

# ***VERMONT2007***

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## *Substance Abuse Treatment*

Report to the Legislature on **Act 65**  
January 15, 2008



**DEPARTMENT OF HEALTH**  
**Agency of Human Services**

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## **Executive Summary**

In accordance with **Act 65**

### **The Task Force's Charge:**

Review the treatment services currently in place and identify how to integrate them into a more systematic response to addictive problems.

Work with staff to analyze the population projected to be in need of treatment services and create a design for the services needed in communities by level of care, and to support long-term recovery. This plan should be based on the Blueprint for Health Chronic Care approach.

The Substance Abuse treatment summer study concluded that substance abuse care in Vermont currently uses an acute, episodic care approach, rather than a chronic care system as described in the Blueprint for Health. Challenges continue to exist in availability of adolescent treatment, as well as outpatient treatment for adults. An aging workforce compounds a lack of available, well-trained staff. At the same time, the State of Vermont has had great success in establishing medication assisted treatment, with 800 % more physicians waived than any other state in the country. Methadone treatment slots have been increased from 0 in 2002 to 475 in late 2007, although all clinics still report waiting lists of varying lengths. Treatment specific to women and adolescent treatment slots have been established at Valley Vista, which opened in 2003 with 18 adolescent and 42 female slots. These two groups of clients are thus now able to access treatment within the state.

The governor and the legislature worked together to maximize the number of student assistant professionals (SAP's), so that nearly every secondary and high

school that applied to have an SAP was funded. The CRASH<sup>1</sup> program has seen a consistent decrease in DUI deaths, from 37.33 on average in the years 1995-1997, to 29.00 on average in the years 2003-2005. A second weekend DUI program, fulfilling the requirements for reinstatement of a driver's license, was established in 2004. Due to a collaborative effort between ADAP, Fletcher Allen, the Lund Center and Howard Center, women who participated in methadone or buprenorphine treatment programs received much earlier and higher quality pre-natal care, the results of which are reflected in a significant reduction of infants born addicted to illegal drugs, at a great savings to the citizens of the state. Finally, the application paperwork requirements for ADAP funding for preferred providers have been dramatically reduced, thus freeing up resources to be focused on clients. In order to take the momentum gained by these successes and use it to tackle the challenges we are still facing, the study group recommends that a standing committee be charged to develop a 5-year strategic services plan to be presented to the legislature within a year. Current treatment services were mapped by district, the compiled lists of services, due to their size, are located electronically at [healthvermont.gov/adap/treatment/SubstanceAbuseTreatmentAdvisory.aspx](http://healthvermont.gov/adap/treatment/SubstanceAbuseTreatmentAdvisory.aspx)

[healthvermont.gov/adap/treatment/SubstanceAbuseTreatmentAdvisory.aspx](http://healthvermont.gov/adap/treatment/SubstanceAbuseTreatmentAdvisory.aspx)

**Vision for the Future & Stakeholder Impacts:** In five years, we envision Vermont to have a well respected, evidence-based behavioral health system supported by accountable and balanced federal and state funding. Consumers will rely on a “No Wrong Door” model to easily obtain needed, high quality community-based services and supports in all regions of the state. The system will be characterized by short wait times for and strong linkages between services, as well as an adequate and sufficiently trained workforce. There will be consistent communication between all parts of the system, so consumers transition smoothly through a comprehensive continuum of services. Precise monitoring approaches and quality assurance methods will be in place throughout the system to assure accurate treatment and medical records, as emphasized in the Blueprint for Health. Development of appropriate treatment services as alternatives to incarceration will be priorities for preferred providers.

**Recommendations:**

- Develop an official advisory committee to offer consumer and provider stakeholder input, leading to a 5 year plan for substance abuse treatment, intervention and recovery supports.<sup>2</sup> This plan should continue the work of the initial group and be presented within a year to the Health Care Access Oversight Committee, with updates following annually thereafter.
- Increase intake assessments of clients with standardized, validated tool at the community level from 2% to 100% within 30 days prior to residential treatment.<sup>3</sup> Just as the Blueprint for Health is modeling in the Chronic Care approach, this assessment will guide the treatment plan and follow the client through various stages and levels of treatment.
- Ensure physicians are adequately trained and knowledgeable in the use of medication for alcoholism and other drug addictions as funding permits.
- Ensure adequate numbers of community-based outpatient clinicians to help address gaps in services as funding permits.
- Evaluate need for long-term substance abuse treatment services as funding permits.

- Redirect patients out of the criminal justice system into a comprehensive health care approach that is holistic and adequately addresses physical, mental health and substance abuse issues as funding permits. Develop multiple points of diversion in order to meet the needs of the patient as appropriate.
- Re-assess program eligibility criteria for entrance into promising Department of Corrections programs as funding permits to ensure they serve the greatest number of citizens in the programs already funded, such as ISAP.
- Workforce development:
  - Support, as funding permits, the work needed to best position the Workforce Development Committee to be a part of the AHEC loan repayment program.
  - Re-evaluate the financial assistance that used to exist for scholarships as funding permits. Although loan repayment is helpful with retention, recruitment remains an urgent need.
  - Address salary and career ladder issues as funding permits.
  - Support counselors as an integral part of assuring the best care for clients as funding permits.
  - Review and, where indicated, streamline state paperwork requirements.

