COMMONWEALTH of VIRGINIA

Substance Abuse Services Council

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

December 1, 2025

To: The Honorable Glenn Youngkin, Governor of Virginia
The Honorable Winsome Earle-Sears, Lieutenant Governor of Virginia
The Honorable Don Scott, Speaker, Virginia House of Delegates

From: The Virginia Addiction and Recovery Council

The 2004 Session of the General Assembly amended §2.2-2697.B. of the *Code of Virginia*, to direct the Virginia Addiction & Recovery Council, formerly named the Substance Abuse Services Council (referred to as the Council in this report), to collect information about the impact and cost of substance use disorder treatment provided by public agencies in the Commonwealth. In accordance with that language, please find attached the *Virginia Addiction & Recovery Council's Report on Treatment Programs for FY 2025*.

Cc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources
The Honorable Marcus Anderson, Secretary of Public Safety and Homeland Security
Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services
Chadwick S. Dotson, Director, Department of Corrections
Amy Floriano, Director, Department of Juvenile Justice
Cheryl Roberts, Director, Department of Medical Assistance Services

VIRGINIA ADDICTION & RECOVERY COUNCIL'S REPORT ON TREATMENT PROGRAMS FY 2025 (Code of Virginia § 2.2-2697)

To the Governor

and the

General Assembly

COMMONWEALTH OF VIRGINIA

December 1, 2025

Preface

Section 2.2-2697.B of the Code of Virginia directs the Council to report by December 1 to the Governor and the General Assembly information about the impact and cost of substance use disorder treatment provided by each agency in state government. The specific requirements of this section are below and have been revised to use non-stigmatizing language based on the Centers for Disease Control Health Equity Style Guide:

§ 2.2-2697. Review of state agency substance use disorder treatment programs and recovery services.

B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance use disorder treatment program and recovery services:

(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 use disorder treatment and recovery services, 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.

VIRGINIA ADDICTION & RECOVERY COUNCIL
REPORT ON TREATMENT PROGRAMS
FY 2025

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VIRGINIA ADDICTION & RECOVERY COUNCIL REPORT ON TREATMENT PROGRAMS FOR FY 2025

Introduction

This report summarizes information from the four executive branch agencies that provide substance use disorder treatment and recovery services: The Department of Behavioral Health and Developmental Services (DBHDS), the Department of Juvenile Justice (DJJ), the Department of Corrections (DOC) and the Department of Medical Assistance Services (DMAS). These agencies share the common goals of increasing the health and wellness of Virginia's individuals, families, and communities, increasing access to substance use disorder treatment and recovery services, and reducing the impact of those with a substance use disorder and involvement in the criminal justice system. All agencies included in this report are invested in providing evidence-based treatment and recovery services within the specific constraints each has on its ability to provide these services. In this report, the following information is detailed concerning each of these four agencies' substance use disorder treatment programs:

1. Amount of funding spent for the program in FY 2025;
2. Unduplicated number of individuals who received services in FY 2025;
3. Extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures;
4. Identifying the most effective substance use disorder 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 use disorders and does not include prevention services.

Treatment Programs for FY 2025

This report provides focused data on specific outcomes. Every fatal drug overdose represents many affected individuals, and every individual who commits a crime associated with substance use disorder represents many others who are also involved.[1] Many of these individuals are struggling with functional impairment due to their substance use disorder and this is reflected in decreased workforce participation,[2] negative impact on the economy,[3] the potential for dissemination of blood borne diseases,[4] and recidivism.

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[1] Virginia Department of Health: Office of the Chief Medical Examiner. (2025). *Fatal Drug Overdose Quarterly Report*. Retrieved from https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[2] Over the last 15 years, LFP fell more in counties where more opioids were prescribed." Alan B. Krueger; BPEA Article; Brookings Institute; Thursday, September 7, 2017; "Where have all the workers gone? An inquiry into the decline of the U.S. labor force participation rate"; https://www.brookings.edu/articles/where-have-all-the-workers-gone-an-inquiry-into-the-decline-of-the-u-s-labor-force-participation-rate/

[3] Midgette, Gregory, Steven Davenport, Jonathan P. Caulkins, and Beau Kilmer, What America's Users Spend on Illegal Drugs, 2006–2016. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3140.html. Also available in print form.

[4] County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who

The inclusion of methamphetamine treatment in monies allocated for 2020 allowed for much needed expansion of services. It should be noted that earmarking funds to ameliorate the impact specific drugs have on health outcomes may fail to acknowledge that substance use, or substance use disorder (SUD) is not limited to a specific drug. SUD is a non-substance specific recognized and diagnosable disorder. Lack of flexibility to utilize funding when addressing misuse of ALL drugs may indirectly result in increased use of others.

While fatal overdoses due to opioids and methamphetamines decreased from 2022 to 2023, they increased for cocaine.[5] Deaths from all three types of drugs exhibited a sharp decline from 2023 to 2024. In fact, the number of fatal overdoses from all drugs decreased by 33.5 percent and by 43.6 percent for fentanyl during this same time period. However, the rate of decline appears decreasing, and we may be reaching a plateau based on Q1 2025 data. Cocaine and fentanyl are the most common combination of substances causing fatal overdoses, accounting for 28.9 percent of all overdose deaths.

Further, it appears that deaths attributable to benzodiazepines and prescription opioids (excluding fentanyl) are increasing in 2025.[6] These data illustrate that the number of overdose deaths from different substances can trend independently of one another. This clearly indicates that a reactive or drug specific approach to substance use funding may result in duplicated services, and poorer outcomes.

Inject Drugs, United States; Buchanan et. al. MJAIDS Journal of Acquired Immune Deficiency Syndromes: November 1, 2016 - Volume 73 - Issue 3 - p 323–331 doi: 10.1097/QAI.0000000000001098 Epidemiology and Prevention

[5] Virginia Department of Health: Office of the Chief Medical Examiner. (2025). *Fatal Drug Overdose Quarterly Report*. Retrieved from https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[6] Virginia Department of Health: Office of the Chief Medical Examiner. (2025). *Fatal Drug Overdose Quarterly Report*. Retrieved from https://www.vdh.virginia.gov/medical-exam`iner/forensic-epidemiology/

Department of Behavioral Health and Developmental Services (DBHDS)

The publicly funded behavioral health and developmental services system provides services to individuals with mental illness, substance use disorders, developmental disabilities, as well as co-occurring disorders through state hospitals and training centers operated by DBHDS, the 40 community services boards (CSBs), one of which is designated a Behavioral Health Authority (BHA), and a network of collaborative private providers. CSBs were established by Virginia's 133 cities or counties pursuant to Chapters 5 and 6 of Title 37.2 of the Code of Virginia. CSBs are public health agencies that provide services directly to their population and through contracts with private providers.

Summary information regarding these services is presented below.

1. Amount of Funding Spent for the Program in FY 2025.

Expenditures for substance use disorder treatment services totaled $231,529,194. This amount includes state and federal funds, local funds, fees, and funding from other sources. The table below provides details about the sources of these funds.

Expenditures for Substance Use Disorder Treatment Services by Source	
State Funds	$83,188,126
Local Funds	$58,183,331*
Medicaid Fees	$24,620,327
Other Fees	$5,324,669*
Federal Funds	$51,913,895
Other Funds	$8,245,461*

*Local Funds and Other Funds may have been utilized to support prevention activities.

2. Unduplicated Number of Individuals Who Received Services in FY 2025.

A total of 21,902* unduplicated individuals received substance use disorder treatment services supported by this funding.

*FY 2025 Q4 data include April 2025 only. Due to the statewide transition to the new Enterprise Data Warehouse, May and June 2025 submissions did not meet DBHDS data quality standards and are excluded from this report.

3. Extent Program Objectives Have Been Accomplished as Reflected by an Evaluation of Outcome Measures.

Currently, DBHDS uses the following substance use disorder services quality measures for each CSB:

- **Initiation of Substance Use Disorder Services**: Initiation of services is measured by calculating a percentage. The denominator is the number of all individuals admitted to the substance use disorder services program area with a new substance use diagnosis during the fiscal year. The numerator is all individuals in the fiscal year who then received a first substance use service within 14 days of that new diagnosis. The state average for FY 2025 was 80 percent (the goal for FY 2025 was 75 percent) of all individuals being successfully initiated within 14 days of new substance use diagnosis. This far exceeds the latest national average for this measure of 38 percent indicated on the National Committee for Quality Assurance's website.

