a quality improvement process for CSBs and state mental health hospitals. A platform to improve program effectiveness can be provided through focusing on quality improvement and funding substance abuse services at a level adequate to make an expanded continuum of care and array of evidence-based practices available across the state.

6. An Estimate of the Cost Effectiveness of These Programs – Over the last 10 years, a number of national studies have documented the tremendous financial burden placed on society as a result of substance use disorders. The National Institute on Drug Abuse (NIDA) monitors the prevalence and trends regarding drug abuse in the United States. As shown in the table below, abuse of tobacco, alcohol, and illicit drugs exact more than $740 billion annually in costs related to crime, lost work productivity and health care.

ECONOMIC IMPACT OF SUBSTANCE ABUSE IN THE UNITED STATES

	Health Care	Overall	Year of Estimate	Sources
Tobacco	$168 billion	$300 billion	2010	U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General*. Atlanta, GA Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual Healthcare Spending Attributable to Cigarette Smoking: An Update. American Journal of Preventive Medicine 2014;48(3):326–33

	Health Care	Overall	Year of Estimate	Sources
Alcohol	$27 billion	$249 billion	2010	Centers for Disease Control and Prevention. Excessive Drinking is Draining the U.S.
Illicit Drugs	$11 billion	$193 billion	2007	National Drug Intelligence Center. National Drug Threat Assessment. Washington, DC: United States Department of Justice; 2011
Prescription Opioids	$26 billion	$78.5 billion	2013	Birnbaum, HG. et al. Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States. Pain Medicine 2011; 12: 657-667. Florence, CS et al. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013; Medical Care. Volume 54, Number 10, October 2016

The overall cost of illicit drugs includes the misuse of prescription drugs. A separate analysis of 2007 data estimated US costs of prescription opioid misuse at $55.7 billion. The most recent estimate of prescription opioid misuse, based on 2013 data, updated this cost to $78.5 billion, an increase of more than $20 billion per year compared to six years earlier. Taken together, with the growing misuse of opioids and related health consequences, the cost estimates for illicit drug use in the US are likely to have risen substantially since the 2007 estimate.

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. The resulting report, *Mitigating the Costs of Substance Abuse in Virginia*, indicated that the adverse consequences of substance abuse in 2006 cost Virginia and its localities between $359 million and $1.3 billion[2]. The report 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] While the cost estimates in this report are becoming somewhat out of date, the escalation of the opioid crisis over the last ten years makes it likely they are still useful in providing a conservative benchmark of Virginia-specific costs.

7. Funding Recommendations – Numerous reports, including the 2007 JLARC report cited above, have called for additional funding to support the expansion of services and improved quality of care for individuals receiving services from CSBs. DBHDS initiated a stakeholder transformation process (completed in 2016) to comprehensively review the state behavioral health and developmental services system. This effort focused on access, quality, consistency

[2] Joint Legislative Audit and Review Commission, Commonwealth of Virginia. Mitigating the Cost of Substance Abuse in Virginia (2007), p.39.

[3] Ibid., 129.

and accountability. This transformation process is grounded in the principles of recovery, resiliency, self-determination, and wellness for everyone who receives services supported by DBHDS. In addition, Governor McAuliffe's Task Force on Heroin and Prescription Drug Abuse (2014-2015) recommended funding to implement evidence-based strategies to address the opioid epidemic, specifically, improving access to medication assisted treatment and to naloxone, a life-saving medication that can be administered in emergencies to reverse opioid overdoses. [4]

Department of Juvenile Justice (DJJ)

DJJ provides substance abuse treatment services to residents meeting the appropriate criteria at its juvenile correctional centers (JCCs). The following information reflects these services.

1. Amount of Funding Spent for Programs in FY 2016 – Expenditures for substance abuse treatment services totaled $758,902.

2. Unduplicated Number of Individuals Who Received Services in FY 2016 – In FY 2016, 250 (78.4 percent) of the 319 residents admitted to JCCs were assigned a substance abuse treatment need. Effective October 15, 2015, DJJ revised its Length of Stay Guidelines for Indeterminately Committed Juveniles (LOS Guidelines). Instead of mandatory and recommended substance abuse treatment needs, juveniles admitted under the new LOS Guidelines are assigned Track I and Track II to reflect their individual needs. Of the 90 juveniles admitted under the previous LOS Guidelines, 32.2 percent had a mandatory treatment need and 38.9 percent had a recommended treatment need. Of the 229 juveniles admitted under the new LOS Guidelines, 72.1 percent were assigned a Track I treatment need and 9.2 percent were assigned a Track II treatment. Overall, 51.7 percent of the 319 admissions were assigned Track I, 6.6 percent were assigned Track II, 9.1 percent were assigned mandatory, 11.0 percent were assigned recommended, and 21.6 percent were not assigned a substance abuse treatment need.

