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Premier Mental Health, Mental Retardation, and Substance Abuse Services in Virginia's Communities

Policy and Funding-Substance Use Disorders Treatment and Prevention

VACSB

September 25, 2008

SJR 77 Subcommittee

Outline

- Overview of Key Points
- Impact of Substance Use Disorders
- Treatment Efficacy and Capacity Issues
- Virginia Milestones
- Evidence-Based Practices; Treatment and Prevention Services Systems in Transition
- Funding, Services, Costs
- Prevention as a First Step
- Conclusions
- Funding Options for Prevention and Treatment

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Key Points

- Untreated Addiction Can Be Fatal and Its Costs Are High
- Both Prevention and Treatment of Substance Use Disorders are Cost Effective and Have Demonstrated Efficacy
- Most Services in Virginia are Evidence-Based, but Not All Evidence-Based Practices are Available to the Citizens of Virginia, and No Community has a Full Continuum of or Adequate Capacity for Providing Evidence Based Practices
- Community-Based Prevention and Treatment Services Funding has been Historically Low and Erratic, Directly Affecting Service and Workforce Capacity
- New View of Prevention-Across the Life Span
- Treatment Services are Transitioning from an Acute Care Model to a Chronic Disease – Recovery Management Model

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Impact-Substance Use Disorders

- Over 517,000 Virginians aged 12 or older are dependent on or abuse drugs or alcohol, or both
- 138,000 need but do not receive treatment for drug abuse or dependence
- 424,000 need but do not receive treatment for alcohol abuse or dependence
- In FY 2007, CSBs served 53,905 Virginians with SUD
- SUD involved in 70% of all child abuse and neglect cases

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Impact-Substance Use Disorders

- SUD involved in over 50% of violent crimes
- SUD involvement for 70% of those in local and state correctional facilities
- Estimated cost to society of SUD in 2002 was $181 Billion
- Of this, $107 Billion associated with drug-related crime
- Treatment options remain limited and treatment and prevention funding historically low

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Treatment Efficacy

According to OIG Report-August 2006, of consumers with a LOS of 1.7 years in outpatient treatment services:

- 91% saw decrease in A/D use
- 64% were employed
- 86% had stable housing
- 81% had no drug-related arrests or convictions

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Treatment Capacity: OIG Report

- **Over 70% of CSBs reported no or inadequate capacity** in the following, all of which have an evidence base:
- Detox, Medical or Social
- Medication Assisted Treatment
- Day Treatment, Intensive OP
- Residential
- Case management
- Services for those incarcerated

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Treatment Capacity: OIG Report

- Elimination of SABRE Funding from FY 2002 to FY 2003 resulted in the lost of 92.62 staff positions, the elimination of 36 service programs, and the capacity to treat 13,161 clients (6,425 youths, and 6,736 adults).
- Current average wait for treatment services is 25.4 days (OIG Report, 2006)

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Historical Milestones

- 1970's - Substance Use Disorders added to Department and CSB mission
- 1980's - Heavy Reliance on Federal Block Grants - Heavily regulated
- 1988 *Make Waves* initiative added General Funds for SUD treatment services
- Perception, attitudes and stigma have influenced policy and funding, or lack thereof

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Milestones: 1990's

- 1990s - Managed Care, *reduced insurance coverage for addiction treatment* - loss of capacity and the demise of 30-day residential programs
- Late 1990's - Governor Gilmore introduced the Substance Abuse Reduction Efforts (SABRE), to address the need for Substance Use Disorder Treatment among those in the criminal justice system
- SABRE resulted in increased service capacity, including expanded detox and residential capacities
- Public and private providers began contracting with public safety and Criminal and Juvenile Justice System agencies

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Milestones: 1990's, *cont.*

- Private providers and CSBs developed SUD professionals and certified counselors
- Hall-Gartlan Subcommittee recognized that *Treatment Works* and brought deeper understanding of SUD
- Mercer study of SUD Medicaid service potential reported to Hall-Gartlan. General Assembly responded with funding
- SAARA of Virginia is formed – advocacy has a name – *the Substance Abuse and Addiction Recovery Alliance*

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Milestones: 2000's

- General Assembly legislation included substance use disorder in insurance parity (disease-based research)
- Strong self-advocacy and recovery movement takes root with SAARA, Substance Abuse and Addiction Recovery Alliance, establishing local chapters in many communities throughout Virginia
- 2002-2003 budget deficit policy decisions meant *abrupt elimination* of SABRE funds and delay in implementing Medicaid coverage for SUD treatment services
- Private provider capacity severely damaged and CSB capacity compromised; some programs went out of business

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Treatment and Prevention Services In Transition