- **Engagement in Substance Use Disorder Services**: Engagement is measured by calculating a percentage. The denominator is the number of all individuals admitted to the substance use disorder services program area with a new substance use diagnosis during the fiscal year. The numerator is all individuals in the fiscal year who then received a first substance use service within 14 days of that diagnosis and received an additional two substance use services 30 days thereafter. The state average in FY 2025 was 60.4 percent (the goal for FY 2025 was 58 percent) of individuals meeting the requirement for engagement. Similarly to the initiation measure, this state average far surpasses the latest national average for the engagement measure of 10.3 percent listed on the National Committee for Quality Assurance's website.

4. Identifying the Most Effective Substance Use Disorder Treatment.

The sometimes chronic, relapsing nature of substance use disorder often results in non-linear pathways to a sustained recovery. This makes identifying the most effective type of treatment difficult. Evidence-based treatment for substance use disorders consists of an array of modalities and interventions provided to individuals in need based on many factors. These modalities are presented and implemented through a lens of person-centered treatment planning and therefore are tailored to the specific needs of each individual seeking treatment, coupled with their American Society of Addiction Medicine (ASAM) criteria (assessment of level of need) and partnered with their willingness to participate. Other factors, such as legal status, probation requirements, transportation difficulties, family expectations/responsibilities, and co-occurring behavioral health and medical issues further complicate measures of effectiveness across populations.

The lack of a consistently available and accessible array of services across Virginia may cause additional stressors to individuals seeking care as well as their support systems. The factors mentioned above can make it difficult to match individuals to the appropriate level of care. Virginia continues to work on system transformation through initiatives such as STEP-VA and Behavioral Health Redesign to address and correct the inconsistency of available services and support individuals in care by ensuring appropriate reimbursement and coverage rates with Addiction Recovery and Treatment Services (ARTS) and Medicaid expansion.

It is important to note workforce shortages in behavioral healthcare play a significant role in one's ability to engage in services. Virginia has a significant shortage of providers for substance use disorder related to services that is mirrored by many other states. In Virginia, the

workforce issues have many causes, including an aging workforce, the lingering labor market impacts of COVID-19, low wages for treating staff, increasing regulations and certifications, and a significant lack of engagement from younger individuals entering the field. These issues can lead to longer wait times to access services, larger group sizes, increased engagement issues, and higher caseloads. When this information is applied to a population of individuals who often seek to enter treatment services immediately to avoid additional use, there can be serious consequences.

The deadly opioid overdose epidemic began in the mid-2000s before peaking with 2,229 deaths in calendar year 2021[7]. Opioid overdose deaths have been steadily decreasing since then, with a significant drop from 2023 to 2024[8]. This indicates the importance of comprehensive, expansive, and evidence-based treatments for all individuals and their families. However, 1,221 individuals still lost their lives to opioid overdose in 2024, and the early indicators of 2025 data illustrate a plateau, with deaths decreasing at a lower rate than in 2024[9]. While the decline is encouraging, this plateau shows that it is as important as ever to continue ALL mitigation efforts to ensure the decline continues. To this end DBHDS continues to actively support our CSB partners in providing (among other services) medication-assisted treatment (MAT), the evidence-based standard of care for opioid use disorder through time-limited federal grant funding, as it is costly to provide.

It is worth emphasizing that Virginia, like the rest of the United States, is seeing a rise in Methamphetamine use.[10] Further, fatal overdoses due to cocaine did not decrease in 2022 and 2023 but rather continued to increase.[11] While deaths due to cocaine did exhibit substantial decline from 2023 to 2024, other drugs such as benzodiazepines and prescription opioids appear to be increasing in 2025.[12] This is to be expected, as substance use disorder is *not* substance specific. Failure to treat substance use disorder in its totality using evidence-based practices will continue to result in the loss of life, inefficient use of resources due to being restricted to specific drug types, and community wide impact related to the continued spread of use and other complicating factors.

5. How Effectiveness Could Be Improved.

Successful healthcare outcomes are dependent on individuals receiving the appropriate level of care for their needs as well as a holistic approach to them as an individual. CSBs continue to experience level funding from federal and state sources. DBHDS is moving toward significant changes in funding structure and has implemented as of July 1, 2022, the use of an invoicing

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[7] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[8] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[9] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[10] 116th Congress second session S4491 To designate methamphetamine as an emerging threat, introduced by Ms. Feinstein and Mr. Grassley

[11] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[12] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

system for payment of services related to federal dollars. This should allow for better use of funding across the state and better tracking at the state level. However, the funding streams used for services remain, in some cases, restricted based on the substance used and therefore create difficulties in the treatment system related to allocations for funds across all populations. It is important to note, 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 needs and concerns, such as trauma-informed care or co-occurring disorders. This leads to the rise in costs for service.

Furthermore, individuals seeking and needing services frequently experience other life issues that present barriers to successful recovery such as lack of transportation, lack of stable employment, lack of childcare, unsafe housing, or serious health or mental health issues which create dynamics that may be difficult for providers to address depending on their available service array. Successful treatment programs require personnel and resources to help individuals in care address these problems across many populations. Increased access to safe and equitable transportation assistance that works across urban and rural areas, opportunities to participate in supported employment programs, secure housing options, and increased access to psychiatric care are imperative to successful engagement and sustainment in treatment options as well as helping to bolster a recovery-oriented approach to all services.

For providers to remain educated, supported, and clinically efficient, ongoing dedicated funding related to continuing clinical training in support of the use of evidenced based practices across the Commonwealth is imperative to provide sustainable support of clinical expertise and goals within the existing workforce already heavily influenced by other factors in Virginia.

To support system change, DBHDS continues to move toward and support a data driven, outcomes-based approach coupled with quality improvement initiatives at state and provider levels. DBHDS has developed a quality improvement process for CSBs that includes technical assistance in a comprehensive way based on areas of need. A comprehensive data driven ecosystem is being developed to improve program effectiveness, support quality improvement and further strengthen the case for the funding of substance use services at a level adequate to make an expanded continuum of care and array of evidence-based practices available across the state.

Continued work to move toward ongoing training and support of evidence-based models of treatment for individuals with the disease of addiction will initially require more resources but will result in lowered costs. Like any other disease, incorrect diagnosis results in incorrect treatment resulting in poor outcomes. DBHDS is partnering with DMAS to provide ongoing ASAM training for providers to ensure the appropriate levels of care for the individual being served. With increased access to evidence-based treatment for the disease of addiction, we expect to see better functioning workers and increased tax revenues, decreased crime, decreases in associated medical costs (HIV, Hepatitis C, endocarditis resulting in valve replacement, Neonatal abstinence syndrome, trauma and accidents, etc.), improved life expectancy and a happier more productive population.

6. An Estimate of the Cost Effectiveness of These Programs.

It remains difficult to assess and make recommendations on the cost effectiveness of programs as

they vary across the state and as those struggling with addiction often involve levels of complexity which impact care and treatment. However, the ability to access an appropriate level of care is a measure that impacts successful treatment and outcomes. It is recommended that cost effective evaluations focus on the use of evidence-based treatment and holistic outcomes for assertion of the long-term effectiveness of treatment.

It is also important to note the influence on service options from COVID-19. With the implementation of telehealth as a part of the pandemic response, treatment services may now be available to individuals that were previously not served. Throughout the pandemic treatment providers have indicated an increase in retention and engagement from individuals in care, however it is important to keep in mind potential privacy issues related to telehealth and group services over telehealth vary by providers. Given the value provided by telehealth, it is recommended that while privacy concerns remain a priority, the opportunities provided by the service expansion outweigh most negatives and would continue to be a valuable option for Virginians. Additionally, though the initial costs of telehealth may be higher compared to other treatment options, the potential for long term savings, coupled with decreasing care timelines, telehealth offers a great opportunity.

7. Funding Recommendations.

The Department of Medical Assistance Services (DMAS) continues to offer a waiver that supports a wide array of treatment services for individuals with substance use disorders, based on criteria developed by the American Society of Addiction Medicine. This array included improved access to MAT for individuals with opioid use disorder. DBHDS continues to use the Substance Abuse and Mental Health Services Administration (SAMSHA) State Opioid Response (SOR) funds to support, improve, and develop services that are more comprehensive across prevention, treatment, and recovery services statewide where needed. It is important to note that while DBHDS did receive the notice of Notice of Award for Federal FY 2025 in late September this year, historically the NOA for the SOR Award is not confirmed until October of each year. This can create a delay in the state's ability to process any funding awards prior to the beginning of the federal fiscal year. In the long term, the systems and programs that SOR supports will need to proactively plan for how to support services in case this funding is not renewed at the federal level.