Where **substance abuse** can be defined as the continued use of a substance despite negative consequences,<sup>4</sup> **addiction**, a chronic brain disease, involves compulsive behaviors. Addicts often use substances in larger amounts or for longer periods of time than was intended; unsuccessfully try to cut down or control substance use; spend a great deal of time in activities to obtain substances or recover from their use; continue to use despite knowledge that the substance use is causing physical or psychological problems. Brain imaging studies from substance-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.

Similar to other *chronic, relapsing* diseases, such as diabetes, asthma, or heart disease, substance addiction can be managed successfully.<sup>5</sup> And, as with other chronic diseases, it is not uncommon for a person to relapse and begin abusing substances again. Relapse, however, does not signal failure—rather, it indicates that treatment should be reinstated, adjusted, or that alternate treatment is needed to help the individual regain control and recover. Empirical evidence suggests that addiction and substance abuse treatment effects, as with other chronic conditions, diminish after care stops. Retention is essential, as patients who are out of contact are at elevated risk for relapse. In the chronic care model early, intensive stages of treatment prepare patients for later, less intensive care. Symptoms and function determine care intensity with a goal of self-management. The standard of care during treatment is continued evaluation and monitoring, with improved functioning leading to continued care, while diminished function leads to a change in care.

The Blueprint for Health<sup>6</sup> aims to refocus health care from a reactive to a proactive system, in which preventing illness and complications, rather than responding to acute health emergencies only, are central.<sup>7</sup> A recovery-oriented continuum of care<sup>8</sup> for addictions moves the patient from screenings and brief intervention to detox and stabilization as indicated, followed by rehabilitation and continuing care/recovery support. Over 90% of rehabilitation today takes place in outpatient settings. Research suggests that clients that receive care for 90 days have better results than clients that receive care for fewer days. Recovery support services can be provided in many settings, such as an adjunct to outpatient treatment or in recovery centers. Recovery support and continuing care are critical elements in the continuum of care. Intervening with patients who are beginning to relapse as early as possible is an important part of recovery support.

**Funding history:**

Alcohol and Drug Abuse Program expenditures have grown significantly over the past few years, driven largely by residential treatment costs, which have more than doubled since SFY2002. See the appendix for graphs detailing expenditures.

**The review of treatment services revealed:<sup>9</sup>**

The gateway to services for clients should usually be the outpatient system, where they can be screened, assessed and referred to an appropriate level of care. Where community-based care meets client needs, financial savings can be realized over residential treatment. However, based on ADAP estimates, the outpatient treatment capacity is insufficient in all areas of the state for both adolescent and adult populations, leading to waiting lists and gaps in services. There is limited access to medication assisted treatment across the state, while some parts do not have any services at all.<sup>10</sup> These ADAP estimates also indicate that ample residential treatment is available within the state for those clients whose needs cannot be met in outpatient settings initially. With adolescents, we even have difficulty filling the current residential capacity. Increased focus is needed in the areas of community screening, assessment, and engagement in treatment.

Treatment services are challenged by discontinuity of information, so that patients may receive multiple assessments by different providers, or their assessments and treatment plans may not follow them from a community level of care to residential treatment and back into the community for aftercare.<sup>11</sup> This highlights the need for a consistent, reliable medical record information system as advocated by the Blueprint for Health.

**Population projected to be in need:**

The prevalence of other drugs in Vermont is relatively low compared to alcohol, tobacco, and marijuana. Given a careful analysis of the data available, comprised mainly of NSDUH (National Survey of Drug Use & Health) and YRBS (Youth Risk Behavior Survey) this study group concluded that approximately 50,000 Vermonters are in need of substance abuse treatment services. It is unknown how many are treated by primary care providers, as they are not obligated to report to ADAP's data system. Research suggests that some people reach recovery without treatment, an avenue that remains insufficiently explored.<sup>12</sup>

**Workforce preparation:**

Professionals providing addictions treatment in Vermont engage complex clients with many needs. These clients are involved in a variety of systems, including corrections, physical health, child welfare, and mental health. Addictions research has led us to a deeper understanding of best practices, including the recognition that services for clients in need of both addictions and mental health treatment have to be provided in an integrated fashion. The increased complexity of clients has also led to changes in education and training to adequately prepare the work force. Thus a higher education degree and on-going training to ensure competency in addictions and co-occurring disorders are essential for professionals. During this time of increased work demands, salaries have not been able to keep pace with many other professions. Additionally, we have an aging workforce with inadequate numbers joining as new professionals. These workforce issues must be addressed in order for Vermont's treatment system to provide service to clients in need.