- Prevention Services must involve the broader community, focus on multiple indicators of community health, and target the entire life span
- Treatment services, to date, have primarily been delivered in an *acute care model* of intervention: treat someone as quickly as possible, stabilize the acute stress and return them to the community
- Treatment services must transition from the acute care model to a *Chronic Disease – Recovery Management Model* of service delivery
- Treatment and recovery outcomes are most effective when people are engaged in both formal, structured treatment and ongoing self-help support groups

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Key Principles of Effective Treatment

- <u>When the person is ready, treatment is available</u>
- Treatment is recovery-focused
- Peer support, such as 12 step, effective in recovery
- No single treatment is appropriate for all individuals
- Effective treatment attends to multiple needs of the individual - wraparound approach
- Remaining in treatment for an adequate period of time is *critical* for treatment effectiveness
- Individual's treatment needs/recovery progress is monitored regularly and services and supports modified to address these changes

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Key Principles of Effective Treatment

- Medications can be an important element of treatment
- Treatment does not need to be voluntary to be effective
- Counseling is an essential component of treatment
- Other health conditions related to addiction, such as TB, HIV and hepatitis B&C, addressed
- Integrated treatment for Individuals with co-occurring mental illness and substance use disorders
- Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment

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Key Principles of Effective Prevention

- Engages the entire community, not just the schools, and the focus is expanded to view prevention services across the lifespan
- Aim is to build protective factors, promote resiliency and decrease risks
- Incorporates public health research and evidence-based prevention programs to build capacity utilizing a five step plan:

  Assessment ➔ Capacity Development ➔

  Planning ➔ Implementation ➔ Evaluation

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EBPs and Transformation

- Numerous treatment and prevention practices have been shown to be effective – *evidence-based practices and programs* (e.g., Al's Pals, Too Good for Drugs, Use of Certain Medications in Treatment, Drug Courts, Provision of Wrap Around Supports, Contingency Management)
- Adoption of innovative, evidence-based practices (EBPs) *requires* organizational culture change, extensive training and supervision, and consistent leadership support
- Additional costs of implementing EBPs includes initial and ongoing training, purchase of proprietary materials, expanded types and amounts of supervision, recruitment of qualified staff, purchasing appropriate medications or manuals, and evaluation

Current SUD Funding - CSBs

- Approximately $42.9 Million in Substance Abuse Treatment and Prevention Block Grant Funds , heavily regulated
- Approximately $42.4 million in General Funds, the last increase thanks to members of the General Assembly
- $13.7 M in fees (Insurance, Medicaid, sliding scale fees)
- $41.7 M Local funds - specific localities only

Current SUD Funding - CSBs

- Thanks to the General Assembly action and persistence, certain SUD services are now Medicaid-reimbursable
- CMS, not DMAS, responsible for limiting billing units and the circumstances under which services can be reimbursed
- DMAS responsible for rate setting, and staff credentialing and documentation requirements
- Services have been difficult to "jump start" – billable units very different than for MH and MR, units; staff not all appropriately credentialed, can't bill in certain circumstances

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SUD Funding: Federal BG

SAPT Block grant funds require the following minimums:

- 70% Treatment
  - Priority admission to pregnant and parenting women and persons who inject drugs
- 20% Prevention

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SUD Services: General Funds

General Fund allocations support:

- Crisis Intervention
- Outpatient
- Case management
- Residential
- Day Support
- Employment
- Assessment/Monitoring
- Peer Recovery Support

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SUD Funding: Medicaid

Medicaid will reimburse the following services, for certain people (*Medicaid eligible and enrolled*) under certain conditions (e.g., *not in residential treatment or other IMD, not in jail*):

- Intensive Outpatient
- Case Management
- Crisis Intervention
- Day Treatment
- Psychiatric Services
- Opioid Treatment

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Other Effective Technologies

- Drug Courts: *21 in Virginia* – completion of drug courts results in less than 5% felony recidivism rate with adherence to program
- Individuals in Recovery able and encouraged to provide professional or peer recovery support services through public and private providers
- New Crisis stabilization programs may have detox capability
- Specialized criminal justice system services, provided on-site, such as at Probation and Parole offices

Challenging Developments

- Most rapidly growing Addiction is to prescription medications, especially prescription pain medication, e.g., Oxycontin
- Varied OTC drug use and abuse
- Steady loss of detox and residential capacity statewide, for the past decade
- Decrease in outpatient capacity for primary SUD Services

Positive Developments

- Medications that assist treatment (e.g., naltrexone, buprenorphine)
- Disease-based research continues
- Project Remote in SW Virginia
- SAARA chapters strong within state as advocates and support services partners
- Public figures have experienced the issue within family or with friends and are talking more openly about it

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Cost of Services: Outpatient