Medicaid expansion, which became effective January 1, 2019, continues to help support some needed infrastructure development, such as provider training to support implementation of evidence-based practices. However, a portion of Virginia's population has income greater than 138 percent of Federal Poverty Level (income eligibility threshold effective January 1, 2019) but cannot afford to purchase private insurance. This population, combined with those who do not qualify for Medicaid Expansion, remain in need of resources and services. Additionally, the full impact of the recently passed H.R.1 by the U.S. Congress are still under evaluation as DBHDS, DMAS and other agencies receive official guidance from the Centers for Medicare and Medicaid Services (CMS) on how changes are to be operationalized.

DBHDS also was awarded an increase of $5 million to its baseline funding to support substance use treatment. Such funding, not restricted by substance, allows for innovative

support of the substance use disorder services system in a comprehensive way and help to address several holes in services such as transition aged youth (18 – 25) and individuals with intellectual disabilities who are struggling with substance use. This funding has also been used to support Naloxone access in the Commonwealth. Any increases in baseline funding will expand the availability of services to individuals battling SUD thereby improving outcomes.

Department of Juvenile Justice (DJJ)

The Department of Juvenile Justice (DJJ) provides and contracts with mental health / substance use treatment providers to provide substance use treatment services to youth under community supervision and in direct care who are assessed as needing substance use treatment. Youth in the community receive mental health and substance use services through a variety of agencies, referral sources and funding entities. Those include services made available through local Community Services Boards, services arranged by local Family Assessment & Planning Teams and services contracted and funded by DJJ through the Regional Service Coordination (RSC) model. In addition to youth in the community, youth in direct care status receive mental health and substance use services in a variety of settings including Bon Air Juvenile Correctional Center (JCC), local juvenile detention centers (JDCs) including direct care intake placements, Community Placement Programs, and individual bed placements, and residential programs including residential treatment centers and therapeutic group homes. Residential programs and services for youth in direct care intake placements and individual bed placements are secured through the RSC model.

DJJ manages Virginia Juvenile Community Crime Control Act (VJCCCA) funds, which are administered through a formula grant to all 133 cities and counties in the Commonwealth. Each locality or grouping of localities develops biennial plans for the use of VJCCCA funds that are consistent with the needs of their communities. Code changes that took effect July 2019 allow localities to incorporate prevention services into future biennial plans. The current biennium began on July 1, 2024 and concludes on June 30, 2026. Some but not all localities included substance use services on their FY 2025 – FY 2026 biennial plans. Of the 76 local VJCCCA plans, during the first year of the biennium (FY 2025), 32 local plans included funds budgeted for programming or services in the category of substance use assessments/ evaluations, substance use education and /or treatment.

In FY 2025, DJJ contracted with Evidence-Based Associates (EBA) to serve as the RSC and assist DJJ with continuing to build a statewide continuum of services for youth and families. The RSC model consists of centralized referral processing, service coordination, quality assurance, billing, and reporting. Through the model, DJJ is able to assess existing programming, develop new service capacity, and execute contracts with Direct Service Providers (DSPs). The model is inclusive of ongoing monitoring of service delivery, including fidelity to evidence-based practices and programs.

The RSC model has increased youth access to evidence-based models addressing substance use including but not limited to Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Adolescent Community Reinforcement Approach (A-CRA), Substance Abuse Intensive Outpatient Program (SAIOP), Seven Challenges, and Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

1. The Amount of Funding Expended for the Program

Bon Air JCC Programs in FY 2025:

Substance Use Services Expenditures: $4,190,462
Total Residential Division Expenditures*: $51,075,067

* Total division expenditures exclude closed facilities as well as the Virginia Public Safety Training Center (VPSTC) and all related costs. Substance use services expenditures at Bon Air JCC are derived from the total amount of treatment services offered to youth; there has been a change in methodology for FY 2025 over previous reports. Substance-related expenditures at non-JCC direct care placements cannot be separated from overall expenditures; therefore, the total residential division expenditures are included to provide additional context.

VJCCCA Substance-Related Programs in FY 2025: $494,927
Substance Use Evaluations/Assessments Expenditures: $11,648
Substance Use Services under the category of Specialized Program Services Expenditures: $2,955 (includes assessments/evaluations, education and treatment)
Substance Use Education Expenditures: $9750
Substance Use Education/Treatment Expenditures: $300,268
Substance Use Prevention Expenditures: $50,354

** RSC data for FY 2025 is not available due to data quality. Beginning in FY 2026, DJJ will manage the RSC Service Delivery Model internally and will work directly with service providers and manage data collection.

2. The Number of Individuals Served by the Program Using that Funding in FY 2025

In FY 2025, 162 (93.6 percent) of the 173 residents admitted to direct care were assigned a substance use treatment need. Youth can be assigned to Track I or Track II to reflect their individual needs. Track I is for youth meeting the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for Substance Use Disorder and in need of intensive services. Track II is for youth who have experimented with substances but do not meet the DSM criteria for Substance Use Disorder. Of the 173 youth admitted, 79.2 percent were assigned a Track I treatment need, and 14.5 percent were assigned a Track II treatment. These youth may have received treatment at Bon Air JCC, direct care JDC placements, or in a residential program.

In FY 2025, 592 youth (plus 441 prevention youth) received VJCCCA funding for substance use services to include assessments/evaluations, education, and treatment. Final FY numbers have not been finalized as of this report.

Additionally, many youth in contact with DJJ receive various services across the state through the RSC model, including youth on probation, on parole, and in direct care. The most recent year for which service-level RSC data are available is FY 2023. Following referrals during FY 2023, 181 youth received substance use evaluations and 163 youth began one or more substance abuse treatment services through the RSCs. Most youth receiving substance use treatment through the RSCs received individual therapy for substance use (60.1 percent) and/or relapse prevention services (24.5 percent). Some youth receiving RSC services for substance use issues participated in the Seven Challenges® services (19.2 percent), substance use family therapy (3.7 percent), substance use intensive outpatient program (3.1 percent), and/or group therapy for substance use (0.6 percent). In addition to services specifically labeled substance use treatment, youth

participating in individual therapy, FFT, and MST had an identified need in the area of substance use, which may have been addressed by those services; however, those services are not included in the expenditures or counts above.

Data for FY 2024 and FY 2025 are not available due to data quality. Beginning in FY 2026, DJJ will manage the RSC Service Delivery Model internally and will work directly with service providers and manage data collection.

3. Extent to Which Program Objectives Have Been Accomplished as Reflected by an Evaluation of Outcome Measures

DJJ calculates 12-month rearrest rates for residents who had an assigned substance use treatment need. Rates are calculated based on a rearrest for any offense, excluding technical violations. An assigned treatment need does not indicate treatment completion. The most recent rearrest rates available are for youth released during FY 2023. It is important to note that rearrest rates do not measure whether a youth used substances (or not) after discharge and is therefore not a direct outcome measure of treatment program success. Substance use treatment within DJJ primarily focuses on preventing and/or minimizing future substance use. Notwithstanding, while substance use treatment is not inherently focused on reducing reoffending behaviors, it directly addresses criminogenic risk factors related to decision-making, impulse control, emotion regulation, prosocial skills, etc. Additional limitations are described below.

In FY 2023, 51.4 percent of former residents with a substance use treatment need were rearrested within 12 months of release, as compared to 49.6 percent of all residents. Rearrest rates for residents with a substance use treatment need reflect rearrests for any offense, not specifically a drug offense.

Youth with higher substance use treatment needs (Track I) had higher rearrest rates than those in Track II. Of youth released in FY 2023, 37.5 percent of Track II youth were rearrested in the 12 months following their release, as compared to 52.5 percent of Track I youth. The rate for Track II youth may be influenced by a low number of releases. In FY 2023, nearly all (93.6 percent) of youth assigned substance use treatment completed treatment prior to their release.

RSC data for FY 2024 and FY 2025 are not available due to data quality. As noted previously, beginning in FY 2026, DJJ will manage the RSC Service Delivery Model internally and will work directly with service providers and manage the data collection.