3. Extent Program Objectives Have Been Accomplished – DJJ calculates 12-month re-arrest rates for residents who had an assigned substance abuse treatment need. Rates are calculated based on a re-arrest for any offense. The substance abuse treatment need subgroup of direct care releases includes juveniles with any type of substance abuse treatment need. An assigned treatment need does not indicate treatment completion.

Re-arrest rates are slightly lower for all juveniles than for those with a substance abuse treatment need. In FY 2015, 52.8 percent of residents with a substance abuse treatment need were rearrested within 12 months of release, as compared to 51.5 percent of all residents. In FY 2014, 51.2 percent of residents with a substance abuse treatment need were rearrested within 12 months of release, as compared to 49.5 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

[4] Commonwealth of Virginia, Recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse, Implementation Plan – Update, Fall 2015, October 20, 2015, p.14, p. 27, p. 30, p. 32.

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.

4. Identifying the Most Effective Substance Abuse Treatment – 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 members also administer aggression management and sex offender treatment and perform other tasks within the behavioral services unit 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.

5. 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 programming outlooks.

6. 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.

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

Department of Corrections (DOC)

1. Amount of Funding Spent for the Program in FY 2016 – Treatment services expenditures totaled $6,487,879 for FY 2016 with community corrections expending $2,965,588 and institutions expending $3,522,291.

2. **Unduplicated Number of Individuals Who Received Services in FY 2016 –** As of July 31, 2016 there were 62,135 offenders under active supervision in the community. DOC utilizes the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment tool for risk assessment and service planning. Information collected from this process indicates that approximately 70 percent of those under active supervision, which would equate to over 43,000 probationers or parolees, have some history of substance abuse and may require treatment or support services. These services are provided mainly by CSBs and private vendors. Offenders on probation or parole also access community Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups.

In institutions, there are 1,175 participants in correctional therapeutic communities (CTCs). The Matrix Model program (an evidence-based treatment) 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 Model program each year. The number of offenders participating in support services such as NA and AA varies. The support services are generally provided by volunteers.

3. Extent Program Objectives Have Been Accomplished – In September 2005, the DOC submitted the *Report on Substance Abuse Treatment Programs* that contained research information on the effectiveness of 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 check completed for the calendar year 2012 cohort indicated a promising recommitment rate of eight percent. Since this status check is not a formal outcome evaluation, caution should be exercised in the interpretation of the data.

4. Identifying the Most Effective Substance Abuse Treatment – 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 as well as the community has a positive monetary benefit. Of course, in order for evidence-based treatment programs to be cost effective and achieve positive outcomes, they must be implemented as designed, a concept referred to as fidelity. DOC has placed an emphasis on implementation fidelity and created program fidelity reviews for this purpose. This is an important first step that is necessary prior to performing any cost effectiveness studies.

5. How Effectiveness Could be Improved – DOC continues to face a number of challenges related to providing effective 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, 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 illnesses;
- Lack of inpatient residential treatment services;
- Limited evaluation resources; and
- Sometimes a lack of optimal programming space in prisons and related security posts in prisons.

Fully funding DOC's substance use disorder treatment services based on the needs listed above would increase the number of offenders who could receive treatment and enhance the quality of the programs, thus producing better outcomes.

6. 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 per capita cost of housing offenders for the entire agency was $28,997 in FY 2016. The cost avoidance and benefits to society that are achieved from offenders not returning or not coming into prison offset treatment costs. In addition, effective treatment benefits local communities as former offenders can become productive citizens by being employed, paying taxes, and supporting families. In addition, when former offenders can interrupt the generational cycle of crime by becoming effective parents and role models, the community is also enhanced.

7. Funding Recommendations – 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 CTC for offenders assessed with higher treatment needs and the Matrix Model for those with moderate treatment needs. DOC has established a fidelity review process 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. In addition, the scope of services for Community Corrections vendor contracts to provide treatment services for individuals with substance use disorders have been restructured to require specific evidence-based programs that will allow DOC to monitor offender progress and program fidelity more effectively. The implementation of the Virginia Corrections Information System (CORIS) has improved the collection of data that can be used in future outcome and cost effectiveness studies. The DOC continually looks for grants to be able to expand substance abuse treatment, and treatment is particularly needed for those with opioid addiction and for offenders housed in DOC's minimum custody facilities where treatment resources are lacking. DOC will continue to make every effort within its resources to provide substance abuse services to offenders in need of them.