**Evidence-based alternatives to Corrections:**

The Department of Corrections' Intensive Substance Abuse Program (ISAP) is an Intermediate Sanction Program operating in the community, as well as within correctional institutions. Integrating treatment and supervision has been shown to be effective in both keeping people out of jail and keeping their recidivism rates lower,<sup>13</sup> all at a cost of \$21.40 per client for each group session. However, the Department of Corrections has significant numbers of people with serious substance abuse problems that are not eligible for ISAP. Often, they are on a low level of probation since they have been convicted of a lower level crime. These individuals would likely benefit from receiving coordinated treatment in community programs or with independent providers, potentially reducing their recidivism rates. Other states have had good results with rewards systems that offer incentives for treatment compliance.

Drug/Treatment courts provide an intensive regimen of substance abuse treatment, mental health services, wrap around case management, drug testing, job skills training,

educational services, housing etc. These programs have led to lower rates of recidivism among graduates, as well as lower rates of drug-positive babies being born to mothers in the program,<sup>14</sup> at a savings of an estimated cost of \$1M over the lifetime of each child.<sup>15</sup> As the evidence shows, addicted parents involved in the drug courts increase their income levels, their health status and their parenting skills over time. These results, therefore, are encouraging both for the parent generation and the future aspirations of their children.

In FY07, the CRASH<sup>16</sup> program provided education to nearly 2600 individuals, and assessed almost 2500 of those same people, who had been stopped for operating a motor vehicle under the influence of a substance. This program requires individuals to pay their own education and assessment expenses and generated an income to the State of over \$170,000. Those in need of treatment were referred for further assessment and treatment.

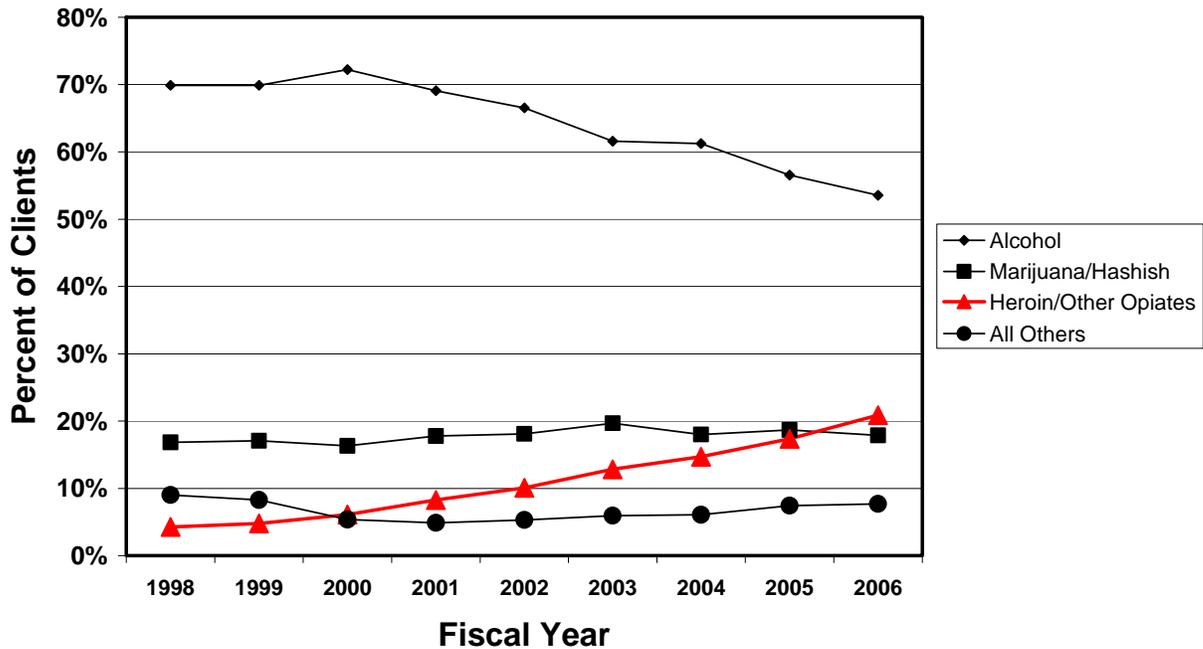
### **Background**

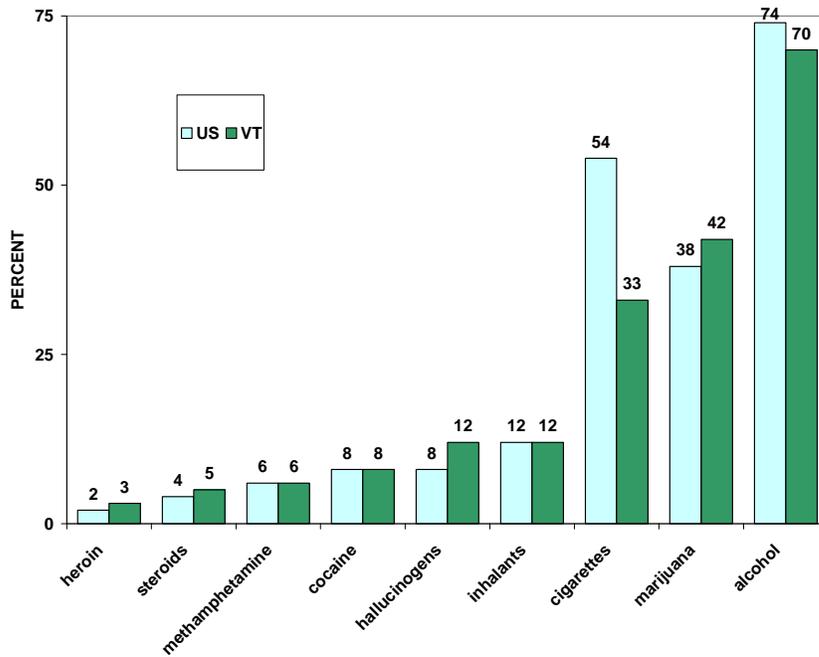
Alcohol and marijuana remain the top drugs of abuse in Vermont, a trend which has been stable over the last several years. Increasing non-medical use of prescription opiates is a disturbing trend. Graphs detailing use by substance and age group can be found in Appendix A.