While recidivism rates provide some insight into the effectiveness of programs, the rates presented here cannot be interpreted as a sound program evaluation due to a number of limitations. First, residents with assigned treatment needs may have risk characteristics different from those not assigned a treatment need or those assigned a different level; because youth 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. Second, an assigned treatment need does not indicate treatment completion. Third, data on whether re-offenses were substance-related are not available at this time. As mentioned above, rearrest rates do not reflect the focus of substance use treatment, which is to prevent and/or minimize future substance use rather than reoffending behaviors. Lastly, FY 2021 rearrest rates especially should not be used to evaluate program

efficacy. Due to the COVID-19 pandemic, FY 2021 saw many changes across the juvenile justice system, impacting actual and tracked criminal and delinquent behaviors. Recidivism rates decreased system-wide for most groups in contact with DJJ in FY 2021 (see the Recidivism section of the FY 2024 DJJ Data Resource Guide for more information). FY 2021 groups are much smaller than previous years; therefore, FY 2021 rearrest rates compared to those of previous years are more strongly influenced by the re-offense of only a few youth. While most rearrest rates increased in FY 2022, in FY 2023, all rearrest rates remained lower than or comparable to pre-pandemic rates (i.e., FY 2019).

4. Identifying the Most Effective Substance Use Disorder Treatment

Committed youth are assessed for treatment services at the Bon Air Juvenile Correctional Center (JCC), or at a Juvenile Detention Center (JDC), as a direct care placement by the Central Admission and Placement (CAP) Unit for the most appropriate level of substance use treatment. The process includes medical, psychological, behavioral, educational, and career readiness evaluations. Depending on the youth's individual needs, youth may be assigned to one or more treatment programs to include aggression management, substance use and/or sex offender treatment.

A new endeavor in FY 2025, DJJ launched clinical staff training for Seven Challenges, a comprehensive counseling program for youth and young adults that incorporates work on drug problems. Seven Challenges is a health decision-making model that guides youth through the process of weighing the benefits versus the harm of their drug use, and other behavior. Seven Challenges will transition to become JCC's primary substance use treatment program in FY2026 for residents with severe substance use disorders.

Prior to the launch of Seven Challenges, in FY 2025, male youth in JCC who were assessed as having a substance use disorder, as identified in the current version of the DSM, were referred for Track 1 substance use treatment, which was addressed through the CBT-MET Cannabis Youth Treatment Program. CBT and MET, otherwise known as Cognitive Behavioral Therapy, and Motivational Enhancement Treatment, are well known evidence-based treatment models for adolescents. Male youth who did not meet the DSM criteria for a substance use disorder but had a history of experimentation with marijuana and/or alcohol were referred to Track 2 services, which were provided through an individualized treatment plan that pulled from various resource materials.

Female youth who were assessed as having a substance use disorder, as indicated in the current version of the DSM, were referred to Track 1 services and received VOICES, a gender specific journaling-based program that focuses on a variety of topics. VOICES is designed using the foundational evidence-based practice of interactive journaling and is listed as a Legacy Program in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices. In addition to the above, all direct care youth are assigned to a therapist, and those youth with a co-occurring disorder can receive mental health treatment to address individual needs as applicable to their assessed risk, needs and responsivity.

For justice-involved youth in the community, Probation or Parole Officers coordinate a variety of services to achieve a balanced evidence-based approach to public safety, accountability and

competency development. For those youth in need of substance use treatment, community-based services are provided by public or private sector DSPs and may differ according to region and the availability of services.

5. How Effectiveness Could be Improved

DJJ will continue its launch of the Seven Challenges Program throughout FY 2026 as well as individualized treatment for direct care youth with co-occurring disorders.

DJJ also utilizes an RSC model that facilitates a continuum of services to youth and families across the state. This service model has increased DJJ's access to evidence-based models and pre-release services for direct care youth returning to the community on parole. This reentry and community-based service should continue their collaboration to ensure smooth transition of residents to the community, residential diversion and public safety.

DJJ has also adopted and is implementing an evidence-based program evaluation process, the Standardized Program Evaluation Protocol, (SPEP™). SPEP™ will allow DJJ to evaluate programs and services for their effectiveness.

6. An Estimate of the Cost Effectiveness of These Programs

Due to an inability to calculate per person costs, estimates are not available to address this issue.

7. Recommendations on the Funding of Programs

Program funding for youth in direct care with substance use treatment needs should continue. Addressing these needs is an important aspect of youth's overall treatment and preparation for reentry to their home communities.

Funding for community-based treatment, including for substance use treatment, should continue. Addressing these needs in the community is critical so that youth's usage does not worsen and lead to a need for in-patient treatment.

Virginia Department of Corrections (VADOC)

1. Amount of Funding Spent for the Programs in FY2025.

Treatment services expenditures totaled $11,846,342 for FY 2025. The table below displays how these funds were expended across VADOC programs.

FY 2025 Expenditures:		
Community Corrections Substance Use Disorder		$1,375,736
Spectrum Health:		$6,555,133
Appalachian CCAP	$455,917	
Brunswick CCAP	$462,595	
Cold Springs CCAP	$417,352	
Chesterfield CCAP	$462,595	
Indian Creek	$2,309,224	
State Farm Work Center	$485,692	
VCCW	$456,254	
Nottoway Work Center	$191,031	
Green Rock CC	$402,130	
Fluvanna CC	$12,832	
Greensville CC	$243,246	
Wallens Ridge CC	$282,423	
Pocohontas CC	$373,840	
Facilities (previously RSAT funded)		$1,114,089
Recovery Navigators		$242,964
Roving SUD Cognitive Counselors		$562,821
DOC SUD Support Team		$514,320
State Opioid Response Grant		$389,737
Opioid Abatement Authority Funding		$1,091,541
Total		$11,846,342

2. Unduplicated Number of Individuals Who Received Services in FY 2025.

As of June 30, 2025, there were 60,551 probationers/parolees under active supervision in the community. This data includes participants in the Community Corrections Alternative Programs (CCAPs), those on Shadowtrack Supervision, absconders, and those supervised in Virginia on out of state supervision obligations. The VADOC utilizes the Correctional Offender Management

Profiling for Alternative Sanctions (COMPAS) assessment tool for risk assessment and service planning. Data collected from this screening tool indicates that approximately 70 percent of those under active supervision who have history of substance use disorder (SUD) as indicated by scores of 'Probable' or 'Highly Probable' on the COMPAS substance abuse subscale.

SUD treatment services in the community are provided mainly by community services boards (CSB) and vendor partnerships. During FY 2025, 40 probation and parole districts received SUD treatment services through contracted providers while seven probation and parole districts utilized memorandum of agreements (MOA) with their local CSB. Six probation and parole districts used both private contractors and MOAs. Three community service boards (CSB) also provided access to a residential level of care.
Additionally, probationers/parolees also had access to community support/mutual self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Celebrate Recovery groups facilitated by community volunteers.

The Community Corrections Alternative Programs (CCAPs) continued to offer intensive and moderate SUD services at four locations. CCAPs were designed to offer Circuit Court judges an alternative to incarceration that provides intensive, residential treatment in a controlled setting. The goal of the program is to provide a structured environment where participants acquire and practice the skills necessary to sustain positive behavioral changes and long-term recovery. FY 2025 CCAP graduation data is not yet available. However, in the Calendar Year 2024, 468 participants graduated from a CCAP.

Throughout FY 2025, the VADOC continued to ensure that medications for opioid use disorder (MOUD) were accessible through consultation between the prescriber and patient. Both continuation of care and induction were offered. The VADOC can continue treatments initiated from a regional jail, adult detention center, or community provider with a MOUD product prescription. In FY 2025, the VADOC continued to offer Buprenorphine, Brixadi, Sublocade, Suboxone, Vivitrol, Naltrexone, and Methadone options.

In FY 2025, the VADOC offered two-dose Naloxone rescue kits to all inmates upon release from incarceration. Additionally, Narcan education was provided to all inmates as part of the Reentry Release Packet. This packet contained a wealth of information, including SUD treatment resources, Narcan distribution sites, and instructions on how to administer Narcan. A total of 2289 rescue kits were distributed during FY 2025. Beginning in May of 2025, in partnership with the Virginia Department of Health, the VADOC launch the Reentry Wellness Kit program. This program provides a wellness kit to every releasing inmate and CCAP participant. The Reentry Wellness Kits contain essential overdose response and health supplies such as Narcan, medication destruction packs, illicit drug test strips, and links to community resources. Since launch, 579 kits were distributed prior to the close of FY 2025.