- Outpatient or Intensive Outpatient services, with ongoing Wraparound Supports (transportation, child care, peer supports) and Case Management, costs an average of $10,000 per person for one year, as a package of bundled services.
- 18 months to two years is the recommended length of active treatment
- Includes assessment, planning, screens, intensive counseling, transportation, child care, vocation, employment, case management
- Less costly than extended and repetitive stays in jail or state correctional facilities

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Costs of Services: Residential

- Medical detox - $286 per day (41 beds)
- Social detox - $328 per day (96 beds)
- Residential - $171.95 per day (522 beds) LOS-45 days for clinical efficacy
- These services, immediately followed with adequate Outpatient Services, have profound impact for life changes

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Preventing ATOD Use

Funding

- Federal Block Grant (SAPT) to VA of $43 million - $8 million is required allocation for Prevention
- State Funds allocated to CSB Prevention $0
- Total estimated Prevention funding is $21.5 million as compared to Treatment funding of $175.3 million, from all sources
- Prevention funding has decreased by 16% during the past five years

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Costs of Underage Drinking in Virginia: 2005

- Youth Violence $541.5
- Youth Traffic Crashes $385.1
- High-Risk Sex, Ages 14 to20 $117.1
- Youth Property Crime $53.4
- Youth Injury $43.5
- Poisonings and Psychoses $11.4
- **Total Cost** **$1.226 Billion**
- $1,706 per year for each youth in Virginia

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Alcohol consumption by Youth in Virginia

- Approximately 319,00 underage youth drink alcohol each year in Virginia generating $418 million in sales
- In 2005, underage drinkers consumed 14.8% of all alcohol sold in Virginia
- 76% of 12th graders reported that they had used alcohol at some point during their life
- 44% of 12th graders reported that they had used marijuana at some point during their life
- 25% had their first drink before age 13
- 18% had five or drinks in a row in the past 2 weeks

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Effective Prevention Programs Benefit Youth

- JLARC reported 25 studies confirming positive outcomes from prevention programs ranging from 2 to 15 years after program completion.
- A review of substance abuse prevention studies published indicate that 76% of the prevention programs reviewed produced positive results.
- All Community Services Boards in Virginia utilize Prevention Programs which have been evaluated and proven effective.
- Effective Prevention Programs are identified by SAMHSA, D.O.E. and the Department of Juvenile Justice

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Un-served and Underserved Populations Needing Prevention Services

- School Dropouts (59%)
- Children of Substance Abusers (42%)
- Delinquent Violent Youth (39%)

Conclusion:

Increased funding for proven Prevention Programs will serve high-risk youth and reduce incidence of abuse

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Conclusions

- Demand for prevention and treatment services far exceeds the supply
- Untreated addiction can be fatal and costs over a billion dollars annually
- Appropriate treatment is effective and less costly than incarceration
- Prevention and treatment is especially critical for youth, families and society
- Stable CSB prevention and treatment network must continue and expand

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Conclusions

- Implementation of Recovery-Focused Systems of Care is just beginning and needs to continue
- Use of evidence-based practices and evaluation of services are each critical to overall success
- Local Prevention Coalitions must have the tools to benefit their communities
- Stabilized private provider base is essential
- Increased funding is needed for broader implementation of evidence-based prevention and treatment strategies

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Increased Funding Options

- Establish Substance Abuse Treatment & Prevention Fund: Require ABC Board to deduct five percent of net profits to be paid into this Fund; represents out-of-pocket costs of no more than pennies to the consumer. Estimated $93,000,000.00 generated in first year.
- Direct dedicated Tobacco Settlement funding through DMHMRSAS for CSB Prevention Programs
- Direct additional (new) revenue *from new ABC stores and Sunday opening* through DMHMRSAS for treatment and prevention
- Increase user fees on tobacco and alcohol products:

  Estimate .each10 per pack increase- $6 M

  Estimate .10 per bottle alcohol increase- $77M

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Why Increased Funding?

- Over 517,000 Virginians, 12 and older are dependent on or abuse alcohol and/or drugs yet CSBs could serve only 53,905 of those Virginians
- Estimated cost to society of SUD in 2002 was $181 Billion in VA
- $107 Billion associated with drug-related crime
- Total cost of underage drinking in VA is $1.226 Billion
- Revenues can be obtained from some of the substances that profit from addiction
- Prevention and treatment costs less and produce healthy results!

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Useful Resources

- http://www.dmhmrsas.virginia.gov/documents/reports/OSAS-BiennialReport2004-2005.pdf
- http://www.oig.virginia.gov/documents/SS-SAOP129-06.pdf
- NIDA: Principles of Drug Addiction Treatment: A Research Based Guide
- NSDUH 2006http://oas.samhsa.gov/2k6State/Virginia.htm