**Appendix A: ADAP statistical data**

The following chart shows the prevalence of primary substances of abuse for Vermonters receiving treatment by fiscal year. All prevalence rates are relatively low compared to alcohol and marijuana.

**Primary Substance of Abuse of Vermonters in Substance Abuse Treatment by Fiscal Year**



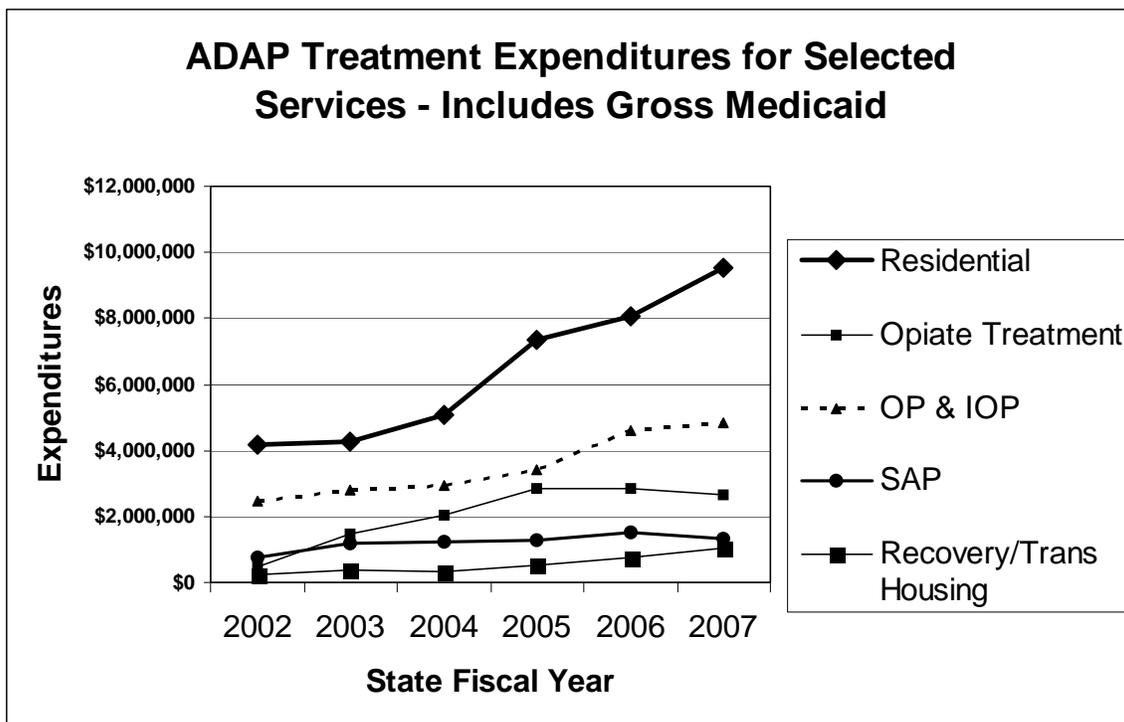


The following chart shows the lifetime prevalence of alcohol, tobacco, and other drugs among Vermont 9-12<sup>th</sup> graders compared to 9-12<sup>th</sup> graders in the US. This chart illustrates the low prevalence of illegal drug use relative to alcohol, tobacco, and marijuana. It also compares VT with the US, illustrating little difference except for cigarette (VT significantly lower) and marijuana use (VT significantly higher).