The State Opioid Response (SOR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), of which VADOC receives as a sub-recipient through the Department of Behavioral Health and Developmental Services (DBHDS), continued funding for a large portion of VADOC's Peer Recovery Specialist (PRS) initiatives. During this reporting year, the VADOC continued to expand recovery services provided by state trained PRSs servicing both institutions and community. The VADOC continued two full time regional PRS positions and elevated the

third, part-time position to full time. These PRSs worked directly with probationers who have opioid use disorder, stimulant use disorder, or a history of overdose. They offered Revive training in their home districts. They also continued to engage the difficult to reach probationer population at times of crisis and supported the probation and parole staff in assisting the supervisee. They further support correctional centers with PRS trainings and CE credit opportunities for incarcerated Certified PRSs.

An average of 18 recovery groups statewide were facilitated by a mix of PRS vendors and VADOC PRS employees on a weekly basis during FY 2025, serving those under probation and parole supervision. This was comprised of approximately 200 participants from 15 probation and parole districts or Community Corrections Alternative Programs. The VADOC continues to contract the facilitation of the Virginia DBHDS PRS training in correctional centers statewide. In FY 2025, the VADOC trained 39 inmates in 7 different correctional centers to offer SUD peer recovery services. This program continued to provide inmate employment positions that offer recovery support to fellow inmates. Inmate PRSs offered coaching and support which augmented current residential SUD programs and expanded peer services to additional correctional centers. The Department has developed a process to offer supervision hours for inmate PRSs to facilitate certification. This practice will continue to enhance recovery access and create healing environments for those incarcerated individuals with SUDs. In addition, professional development has been offered to our growing PRS certified inmates which has included PRS Ethics training. The PRS initiative throughout the VADOC continues to shift the culture within corrections, destigmatizing the disease addiction.

In FY 2025, the District #31 Chesapeake Probation and Parole Office continued to offer the Intensive Opioid Recovery (IOR) program where probationers with opioid use disorder on community supervision can access specialized probation supervision. This included three SOR funded positions; one full time Senior Probation Officer, one Probation Officer, and a wage PRS. Both probation officers possessed advanced training and knowledge in the treatment of SUDs. This program utilized evidence based cognitive behavioral programs, specialized probation supervision, and peer recovery support to provide support to these probationers with opioid use disorders. During FY 2025, 27 supervisees participated in the IORP program. At the end of the fiscal year, 16 (59 percent) were still enrolled in the program, 11 (40 percent) were removed, and 6 completed the program. This program was decommissioned at the end of FY 2025. Since Medicaid expansion, treatment for opioid use disorder has become broadly available in the Chesapeake area. Most eligible probationers and paroles prefer to seek counseling and MOUD from a single Medicaid provider. This led to a decline in census and a decision to reallocate resources. VADOC was able to absorb the probation officers to retain their expertise in the district.

In VADOC Correctional Centers, as of June 30, 2025, there were 721 inmates participating in Cognitive Therapeutic Communities (CTC) programs at Indian Creek Correctional Center and the Virginia Correctional Center for Women. The CTC Programs offer comprehensive, daily programing to support those inmates needing the most intensive level of SUD services. The female CTC Program utilizes a gender responsive SUD curriculum, Helping Women Recover, along with the additional curriculum of Criminal Conduct and Substance Abuse. A Women's Way Through the 12 Steps is available on a voluntary basis. In FY 2025 there were a total of 1500 competitions across all 3 phases of these CTC programs.

The Nottoway Work Center continued to meet level one SUD needs during FY 2025. The 50-bed program is a modified CTC program that consists of assessments, individualized treatment plans, cognitive behavioral interventions for substance abuse supplemented with Spectrum Health curriculum, process groups and aftercare planning. For FY 2025, the program had 30 completions.

The Voluntary Substance Use Disorder Treatment Program (VSUDTP) is located at Green Rock Correctional Center and Indian Creek Correctional Center for male inmates and at Virginia Correctional Center for Women for female inmates. In FY 2025, the VSUDTP continued to provide intensive SUD programs, implementing a modified Cognitive Therapeutic Community (CTC) model. It provided treatment objectives, as appropriate, for a range of primary treatment services for alcohol and other drug use. This was for inmates who self-admit to using substances while incarcerated and volunteered for this program. The program utilizes SUD assessments, individualized treatment plans, evidenced based programs including Spectrum Health Systems Psychoeducational curriculum. The program includes drug education, relapse prevention/management, and peer led groups. FY 2025 had 133 inmates successfully complete VSUDTP at the three facilities.

In November 2023, the Department launched the Residential Illicit Drug Use Program or RIDUP at Greensville Correctional Center. This was a response to risks associated with illicit drug overdose. This program has provided an environment where illicit substances are highly unlikely to enter the unit, removing the temptation and creating safety for participants. RIDUP offers peer support and cognitive restructuring skills that reduce illicit substance use and overdoses within the inmate population. For FY 2025, there were 73 total participants and 52 completions. 14 participants remained enrolled in RIDUP at the close of FY 2025.

In response to the ongoing danger posed by fentanyl in carceral settings, December 2023 marked the Virginia Department of Corrections launch of the Fentanyl Response Program or FRP, at Pocahontas Correctional Center, followed by a high security Fentanyl Response Program at Wallens Ridge State Prison in March 2024. FRP is a four-month residential treatment program to support inmates who have had one or more positive drugs screens for fentanyl. This proactive approach to reducing overdoes and treating SUD has provided treatment programing and peer support to participants. Inmates who complete the program can move forward in sobriety and safety. For FY 2025, there were 222 total participants at Pocahontas with 69 completions. Wallen's Ridge had 105 participants with 73 program completions. Due to ongoing targeted efforts throughout the Virginia Department of Corrections, fentanyl related incidents have decreased. Therefore, the Fentanyl Response Program (FRP) beds at Wallens Ridge State Prison were absorbed by Pocahontas State Correctional Center to centralize the FRP program into one location. 61 participants remained enrolled in FRP at the close of FY 2025.

The VADOC opened an Aftercare Center in April of 2024 at Green Rock Correctional Center. This residential treatment community offers additional support for inmates who complete RIDUP or who complete FRP and are assessed as needing continuing care recovery support. The program provides 4-6 months of evidenced based SUD support including PRS support. This allows treatment participants to return to general population utilizing a phased approach that supports stable recovery. During FY 2025, there were a total of 169 total participants in Aftercare with 65 completions. There were 47 participants remain enrolled in aftercare at the close of FY 2025.

Throughout the Department, Cognitive Behavioral Interventions for Substance Use Adult (CBI-SUA) by the University of Cincinnati, is offered as an evidence based cognitive behavioral approach to treatment. Approximately 352 inmates completed CBI-SUA in 2025. This curriculum was designed for people involved with the criminal justice system who are at moderate to high need of substance abuse services. The curriculum includes 47 sessions. All six current roving SUD cognitive counselors have been trained in facilitating this curriculum. An additional 467 inmates completed the prior version of the program, Cognitive Behavioral Interventions for Substance Abuse (CBI-SA), which was still in use in some locations during FY 2025 as the updated program was being phased in.

To address the SUD treatment needs of inmates with moderate to low treatment needs and a limited time remaining in their prison sentence, Recovery Route was utilized as a program option. There were 1,089 Recovery Route completions in 2025. From FY 2024 to FY 2025, there was an increase of 944 combined CBI-SUA, CBI-SA and Recovery Route completions (964 combined completions in FY 2024). The VADOC employed six mobile SUD cognitive counselors. They provided SUD programming at institutions with higher ratios of inmates who scored probable or highly probable of having an SUD as assessed by the COMPAS substance abuse scales. Interactive Journals supplement SUD programs in the VADOC. The Medication Assisted Treatment (MAT) workbook from the Change Companies, saw 100 completions in FY2025. MAT journals are for individuals who are actively participating in VADOC's MAT programs.

The VADOC has deployed seven MAT Social Workers to coordinate care during incarceration and enhance a warm handoff from incarceration to the community for inmates engaged in Medication Assisted Treatment. Six of these positions were funded through the Opioid Abatement Authority grant funding. In FY 2025, their title was changed to SUD Social Worker to broaden their scope of support. For incarcerated individuals on MOUD, these social workers provided robust group and individual support. The SUD Social Workers were also responsible for leading collaboration between Health Services, Treatment, and Operations. The position also facilitated linkages to the community for a continuum of care post release. In FY 2025, 618 unique individuals were supported by an OAA funded SUD social worker in the VADOC.