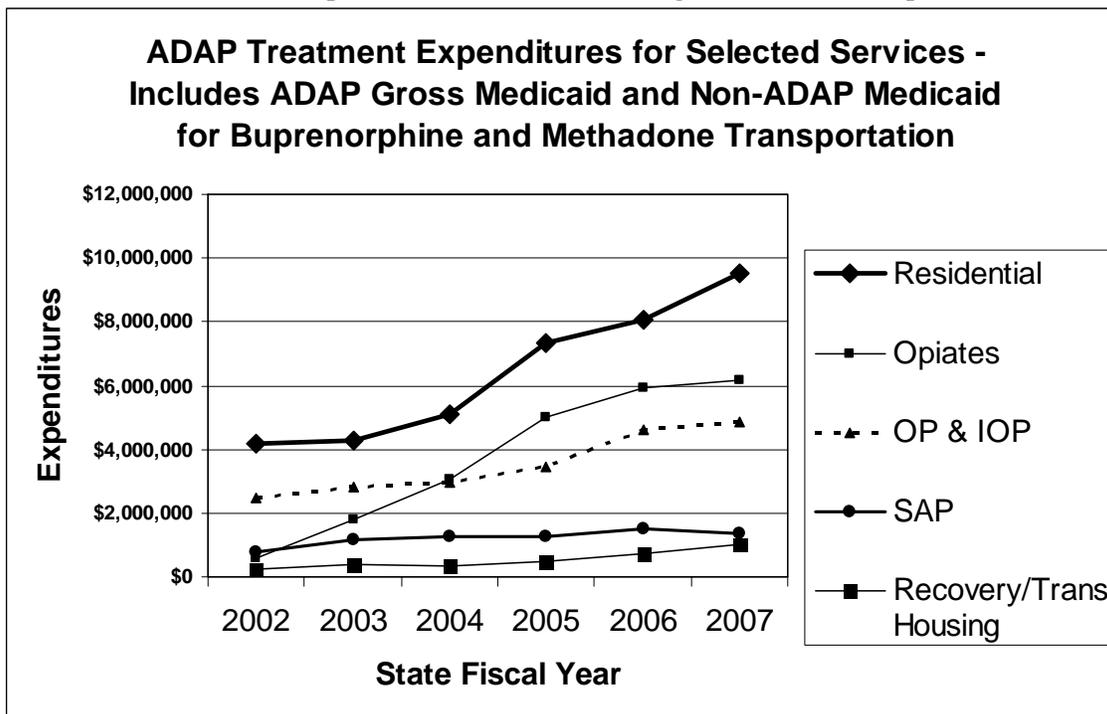
Percent of 9-12<sup>th</sup> Grade Students Who Report Ever Using Drugs (Source: Youth Risk Behavior Survey, Vermont Department of Health)

**ADAP TREATMENT EXPENDITURES** (as of 11/19/07)

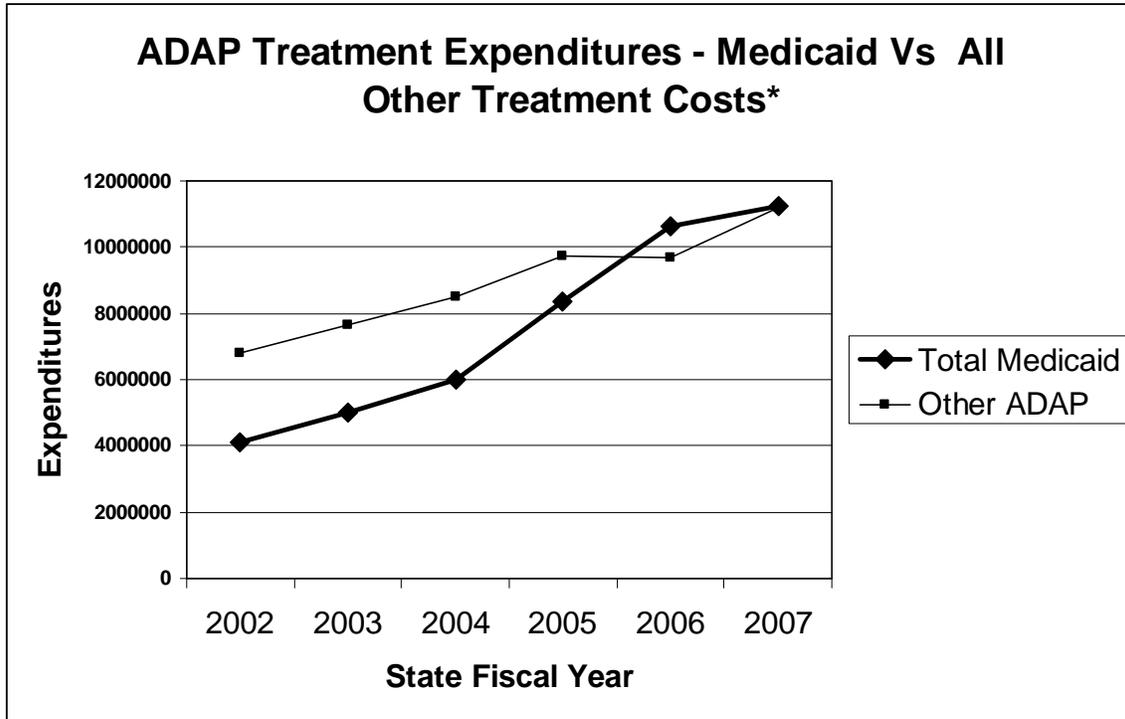
ADAP expenditures have grown significantly over the past few years driven largely by residential treatment costs which have more than doubled since SFY2002.