Throughout the reporting period, Medicaid enrollments have been prioritized for inmates releasing from incarceration, as well as those on probation and parole. This effort ensured greater access to SUD services post release. The VADOC developed a comprehensive training for staff to increase enrollment efforts. From July 1, 2024 to June 30, 2025, there were 6,050 inmates eligible for Medicaid released from VADOC facilities who did not refuse coverage. Of these, 5,256 inmates were released with Medicaid (87 percent), 508 inmates had Medicaid in the past (8 percent), and 117 inmates had submitted applications for Medicaid (2 percent). Medicaid enrollment efforts play a vital role with reentry and ensure continuum of care for inmates and probationers in our custody.

In FY 2025, the VADOC completed production and released the *Recovery is Possible* video. This OAA funded project was created in collaboration with Bookend Creative. This video offers testimonials and educational information from incarcerated PRSs, SUD program participants, and staff members from across the Department. The video is now shown to all individuals intaking into the VADOC. It provides key inspirational stories and critical information for how to access SUD services during incarceration.

3. Extent Program Objectives Have Been Accomplished.

Assessment results for the inmate population have established the need for SUD treatment programs and services, with approximately 67 percent of inmates scoring probable or highly probable on the substance abuse scales of the COMPAS, and 70 percent of probationers/parolees with probable SUDs. According to the most recent SAMHSA National Survey on Drug Use, this is compared with approximately 17.5 percent of the general population, aged 12 or older having a SUD. To combat this rising tide of substance abuse, the VADOC continues to offer evidence-based treatment programs at all levels of care. Residential SUD treatment programs including the Cognitive Therapeutic Community Programs, Fentanyl Response Program, RIDUP, and Aftercare are available. Outpatient groups, self-help support groups, and interactive journals round out the available treatment options. In addition, the VADOC has grown PRS services in correctional centers, CCAPs, and probation/parole supervision. As mentioned, the Department has prioritized Medicaid enrollment to ensure treatment access. All existing SUD programs and services continue to be maximized. The VADOC has implemented a fidelity review process to assess and monitor the quality of vendor SUD treatment services in Community Corrections. The VADOC continues to utilize CORIS for data reporting/collection. The VADOC will continue to assess programs for fidelity and effectiveness and respond with SUD programing appropriate to the changing landscape. It is notable that the number of illicit drug overdoses in Virginia has dropped by 37.2 percent since 2021. This includes a 44 percent year-over-year drop in fentanyl-related overdose deaths in 2024. This resounding success has been the result of tireless work across Virginia's many committed state agencies, government officials, and private industry partners. The VADOC is proud to be a key part of this statewide stand against the Fentanyl crisis.

4. Identifying the Most Effective Substance Use Disorder Treatment.

The VADOC continues to utilize evidenced based programs for treatment of SUDs, as well as regular fidelity reviews of these programs. To maintain fidelity and effectiveness of SUD programs, the programs must be implemented as designed. The VADOC continues to emphasize fidelity, or quality control, to all SUD programs. This includes robust feedback and engagement with treatment providers at all program sites. These fidelity efforts are supported by traveling managers and ongoing program and curriculum development and auditing to ensure the highest quality of inmate support.

5. How Effectiveness Could be Improved.

The VADOC continues to face several challenges related to SUD treatment services:

- Limited specialized staff to address the impact of SUD on those under the care of the VADOC
- Challenges securing programming space in VADOC correctional centers
- Limited screening, assessment, and treatment resources for inmates with co-occurring mental illness and SUD
- Challenges with recruitment and retention of certified SUD professionals due to competitive opportunities in the Medicaid-funded private sector
- Reliance on grants for key sectors of VADOC's SUD treatment offerings including six of seven MAT Social Workers and three full-time PRSs serving those on supervision

- Limited staff to oversee expansion of the PRS initiative and reliance on SOR grant funding for the PRS initiative
- Limited number of administrative positions to supervise existing treatment offerings and expand capacity across the department
- Limited recovery housing options spread geographically throughout the Commonwealth, and limited funding for the housing options that do exist

Based on the challenges listed above, fully funding the VADOC's SUD treatment services would increase the number of inmates and probationers who may receive treatment and services. Furthermore, it would enhance the quality of the programs, thereby producing better outcomes and likely reducing recidivism and risk to overdose. Based on research cited below, the benefits of providing SUD programs for the incarcerated population can decrease overall healthcare costs once the individual is released. This includes costs for inpatient and long-term hospitalizations and emergency room visits. Additionally, inmates who successfully complete treatment and remain in active recovery are less likely to commit additional crimes which leads to reduced recidivism. This is a significant cost savings to the Virginia criminal justice system.

6. An Estimate of the Cost Effectiveness of These Programs.

While Virginia hasn't published a state specific SUD cost benefit analysis for incarcerated populations, emerging evidence from multiple states demonstrates that investing in SUD treatment during incarceration pays dividends. For example, the Washington State Institute for Public Policy (WSIPP) reports that prison-based treatment including therapeutic communities and cognitive behavioral models yield substantial net benefits. WSIPP calculates over $8,200 in total benefits per person treated when factoring in reduced crime, improved labor market outcomes, and lowered healthcare costs. Similarly, Kentucky's FY 2017 evaluation of DOC substance abuse programs estimated a $4.52 reduction in downstream costs for every dollar spent on treatment. WSIPP also found that outpatient treatment during incarceration delivers approximately $32.00 in benefits per dollar spent and remains one of the most powerful interventions for cost-effective crime reduction. We can see a clear alignment between these successes in other states and the SUD treatment ecosystem offered by the VADOC.

Medication-for-Opioid-Use-Disorder (MOUD) in correctional systems also reduces healthcare expenditures. According to SAMHSA, offering MOUD (such as methadone, buprenorphine, or extended-release naltrexone) in prisons and upon reentry significantly decreases emergency department visits, hospital inpatient stays, and overdose incidents.

Beyond economics, SUD treatment in correctional settings drives meaningful improvements in individual and community wellbeing. Participants typically report reduced illicit drug use. Kentucky data shows more than 56 percent remained drug free one year post release, and 56 percent avoided reincarceration. Program engagement also boosts re-entry success. In the Kentucky study 82 percent secured stable housing and nearly 67 percent found employment within a year. These factors are known to reduce recidivism.

SUD treatment for justice involved individuals is wise stewardship of public funds. In Virginia we can see the benefits of SUD treatment for incarcerated individuals, community engagement, and strong continuum of care referrals partially reflected in the current recidivism data. Virginia leads

the nation with a post release success rate of 82.4 percent, noting a recidivism rate of only 17.6 percent. For every dollar invested in SUD programs, states are seeing quadruple or more returns, fewer overdoses, higher employment rates, and safer communities. These findings provide a strong evidence base for expanding correctional SUD services.

7. Funding Recommendations

- Funding for the existing three PRS positions
- SUD Social Workers at all correctional centers to coordinate care and ensure a warm handoff for post release services
- Funding for three designated regional positions to offer supervision and expansion to SUD programs, both in institutions and community corrections, enhancing fidelity for the agency's SUD services
- Additional SUD Roving Cognitive Counselors to flexibly support SUD treatment needs in prisons
- Funding for SUD Specialists to support the probation and parole districts
- PRS positions to expand PRS services in correctional centers
- Funding for resources to provide co-occurring SUD and mental illness assessments, treatment, and post release continuum of care including recovery housing
- Funding for transitional recovery housing to provide aftercare and stability post release from an incarceration SUD program

Department of Medical Assistance Services (DMAS)

Please note: For the purposes of this report to the Council, DMAS is reporting outcomes based on SUD treatment services utilization, access and quality of care among Medicaid members for Calendar Year (CY) 2024, which overlaps with FY 2025 by six months. This is the most recent data that is available for DMAS to report.

The Department of Medical Assistance Services (DMAS) implemented the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017. ARTS expanded coverage of many substance use disorder (SUD) treatment and recovery services for members enrolled in Medicaid and Children's Health Insurance Program (referred to as Medicaid in this report), including Medications for Opioid Use Disorder (MOUD) treatment, outpatient treatment, short-term residential treatment, inpatient withdrawal management services and Peer Recovery Support Services. The Centers for Medicare and Medicaid Services (CMS) approved Virginia's application for a Section 1115 Demonstration Waiver for SUD to allow federal Medicaid payment for addiction treatment services provided in short-term residential facilities in December 2016. CMS approved a five-year extension of the waiver in July 2020 giving DMAS funding authority through December 31, 2024. DMAS submitted an extension application in July 2024 to CMS to renew the 1115 Demonstration for five additional years. This application is under CMS review, and CMS provided a one-year extension of the existing waiver to December 31, 2025 while that review continues.