The graph above does not include the drug costs associated with buprenorphine treatment or any of the Medicaid transportation for methadone clients because these are not included in the ADAP appropriation. When these expenses are included, opiate-related costs overtake OP/IOP expenditures as the second-highest treatment expense.



Medicaid expenditures have increased more rapidly than other sources of funding.



\*Other treatment costs in this graph include all expenses allocated through the state accounting system so this includes all personnel costs, administrative allocations, non-direct treatment expenses, etc. Medicaid is gross Medicaid costs – both State and Federal portions

**Medicaid Expenditures by Category FY20-FY07**

Category	2002	2003	2004	2005	2006	2007
Res	\$2,379,943	\$2,631,693	\$3,140,543	\$4,729,467	\$5,504,465	\$6,004,442
OP	\$1,104,566	\$1,230,520	\$1,209,072	\$1,483,627	\$2,301,850	\$2,424,128
Opiates	\$79,042	\$470,753	\$966,910	\$1,183,702	\$1,672,523	\$1,742,232
IOP	\$434,380	\$555,088	\$589,011	\$794,038	\$960,409	\$937,298
Cs Mgmt	\$4,412	\$53,860	\$91,662	\$127,065	\$170,837	\$137,541
Misc	\$110,417	\$47,992	\$21,897	\$33,633	\$36,275	\$14,022
<b>Total</b>	<b>\$4,112,759</b>	<b>\$4,989,905</b>	<b>\$6,019,095</b>	<b>\$8,351,532</b>	<b>\$10,646,358</b>	<b>\$11,259,663</b>

**ADAP Treatment (Non-Medicaid) Expenditures by Category FY02-FY07**

Category	2002	2003	2004	2005	2006	2007
Residential	\$1,781,439	\$1,655,069	\$1,954,657	\$2,617,179	\$2,555,559	\$3,522,638
Personnel/Special Grants/Misc	\$1,658,215	\$923,714	\$1,381,080	\$999,737	\$1,214,135	\$1,668,574

Student Assistance	\$757,541	\$1,167,811	\$1,249,730	\$1,271,445	\$1,505,344	\$1,340,140
Outpatient	\$768,723	\$834,447	\$959,921	\$948,768	\$1,040,399	\$1,181,055
Opiates	\$415,629	\$991,525	\$1,083,797	\$1,650,109	\$1,157,907	\$931,182
Public Inebriate	\$654,025	\$608,450	\$613,050	\$586,025	\$658,675	\$649,400
Special Populations	\$273,322	\$721,081	\$564,613	\$619,926	\$457,885	\$534,046
HW/Trans Housing	\$247,019	\$306,196	\$209,122	\$208,137	\$444,828	\$516,955
Recovery	\$0	\$90,000	\$127,000	\$295,230	\$304,000	\$510,426
IOP	\$175,768	\$182,365	\$200,805	\$210,181	\$291,675	\$295,300
Case Mgmt	\$78,492	\$203,898	\$211,087	\$199,439	\$162,998	\$89,827
<b>Total Non Medicaid</b>	<b>\$6,810,173</b>	<b>\$7,684,556</b>	<b>\$8,554,862</b>	<b>\$9,606,177</b>	<b>\$9,793,406</b>	<b>\$11,239,542</b>

Between 2002 and 2007, the average client cost for direct services more than doubled from \$991 to \$2,147 per client. If we include the costs associated with Medicaid transportation and the cost of the buprenorphine itself, the cost change is greater – from \$1000 to \$2357 per client. For the purposes of these calculations all clients in the SATIS system were included because of the fluidity of the payment responsibility of substance abuse clients. State funding generally makes up over 70% of most substance abuse treatment facility budgets so without state funding, these programs would not exist.

These cost increases are largely driven by the higher needs of opiate-addicted clients and the increased use and cost of residential treatment.

**Appendix B: Vermont Provider Statement**

The following document outlines the recommendations of the Vermont Association of Addiction Treatment Providers as provided by their president, Jon Coffin.

Vermont Association of Addiction Treatment Providers (VAATP)

**99 Ricks Road**

**Plymouth, VT 05056**

**Summer Study Committee on Substance Abuse Programs**

**Vermont Department of Health**

**Division of Alcohol & Drug Abuse Programs**

**108 Cherry Street**

**P.O. Box 70**

**Burlington, Vermont 05402-0070**

**Dear Committee Members:**

**The following is a summary of the collective concerns of the VAATP. The VAATP is made up of the major substance abuse treatment agencies throughout the State of Vermont. Our overriding position this year is that some of our citizens in Vermont are miserable and dying from alcohol and drug abuse. We accept any role we have had in not passionately communicating the fact that citizens are dying and that we can in many cases, move them toward recovery. We commit to becoming involved in articulate, focused, across the board dialogue on this subject this year. Our specific concerns and recommendations that address the concerns are as follows:**

**Funding for Existing infrastructure is not adequate:**

Though there has been some attention to this issue, current funding does not adequately support supervision, oversight, and access management (intake). Mandated technical management, program development and state mandates around such issues as “best practice” changes or “assurances” have occurred with inadequate funding in support of new developments.

Recommendation:

We are not looking for a free ride or a handout. We are looking for base funding to plan our services. Provider reimbursement rates must be adjusted annually and should reflect all legitimate costs, including financial support for intake and supervision at the best-practice-rate of seven staff to one supervisor, either through a formal rate setting procedure or some other consistent and fair process.

**The problem of substance abuse has not been adequately presented to state stakeholders:**

We have not articulated the dilemma of substance abuse and addiction to the state agencies and other stakeholders which affects our ability to provide services to our clients, who by definition have a chronic, recurrent illness, and are likely to collapse within five years without sustained treatment and recovery activity. We must improve collaboration and mutual understanding with the state, as well as encourage interdepartmental interface. We have not adequately communicated the obstacles we face in getting clinicians in front of clients to both our state funding sources and legislators.

Recommendation: Invite leaders of the Health Department and key legislators to shadow clinicians for two days with a designated agency/contractor. Educate our decision makers about the clinical process and the demands and difficulties that are presented in the process.

**Funding for increasing caseloads of poor Vermonters needing both inpatient and outpatient treatment is inadequate:**

Programs often are well into the fiscal year without any information about whether they will be paid for services. There are many occasions when the provider has used up their grant and/or Medicaid allotment prior to the end of the fiscal year. The situation places the provider in a position where they may have to decrease, withhold services, or provide services at no cost in hopes that the cost will be covered later in the year, or simply suffer the loss.

Recommendation: There is clear evidence that treatment works. We ask the State to commit to funding treatment for those who cannot pay.

**Audits/Licensing/Program reviews are cumbersome and duplicative:**

Many programs are subject to a much more rigorous national accreditation review than the state's review, yet we must also devote considerable time and effort to prepare for a state review that repeats much of the national accreditation.

Recommendation: We need to maintain a focus on client treatment and recognize that accountability is important, but needs to take as little time as possible in order to keep the clinician available to provide services to the client. We think it is now clear and obvious to many that there should be one review from an internal or external (to the State) source, but not more than one. This will meet the requirement, but in the paraphrased words of Chairperson Senator Bartlett, "Let's not operate under the illusion that anyone is being helped or clinicians and programs are being enlightened as a result of these ludicrous audits." National accreditation should be accepted as sufficient evidence of compliance in place of dual review by ADAP, unless a program has no national accreditation, in which compliance would fall to the state.

**Information flow to the state is inadequate:**

The State's computer system does not work to accurately reflect data. Occasional local provider data systems also create problems when trained staff leaves or aging systems develop problems. All providers have experienced reductions in payments due to census disagreements involving computer interface (with the ADAP data system not accurately reflecting the data the provider submitted).

Recommendation: End utilization/fee-for-service as a Quarter-to-Quarter funding criteria. Have programs submit unilateral, documented data to the State as the basis for payments (the State system is dependent on such submissions anyway). The State can audit periodically to assure accurate reporting.

**There are serious questions about whether the current system is sustainable and capable of supporting and adequate availability of clinicians and support staff to meet the increasing needs of Vermonters needing services:**

Recommendation: The State should develop, in conjunction with the provider system advocates and consumers, a mutually agreed upon strategic plan that addresses the long-term sustainability of the substance abuse system of care.

**Funding is always a difficult issue and a challenge for policy makers, yet it is clear that it will be difficult to address the financial needs of the system, in spite of the evidence that treatment works and reduces long term costs.**

Recommendation: Despite sophisticated legislative guidance to the contrary, do indeed consider at least a discussion of the absence of a designated tax—such as a beer tax, after a decade and a half of no increases. This would serve as a statement firing a round across the bow of the “problem,” and be an inspiration to the Treatment Providers

Recommendation: Work with the State’s congressional delegation to assure that federal mandates that drive up costs elsewhere also include attendant funding for outpatient and inpatient treatment. For example, recently SAAS announced \$17 million to go to 50 states to encourage “enforcement of underage drinking laws.” Without funds for treatment to accompany such mandates, we merely identify a problem and spend money admiring it, but take no effective action to reduce it.

Recommendation: To ease spiraling Agency operating costs, explicitly explore possibilities to leverage the State’s buying power. Leveraging healthcare and malpractice plans could save 33-50% of cost to Agencies. Currently, 10 staff cost an Agency roughly \$100,000 in healthcare expenditure.

We appreciate having the opportunity to present our concerns to the Summer Study Committee and we are very willing to work with you to address the need to treat all Vermonters suffering from substance abuse disorders.

Please contact me for clarification or concerns at (802) 488-6116 or email me at

[JonC@howardcenter.org](mailto:JonC@howardcenter.org)

Sincerely,

Jon Coffin, President, VAATP

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<sup>1</sup> Countermeasures Related to Alcohol Safety on the Highway.

<sup>2</sup> The team suggested the following issues be addressed by the advisory committee: Develop a cohesive review mechanism for all State substance abuse services; develop and implement practices for better management of continuum of care and links between levels of care; develop rewards for quality care, so that funding is allocated by outcomes rather than by volume (access to care and length of time in treatment are important quality indicators); review feasibility and usefulness of web-based services for screening and intervention; increase screening and referral by primary care physicians; protect the investment people have made in their own recovery by ensuring that recovery services and opportunities are widely available; ensure emergency services are available for all patients; apply/integrate the AHS quality standards as they are adopted.