Coverage of SUD services through ARTS is based on the American Society of Addiction Medicine (ASAM) National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (ASAM Level 0.5) to medically managed intensive inpatient services (ASAM Level 4). ASAM has released the fourth edition of the ASAM Guidelines, and DMAS is working to incorporate these new Guidelines. This includes a full review of the benefit including all policies and regulations, as well as coordination with other state agencies. As such, DMAS expects this process to take more than 12 months to complete.

ARTS emphasizes evidence-based treatment for opioid use disorder (OUD), which combines pharmacotherapy and counseling. Care coordination services provided by Preferred Office-Based Addiction Treatment providers (OBATs) and Opioid Treatment Programs facilitate integration of addiction treatment services with physical health and social service needs. "Preferred OBATs" refer to addiction treatment services provided by practitioners working in collaboration with licensed behavioral health practitioners providing co-located psychosocial treatment in public and private practice settings. The Preferred OBAT model was initially limited to individuals with a primary OUD diagnosis. Per requirements of Item 313 Section ZZZ of the 2020 Appropriations Act, DMAS expanded the model effective March 1, 2022, to allow for other primary SUDs.

CMS requires an independent evaluation for Section 1115 Demonstration Waivers, which includes the ARTS benefit. DMAS contracts with Virginia Commonwealth University (VCU) School of Medicine to conduct an independent evaluation of the ARTS program. Faculty and staff from the Department of Health Behavior have led the evaluation, which has focused primarily on how the ARTS benefit affected: (1) the number and type of health care practitioners providing ARTS services; (2) members' access to and utilization of ARTS services; (3) outcomes and quality of

care, including hospital emergency department and inpatient visits; and, (4) the performance of new models of care delivery, especially Preferred OBAT programs.

1. Number of individuals who received services in CY 2024.

Utilization of ARTS services continued to increase in CY2024. The table below details the growth in Medicaid members receiving ARTS services since the inception of ARTS in 2017:

Medicaid members served by ARTS since inception of benefit

Post – ARTS (Calendar Year)									
	Apr 2017-Dec 2017	2018	2019	2020	2021	2022	2023	2024	% change 2018-2024
Type of Service									
ASAM 1	8,991	13,215	31,273	39,129	46,300	51,901	57,055	58,972	346.3%
OBAT/OTP	1,805	4,012	11,447	15,007	17,014	17,941	16,858	15,732	292.1%
Care Coordination[1]	795	2,515	7,921	11,085	13,436	14,807	14,007	13,585	440.2%
ASAM 2	584	1,285	4,018	4,825	5,964	7,507	10,354	13,631	960.8%
ASAM 3	556	1,261	3,876	4,377	5,686	7,028	9,734	12,798	914.9%
ASAM 4	6	5	47	100	152	78	94	156	3020.0%
Case Management	641	930	2,842	3,975	4,241	4,445	5,069	6,676	617.8%
Peer Recovery Support Services	33	275	886	1,247	1,652	1,768	2,968	4,031	1365.8%

[1]Refers to care coordination services through OBAT/OTP providers.

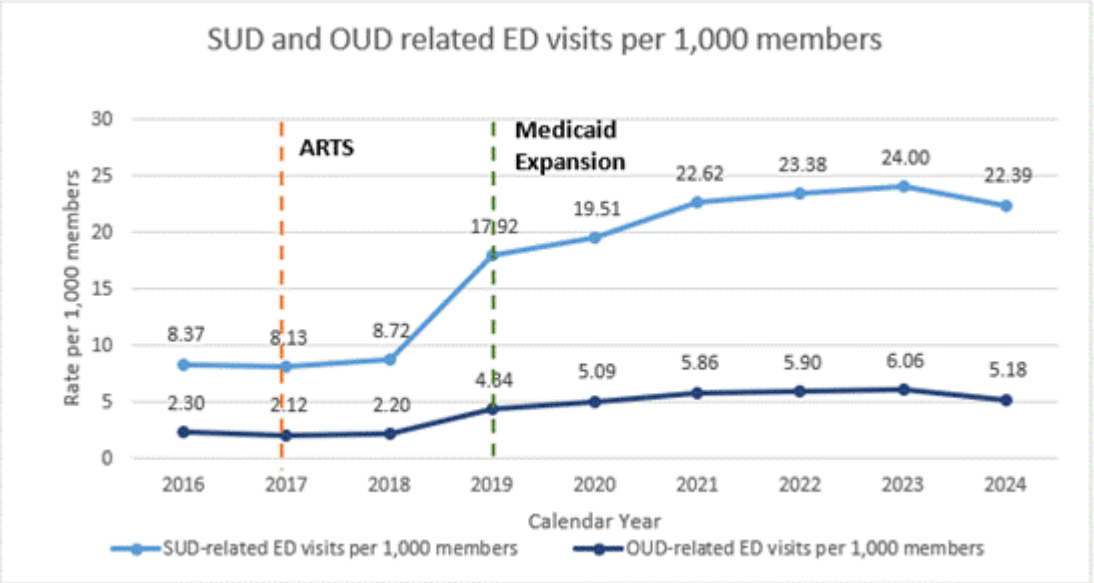
2. Extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures.

<u>The number and type of health care practitioners providing ARTS services:</u>
Eight years after ARTS implementation, the number of providers in the Medicaid network providing ARTS services to Medicaid members continues to increase. As of December 2024, there are more than 7,000 Medicaid-enrolled ARTS providers, which represents continued growth since the inception of ARTS.

ARTS Providers by Calendar Year, 2020-22

Service	2020	2021	2022	2023	2024
ASAM 1	5,058	5,703	6,088	6,541	6,484
ASAM 2	231	254	270	340	379
ASAM 3	52	72	75	84	99
ASAM 4	15	13	8	13	16

Outcomes and quality of care, including hospital emergency department (ED) and inpatient visits:



The performance of new models of care delivery, especially Preferred OBAT programs:

In CY 2024, 48,876 members received MOUD services from Medicaid providers, a 30.9 percent increase since 2020. Increases were seen in all modalities of MOUD, including buprenorphine, methadone, and naltrexone.

Number of Medicaid members with MOUD utilization

	Calendar Year								
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Members with MOUD use or OUD dx	14,505	18,190	22,661	37,233	44,424	50,979	55,481	57,161	58,172
Type of MOUD use									
Any MOUD	6,244	9,070	12,516	24,300	30,959	37,608	43,234	47,787	48,876
Buprenorphine	4,968	6,093	7,240	13,281	17,175	21,702	26,025	28,782	29,163
Methadone	709	2,402	4,719	9,878	12,506	13,740	14,175	14,717	14,998
Naltrexone	645	932	1,472	3,173	4,037	5,191	6,206	8,063	8,671

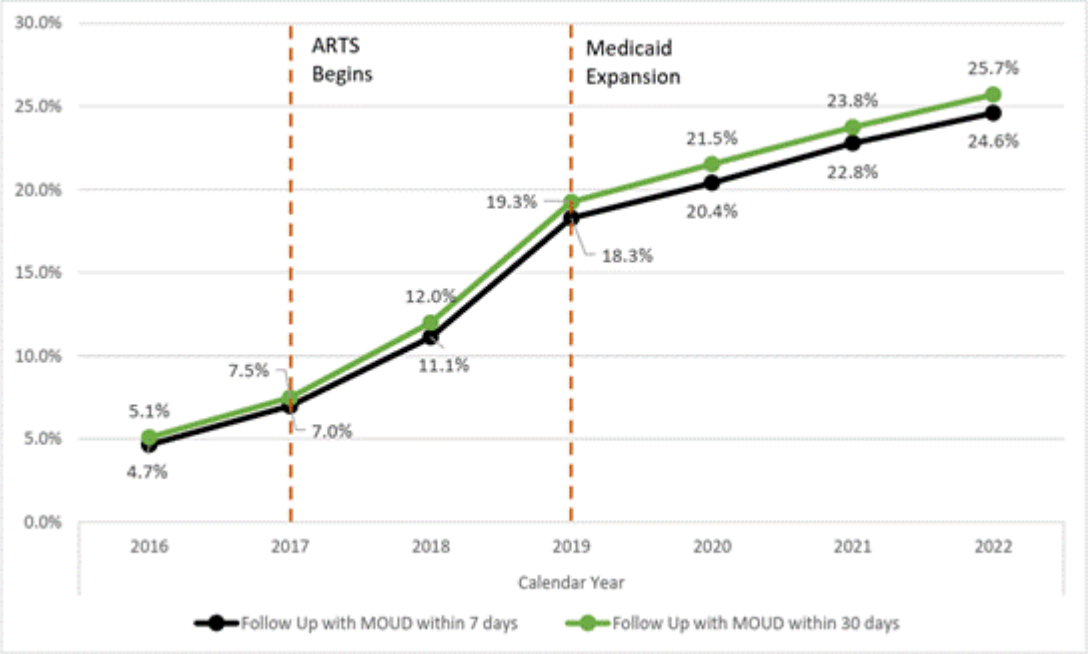
DMAS has also been working with community providers and pharmacists to address issues of buprenorphine access from pharmacies. Members and providers have reported being unable to obtain buprenorphine from pharmacies despite presenting with legitimate prescriptions for this important medication. DMAS participated in a cross-disciplinary effort convened by the Substance Abuse Mental Health Services Administration (SAMHSA) that convened Mid-Atlantic states to help determine the scope and cause of the problem and collaborate to identify opportunities to address them. Additionally, DMAS has worked directly with providers, pharmacies, and pharmacists to review buprenorphine access issues, including referrals to the DMAS Office of the Chief Medical Officer as well as Managed Care Organizations to monitor reported events to ensure that all policies are being followed.