<sup>3</sup>In FY07, fewer than 2% of clients admitted to residential treatment received diagnosis and evaluation services in the 30 days prior to admission to treatment. These statistics do not include private provider assessments, as they do not report data to ADAP.

<sup>4</sup> <http://www.nida.nih.gov/scienceofaddiction/addiction.html>

<sup>5</sup> <http://www.nida.nih.gov/Infofacts/understand.html>

<sup>6</sup> **Blueprint Vision:** “Vermont will have a comprehensive, proactive system of care that improves the quality of life for people with or at risk for chronic conditions. The Blueprint will: utilize the Chronic Care Model (CCM) as the framework for required system changes; utilize a public-private partnership to facilitate and assure sustainability of the new system of care; and coordinate with other statewide initiatives to assure alignment of health care reform efforts.”

<sup>7</sup> The Chronic Care Model, a national model for collaborative care and quality improvement, includes an active role for individuals, communities, the health care and public health systems, and provider practices.

**Insert website**

<sup>8</sup> As demonstrated to be effective by the Treatment Research Institute: <http://tresearch.org>

<sup>9</sup>The charge to the task force reads: “The Department of Health shall convene a high level task force to include representation and participation from members of the preferred provider treatment system, to review the treatment services currently in place and to identify how to integrate them into a more systematic response to addictive problems.

The task force will work with staff to analyze the population projected to be in need of treatment services and will create a design for the services needed in communities by level of care, and to support long-term recovery. This plan should be based on the Blueprint for Health Chronic Care approach.

The analysis shall be evidence-based and project numbers of people that can be diverted from more expensive and crisis-oriented services if we build a more continuous, recovery-based system of supports. Of particular interest is savings that can be realized in the Department of Corrections.

The analysis shall also look at workforce preparation and what needs to be done to develop a mechanism for clinicians to be certified to treat co-occurring mental health and substance abuse disorders.”

<sup>10</sup> Travel time, according to the AHS – OVHA Interagency Agreement for Global Commitment to Health Waiver: “No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers.”

<sup>11</sup> ADAP conducts yearly site visits to ensure that programs are meeting the minimum standards set forth via Title 8, Chapter 107, S4089b and S4099 of the VSA. Although The Commission on Accreditation of Rehabilitation Facilities (CARF) conducts site visits, their focus is on administrative oversight rather than clinical oversight. CARF accreditation alone, due to this focus, is not sufficient for dispensation of block grant funds. Of the 25 site visits conducted by ADAP in 2006, 13 sites met full compliance requirements, 9 met conditional compliance (they had deficiencies and were awarded a certificate for fewer than six months-the remainder of the certificate was awarded when they demonstrated that these deficiencies were corrected.). The remaining three entered 2006 with a certificate that was expiring in 2007.

<sup>12</sup>Journal of Studies on Alcohol, March, 2002 , Gallus Bischof: “Epidemiological studies in various countries give evidence that the majority of changes in the addiction field take place unassisted, revealing rates of unassisted recoveries between 66.7% from alcohol dependence in Germany (Rumpf et al. 2000b) and 77% from problem drinking in Canada (Sobell et al. 1996).

<sup>13</sup>ISAP has a capacity of 350 clients in 35 tracks around the state. Average monthly utilization rate for '07 was 232, yielding an annual utilization rate of 67%. This rate reflects an emphasis on gender/trauma-informed treatment, with all-female treatment groups that are small as women are incarcerated in significantly lower numbers than men. Client completion rates are 67%. Total cost to DOC for each group session per client \$ 21.40 per session. Statistically significant differences exist in recidivism between offenders who completed vs non-completers after a one-year period: 10% for completers; 21% for non-completers. Two years out: 22% for completers; 34% for non-completers. Three years out: 30% for completers; 47% for non-completers.

<sup>14</sup> **Results:** In Chittenden County, 12 of 15 women graduates had no new charges, 3 of 9 male graduates had no new charges. In Rutland, 12 of 15 women had no new charges, 8 of 10 men had no new charges. In Chittenden County, 5 drug free babies were born of mothers in the program, while in Rutland there were 4 drug-free babies.

<sup>15</sup> OJP Drug Court Clearinghouse at American University, Estimated Costs related to the Birth of a Drug and/or Alcohol Exposed Baby. March 2002.

<sup>16</sup> Countermeasures Related to Alcohol Safety on the Highway.

Study Group Members:

Barbara Cimaglio, Deputy Commissioner Health Department

Meika Zilberberg, VDH

Susanna Weller, VDH

Anne VanDonsel, VDH

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Bob Bick, Howard Center  
Bill Young, Maple Leaf  
Bill Carris, Senator  
Barbara Rachelson, Lund Center  
Annie Ramniceanu, Spectrum  
Anna Saxman, Defender General's Office