3. Identifying the most effective substance use disorder treatment.

Treatment of OUD in the ARTS benefit is based on ASAM's National Practice Guidelines including a special focus on same day access for MOUD treatment. MOUD includes the use of buprenorphine, methadone, and naltrexone as part of evidence-based treatment for OUD. This method is considered best practice for treating OUD and has been found to be the most effective treatment in preventing OUD-related overdoses. To further increase access to buprenorphine treatment beginning in March 2019, DMAS removed prior authorization requirements for Suboxone films for in-network prescribers. In Fall 2021, DMAS also added the generic buprenorphine/naloxone tablet to the formulary. More detail about the utilization of MOUD services is included above.

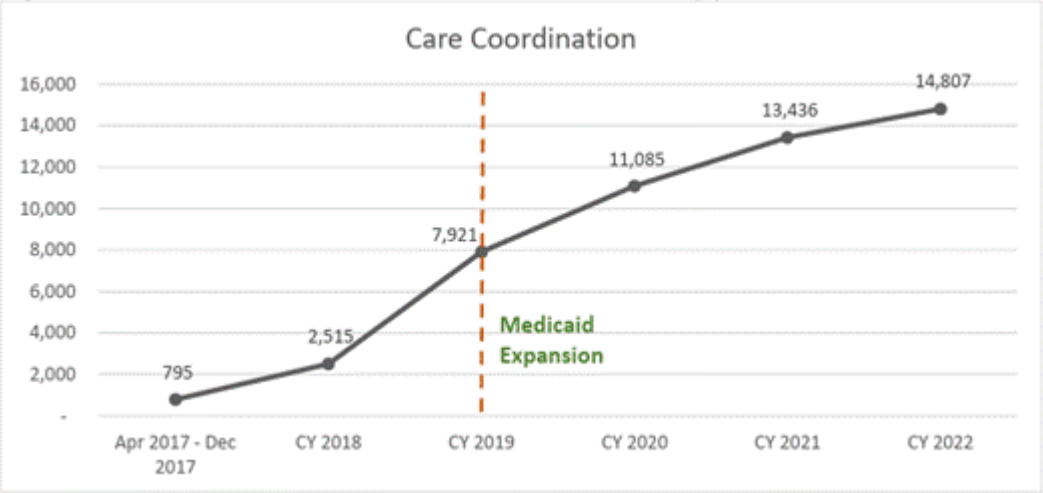
Through the work of the independent evaluators at VCU, DMAS has been able to identify effective substance use disorder treatments. An Interim Evaluation Report, prepared by VCU for the Centers for Medicare and Medicaid Services showed that there have been marked increases in the rates of MOUD treatment after an opioid use disorder-related emergency department visit. These data, commonly known as engagement and retention in treatment, are important indicators of an individual's likelihood of success in treatment and recovery.

Number of Medicaid members with MOUD utilization



As described above, Care Coordination is another vital component of the ARTS program, increasing interaction with members in recovery, providing connection to other behavioral and primary health care services, and improving transitions of care. As illustrated below, the Interim Evaluation Report shows that the utilization of this important component of the OBAT program has also seen marked increases in recent years.

Number of Claims for New Care Coordination Services, by Year



4. How effectiveness could be improved.

Medicaid Expansion – Access to SUD treatment services through the Medicaid program was further expanded on January 1, 2019, when Virginia implemented the Affordable Care Act's expansion of Medicaid eligibility for adults aged 19-64 to include those with family incomes of up to 138 percent of the federal poverty level. As of December 2024, 650,740 Virginians had enrolled in Medicaid through the expanded eligibility criteria, allowing thousands of Virginians to have access to services who otherwise would have not had access to this benefit.

Emergency Department Bridge Clinic Program – To strengthen the transition from post-overdose ED care to community-based treatment (for those individuals who chose to begin their recovery), DMAS continues its efforts to develop and expand the Discharge Bridge Clinic (DBC) program. The DBC program utilizes care coordination, electronic health records integration, telehealth, and other means to provide a direct link for an individual to follow-up community-based care, including a follow-up appointment that is scheduled for the individual before they leave the ED. Telehealth-compliant devices can also be provided to the individual to facilitate their participation in the follow-up appointment. DMAS originally supported this via a grant from the Centers for Medicare and Medicaid Services by engaging with two Virginia hospitals: Carilion Clinic in Roanoke and VCU Health in Richmond to support the implementation of this program.

DMAS has continued the development of the DBP program by applying to the Opioid Abatement Authority for ongoing implementation of this model of care. DMAS has been awarded funds to provide ongoing training and technical assistance focused on the bridge clinic model and intends to apply for funding in the future to incentivize hospitals and health systems to implement the program in their locations.

Access to Peer Recovery Support Services – A number of strategies have been implemented over the past years by DMAS, in partnership with public and private partners, to increase the utilization of Peer Recovery Support (PRS) services. One of the main strategies was an increase in the reimbursement rate for PRSS that was passed by the Virginia General Assembly in the 2022 session, allowing the Commonwealth to significantly increase the amount that providers receive

for providing PRSS, from $6.50 to $19.50 per 15 minutes for individuals and from $2.70 to $8.10 per 15 minutes for groups. DMAS also provided both general and provider-specific training and technical assistance to help providers navigate the challenges of onboarding PRSS as part of their continuum of care. DMAS held a PRSS symposium in October 2022 to continue to publicize this rate change and help providers implement this important service.

Reduction of Drug Overdoses – Strategies that DMAS focused on to impact fatal and non-fatal overdoses include but are not limited to the following: increasing the number of SUD and MOUD treatment providers; increasing access to MOUD in EDs and bridging access to outpatient care; increasing access to Medicaid enrollment and supporting re-entry transition of care for members are experiencing incarceration; increasing access to harm reduction services; increasing access to peer recovery support services; and adding treatment options for polysubstance use.

Review of emerging treatment opportunities – As part of Governor Youngkin's "Right Help. Right Now." Initiative, DMAS prepared an innovations brief, highlighting emerging opportunities that could improve the effectiveness and overall outcomes of treatment for individuals with SUD, including additional dosing options for buprenorphine, contingency management for individuals with stimulant use disorder, and starting buprenorphine treatment in other settings such as emergency response and inpatient hospital settings.

5. An estimate of the cost effectiveness of these programs.

DMAS is monitoring expenditures for ARTS services and measuring quality of care through quality measures reported quarterly to CMS. As part of upcoming program evaluations, VCU, an independent evaluator for the ARTS program, will be including cost analyses into overall program evaluation design. VCU also has prior year ARTS evaluation reports available that provide more details about evaluation activities, which can be found here: https://hbp.vcu.edu/policy-briefs/arts-policy-briefs/.

6. Funding recommendations based on these analyses.

- Continued expansion of ARTS services as aligned with "Right Help. Right Now." through provider and community engagement efforts;
- Expanded person-centered treatment approaches that address the social and psychological risk factors for the recurrence of drug use;
- Continued workforce training for evidence-based practices for SUD treatment and recovery.
- Continued expansion of DBC programs;
- Continued partnership with state and local legal/carceral organizations to strengthen transitions for members upon release from incarcerated settings;
- Continued expansion of access to and provider/member understanding of best practices in telemedicine treatment services;
- Continued expansion of Peer Recovery Support Services provider capacity and service utilization; and
- Support harm reduction providers to promote Medicaid enrollment and service engagement for eligible individuals.